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| **PURPOSE:**  The implementation of evidence-based early recognition and invasive/non-invasive treatment guidelines for Severe Sepsis and Septic Shock for patients presenting on admission through our Emergency Department and those developing severe sepsis or septic shock within our inpatient units. Treatment guidelines follow those recommended by the Surviving Sepsis Campaign, a workgroup of the Society for Critical Care Medicine and the European Society of Intensive Care Medicine and are updated accordingly. |
| **DEFINITIONS:**  *SIRS (Systemic Inflammatory Response Syndrome):* The clinical syndrome that results from a deregulated inflammatory response or to a noninfectious insult.  *Sepsis:* SIRS that is secondary to infection that has been diagnosed clinically.  *Severe Sepsis:* Sepsis plus at least one sign of hypoperfusion or organ dysfunction (see below), that is new, and not explained by other known etiology of organ dysfunction.  *Septic Shock:* Severe Sepsis associated with refractory hypotension (BP<90/60) despite adequate fluid resuscitation and/or a serum lactate level>4.0 mmol/L.  *Presentation Time:* Initial time of recognition of severe sepsis (SIRS and organ dysfunction). Emergency Department presentation is judged to be a patient’s triage time unless clinically evidenced otherwise. All other presentations rely on the time at which signs, symptoms, and laboratory findings are first consistent with the above definitions of severe sepsis/septic shock.  *Sepsis Treatment Handoff Tool:* A form that allows for the nurse to document and pass in report the time that severe sepsis is identified and that the protocol is started.  *Comfort Measures Only (CMO):* An order that supports a dignified, comfortable and natural death without life sustaining intervention. This refers to the medical treatment of a dying person where the natural dying process is permitted while assuring maximum comfort.  **Roles and Responsibilities:**  *House Supervisor –* Point person of Code Sepsis Team. Serves as resource for primary nurse to follow tracking tool and clarify any questions about the requirements of the core measures.  *Primary Nurse –* Either the ED or inpatient nurse primarily responsible for the patient. Routinely screen patients for severe sepsis at appropriate points of care. If a patient is identified with severe sepsis, notify both house supervisor and provider, then initiate severe sepsis tracking tool and work closely with house supervisor and provider to coordinate care of patient per core measure guidelines.  *ED Triage Nurse –* Initial sepsis screen in triage. Communicate to primary ED nurse the results if sepsis screen positive.  *ED Physician –* Identify any patients with severe sepsis not accounted for by nurse screening process. Respond to nursing identification of severe sepsis to coordinate care for patients consistent with the core measures guidelines by ordering the necessary tests and treatments as well as appropriately documenting the diagnoses and plan of care. Provide direct oversight for mid-level practitioners caring for severe sepsis patients.  *Inpatient Provider –* Identify any patients with severe sepsis not accounted for by nurse screening process. Respond to nursing identification of severe sepsis to coordinate care for patients consistent with the core measures guidelines by ordering the necessary tests and treatments as well as appropriately documenting the diagnoses and plan of care. |
| **POLICY:**  Patients are screened for signs and symptoms of SIRS, sepsis, severe sepsis and septic shock as defined by the SEP-1 measure. Adult screening criteria and protocols are applied to all patients except IV therapy and with special considerations in Women and Newborn Care as outlined below.  **Screening Process**  **In the Emergency Department:**   * + Triage nurse assesses all patients for possible sepsis using electronic or paper screening tool and primary nurse reassess if labs obtained.   + If patient screens positive for sepsis, provider should consider workup for underlying organ dysfunction possibly including LFT’s, coagulation studies, lactate level, and cultures as indicated. If positive sepsis screen, begin the Sepsis Treatment Handoff Tool.   + Both ED primary nurse and ED attending are responsible for appropriate hand off to inpatient primary nurse and admitting provider.   **In the inpatient units:**   * Patients are screened for severe sepsis by nurse using either the paper or electronic screening tool upon admission and PRN based on clinical suspicion with support from electronic surveillance tools as available. * If patient screens positive for severe sepsis, nurse to notify house supervisor, admitting provider, and other team members as needed for discussion regarding plan of care and any orders needed. Nurse also to initiate Sepsis Treatment Handoff Tool to be maintained using the house supervisor as a resource. * Once patient has screened positive and Handoff Tool initiated, do not continue screen. * **In the WNC unit**   Inpatients are screened upon admission and under following circumstances:   * Preterm premature rupture of membranes (PPROM) * Rupture of membrane (ROM) for undetermined amount of time * Confirmed or suspected infection (UTI/Pyelonephritis; undiagnosed abdominal pain such as appendicitis, pancreatitis or cholecystitis; influenza, wound or surgical incision infection; meningitis, pneumonia, mastitis, endometritis). * Or as needed based on change in patient condition (i.e. elevated temperature, hypotension, increasing fetal heart rate baseline). * If a patient screens positive for severe sepsis, nurse to notify house supervisor, admitting provider, and other team members as needed for discussion regarding plan of care and any orders needed. Nurse also to initiate Sepsis Treatment Handoff Tool to be maintained using the house supervisor as a resource. * Once the patient has screened positive and Handoff Tool initiated, do not continue to screen.       **Treatment**    Treatment will be driven by SEP-1 Criteria and Surviving Sepsis Campaign recommendations with care tailored to individual patient care needs.  **Code Status Discussion**   * Providers encouraged to address code status with all patients with severe sepsis or septic shock. * If patient is DNR, goals of care should be discussed early on in the course of severe sepsis or septic shock. A decision to make a patient “Comfort Measures Only” should be clearly documented in the patient’s chart (either in notes, orders, or both).   **Exclusion Criteria**   * Patients for whom the interventions in the protocol are clinically contraindicated. * Patients with Advance Directives in place at the time of care which preclude any of the protocol interventions. * Patients for whom the patient or surrogate decision maker declined or is unwilling to consent to such interventions. * Patients enrolled in IRB approved clinical trials for which trial interventions are inconsistent with established protocols. * Pediatric patients <18 years old.     **Education**   * Nursing Staff – Severe sepsis recognition and treatment training are incorporated into new employee orientation and learning assignments. * Resident, Licensed Independent Practitioner and Attending Staff – Severe sepsis recognition and treatment training are incorporated into new employee orientation and learning assignments. |
| **REFERENCES:**  Rhodes A, Evans LE, Alhazzani W, et al, Surviving Sepsis Campaign: International Guidelines forManagement of Severe Sepsis and Septic Shock:2016. *Intensive Care Med.* 2017;43(3)304-377.  doi:10.1007/s00134-017-4683-6 |