Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline
Sepsis (Adult)

qSOFA – 2 or more of the following:
RR > 22
altered mental status (GCS<15)
SBP < 100

Consider sepsis EARLY in *any* patient with suspected infection.

Does pt meet criteria for sepsis or septic shock?

No

Reassess after initial evaluation:
Consider
• fever, leukocytosis, hypotension?
• unexplained altered mental status?
• tachypnea? especially if lungs CTA and SaO_2 WNL?
• unexplained organ dysfunction?
• clinical concern during ongoing care?

Yes

Airway stable?

No

ET intubation with target tidal volume 6 mL/kg for pts without ARDS

Yes

Large bore IV x2.
LABS INCLUDING LACTATE & BLOOD CULTURES.
START FLUID RESUSCITATION immediately: Give 1 L NS or LR bolus with target at least 30 mL/kg within 1-3 hours.

START EMPIRIC ANTIBIOTICS (see guidelines) within 1 hour of recognition of sepsis/septic shock.

REASSESS FREQUENTLY
Assess for adequacy of fluid resuscitation or complications from fluid therapy.

Monitor vital signs, UOP, shock index (HR/SBP > 0.7), mental status, and clinical exam.

Use more than one method to assess resuscitation adequacy and use dynamic variables if possible.

CONSIDER CONSULT/TRANSFER if unstable or not improving and **ACTIVATE MEDEVAC EARLY** if needed.

Is MAP > 65 after 3L of IVF or is patient having complications from volume therapy?

No

START NOREPINEPHRINE or other vasopressor (see guidelines) and **TITRATE** fluids and pressors to **MAP >65.**

Place a central line ASAP but do NOT delay pressors — a well-secured large bore peripheral IV may be used to initiate pressors.

Consider intubation to facilitate appropriate volume resuscitation.

Consider hydrocortisone (see guidelines) *only* for septic shock not responsive to adequate fluid resuscitation and vasopressors.

Yes

If initial lactate is > 2:

RECHECK LACTATE 1-2 hours after starting resuscitation.

GUIDE RESUSCITATION TO NORMALIZE LACTATE.
Primary goal should be to achieve a relative lactate clearance of at least 10% in 1-2 hours.

Lactate > 4 may indicate hypoperfusion and the need for aggressive/continued fluid resuscitation.

GET SOURCE CONTROL and obtain additional cultures PRN.

Continue to reassess frequently while awaiting admission or transfer.

Village Management
• Aggressive hydration. PO if you can't get an IV, and the patient is alert enough to drink.
• Supplemental oxygen via nasal cannula.
• Consider Ceftriaxone 2 grams IM.
• Activate medevac.
• Consider VTC.

SEPSIS 3 & ACEP NOTES

4-6 L of total IVF is often needed during the first 6 hours. After 2 L of NS consider switch to LR. Remember that if the patient fails to respond after the first 2-3 L, pressors should be considered.

In patients with concern for fluid overload (Hx CHF or renal or liver failure) or complications from fluid resuscitation, use less total fluid or smaller boluses with more frequent reassessment of volume status, but **DO NOT DELAY FLUID AND VASOPRESSOR TREATMENT.**

Persistence of elevated lactate, even in the absence of hypotension, is associated with poor outcomes.

CRP and procalcitonin may be elevated but cannot effectively guide ED sepsis care — CHECK (and RECHECK) LACTATE.

In the absence of extenuating circumstances (MI, severe hypoxia, acute blood loss, etc.) transfusion is no longer recommended unless Hgb < 7.

Consider insulin if 2 consecutive blood glucose levels are > 180.

Sodium bicarbonate is not recommended to improve hemodynamics or decrease vasopressor requirements in patients with hypoperfusion-induced lactic acidemia with pH≥7.15.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by MSEC 7/12/17.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Tara_Lathrop@ykhc.org.