Sepsis Screening Tool

Sepsis 60 Minutes to Save a Life

NHS Brighton and Sussex University Hospitals NHS Trust

Patient details sticker

Staff member completing form:

Date: ..... Time arrived in ED: .....

Name (PRINT): .....

Signature: .....

START

1. NEWS ≥4 or 3 in one parameter ☐

and/or **does the patient look sick?** ☐

NEWS total ☐

Yes

Sepsis unlikely at this time:
Differential diagnosis:
Stop form
Signed: **Time:**

No

Screening

2. Could this be due to an infection?

☐ Yes, but source unclear ☐ Respiratory tract ☐ Urinary tract ☐ Abdominal pain or distention

☐ Cellulitis/septic arthritis/wound ☐ Device-related ☐ Meningitis/CNS ☐ Other, specify: .....

Yes

Nursing

3. Are any ONE of the following RED flag criteria present?

☐ **Lactate** ≥ 2mmol/L Result ☐ Time ☐

☐ **Heart rate** > 130 per minute

☐ Non-blanching **rash/mottled/ashen/cyanotic**

☐ Recent **Anti-cancer treatment** (<6 weeks)
Suspected Neutropenic sepsis

☐ **Altered mental state** (or V/P/U on AVPU scale)

☐ **Systolic** B.P. ≤90 mmHg (or drop >40 from normal)

☐ **Respiratory rate** 25>

☐ **Oxygen** now required to keep **SpO_2** >92% (88% in COPD)

☐ **Urine** - not passed urine in 18 hours (or UO <0.5 ml/kg/hr)

Assessment

Yes

No

If no RED FLAG but infection present and clinical concern see overleaf

Doctor

This could be RED FLAG SEPSIS. This is time critical. Inform Clinician (using SBAR).
Time: Name of DR:
Treat with Sepsis 6 Immediately, if sepsis unlikely stop form sign above.

Complete ALL within one hour: Clock start hh:mm **Diagnosis of RED FLAG sepsis**

	Time	Initials	Or, reason not done
1. Oxygen – Aim to keep saturations 94-98% (88-92% if at risk of CO_2 retention.			
2. Blood (+other) cultures – At least 1 set of blood cultures. Also consider: **Think source control** – CXR, urinalysis, LP, urine culture – call surgeon/radiologist? If suspected Neutropenic sepsis then take all bloods before IVabx: FBC, U&Es, LFT's, INR, G&S, CRP and Calcium.			Urinalysis sent: ☐ Time: ☐ Initial: ☐
3. IV antibiotics – According to Trust protocol. Remember if suspected Neutropenic Sepsis follow Trust microguides.Consider allergies prior to administration.			
4. IV fluids – 500ml stat if BP and lactate normal. If hypotensive or lactate >2mmol/L give up to 30ml/kg as per Trust protocol.			
5. Lactates and bloods – Complete arterial sample. If lactate >4mmol/L, consider referral to Critical Care and recheck lactate after after 30 minutes to 1 hour.			
6. Monitor urine output – Consider if urinary catheter required. Commence fluid balance chart + hourly urine measures			

If after delivering Sepsis Six there is: further critical deterioration, no improvement in condition, no reduction in lactate, or if the patient is **critically ill** at any time: **Call Critical Care Outreach team** (bleep 8495 RSCH 6331 PRH) and *consider* referral to **ITU/HDU**.

Management

Nursing

Assessment

4. Are there any Amber flag criteria?

- ☐ **Heart rate** 111-130bpm
- ☐ **Respiratory rate** 21-24 per minute
- ☐ **Temperature** <36°C
- ☐ **Recent surgery**
- ☐ **Immunosuppressed**
- ☐ **Systolic BP** 91-100Hg
- ☐ **Any concern about mental state (new confusion)**
- ☐ **Urine** - not passed urined in 12-18 hours
- ☐ **Pregnant or recent pregnancy** (<6weeks)

No

Sepsis unlikely at this time:
Differential diagnosis:
Stop form
Signed: **Time:**

Yes

Doctor

Management

	Time complete	Initials
Check/send bloods, including: **Venous blood gas, FBC, U+Es, CRP, Clotting screen, and LFT's**		
• Senior Doctor review within 1 hour • Consider IV fluids • Commenced fluid monitoring • Consider blood cultures • Consider discussion with microbiology		
Decision on **antibiotics** within **3** hours		

If sepsis unlikely stop form, sign above.

Yes

Acute kidney Injury present on bloods? or **Lactate >2**

No

Next steps:

- Continue to monitor patient hourly – look out for **RED FLAGS** – if present, treat with **SEPSIS 6** (see overleaf)
- Continue fluid balance chart
- Document plan including escalation

Yes

Treat with Sepsis 6 immediately (see overleaf) This is time critical, action is required (see overleaf) Inform a senior clinician *(using SBAR)* that patient has **Red-flag sepsis**

Document plan / Additional notes

If acutely unwell, or not improving following Sepsis 6, please contact the **Critical Care Outreach Team**:
RSCH Bleep 8495 7:30-20:00 PRH Bleep 6331 (24/7)