SEPSIS

(2 SIRS + suspected/documented infection)

SEVERE SEPSIS/SEPTIC SHOCK

(2 SIRS + suspected/documented infection + organ dysfunction **or** provider documentation of severe sepsis or septic shock)

CMS GUIDELINES

NURSE ROLE	PROVIDER ROLE
Acknowledge BPA for Sepsis Notify Provider	
Within ONE HOUR: Draw Labs: Blood Cultures x 2 (2 different sites), Lactate level, CBC, CMP, CoAgs, Procalcitonin *** must document if any problems in obtaining lab work***	
	Assess Patient for Sepsis or Septic Shock
	Use Sepsis Order Set-order fluids, antibiotics or additional testing.
RN must document start and stop of all fluids *RN –let provider know if fluids were given by EMS prior to arrival.	If SBP < 90 or Lactate > or = 4 must give 30ml/kg fluids (0.9% NS or LR) order must include type of fluid, amount, rate or timeframe to give it.
Vital Signs 2 sets must be done within one hour of conclusion of the 30 ml/kg fluids	Must give Broad Spectrum Antibiotic within 3 hours of presentation
Document Antibiotic Given start and stop time. ** Blood cultures must be drawn prior to antibiotics**	Repeat volume status and tissue perfusion assessment **Use .sepsis exam** ** must be done within 6 hours of presentation of septic shock
Lactate > or = 2 Repeat lactate within 4 hours. (obtain provider order)	Order Repeat Lactate level
Fill out Sepsis Transfer form Report to RN-lab results, amount of fluids given, antibiotics given, time next lactate level is due.	Report to Attending

INPATIENT

Obtain Detailed Report from ED RN- Time Sepsis identified, blood work done, amount of fluids given (any additional fluids need to be given), antibiotics given (any others to be given) Next lactate level due	Report from ED Provider Admission orders –add repeat labs, fluids or antibiotics that must be given

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Suspect SEPSIS Save Lives

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