BSUH NHS Trust Guidelines for Management of Severe Sepsis/Septic Shock

Initial Resuscitation

Target (First 6 hrs)

CVP 8-12 mmHg
MAP ≥ 65 mmHg
Urine output ≥ 0.5 ml/kg/hour
Scv02 ≥ 70% or mixed venous ≥ 65%

Obtain blood cultures 2 or more from percutaneous and vascular device.

Obtain cultures from other sites, CSF, respiratory secretions, urine, wounds and other body fluids.

Antibiotic Therapy

Begin IV antibiotic within first hour of recognition of sepsis and septic shock. (See Trust Antibiotic policy) prescribe on 'STAT' area of drug chart

Fluid Therapy

Give 20 ml/kg (1500-2000ml) bolus. Saline/Hartmann's or colloid. Target CVP ≥ 8 mmhg (≥ 12 mmhg if mechanically ventilated).

Vasopressor

Start Norepinephrine centrally as initial vasopressor. Use Epinephrine as alternative when BP is unresponsive to norepinephrine.

Mechanical Ventilation of Sepsis Induced ARDS

Maintain TV 6ml/kg of lean bodyweight, inspiratory plateau pressures ≤ 30cmH_2O.
Head of bed raised 30° - 45°.
Follow sedation protocol.

Inotropic Therapy

Consider Dobutamine in patient with low cardiac output despite fluid resuscitation.

Steroids - ICU only

Consider Hydrocortisone ≤300mg/day if still hypotensive and unresponsive to vasopressors.

Recombinant Human Activated ProteinC - ICU only

Consider in line with local Critical Care policy. Recommended in patient with two organ failure

Blood Product

Transfuse if Hb < 7.0 g/dl. Target Hb 7-9 g/dl in adults.

Glucose Control

Maintain blood glucose ≤ 8.3 mmol/L. (150mg/dl) Use IV insulin to control hyperglycemia. Follow protocol for dose adjustment.

DVT Prophylaxis

Use low dose unfractionated or low molecular weight heparin.

Stress Ulcer Prophylaxis

Use H2 blocker or proton pump inhibitor.

Adapted from national Surviving Sepsis campaign 2008

Brighton and Sussex University Hospitals NHS Trust

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