Cook Children's Health Care System

Inpatient Sepsis Algorithm

NEGATIVE Sepsis Screen (score 0-4)

POSITIVE Sepsis Screen (score 5-18)

Evaluate Organ Dysfunction Score (ODS)

ODS = 2

If ODS = 2 AND PT shows clinical signs of sepsis

Yes

No

- Continue to screen Q12H **or** with change in status

ODS >2

First time pt ODS >2 in past 24 hour or change in status

Yes

No

- Notify charge nurse and rescreen together
- Rescreen in 4 hours x1
- Document Nurse's Note

If no change, continue to screen Q12H **or** with change in status

- **Complete sepsis BPA Documentation**
- **Call Sepsis Alert**
- **Enter Sepsis Huddle Note and BPA – Best Practice Alert**

MD/PNP confirms clinical sepsis

No

Yes

Tasks to be started immediately and completed within 20 minutes:

1- Place patient on cardiac monitor with pulse oximeter
2- Obtain a full set of VS, including blood pressure
3- Place patient on oxygen, regardless of O2 saturation level, via face mask at 5L or greater
4- Start PIV or access CVL. Obtain order and draw the following labs:
- CBC (order CBC STAT and tube immediately), consider procalcitonin
- blood gas including ionized calcium, lactate, glucose level (RT can draw CBG if RN unable to draw VBG)
- blood culture

5- Administer a rapid fluid bolus of 20-40 mL/kg Plasmalyte or NS by push method over 15 min. (10 mL/kg recommended for cardiac, renal and newborn)
6- Administer broad-spectrum antibiotic within 1 hour

Change in status Definition

- Increasing PEWS score
- Increase OD score
- Parent/Nurse concern

Re-evaluation, Secondary Screen and complete Organ Dysfunction Tool

A secondary sepsis screen should be performed by the patient's primary nurse after intervention performed and completed.
If any provider involved thinks patient should transfer to PICU, automatically transfer.
If patient had 60 mL/kg of fluid over the last 6 hours, consider transfer to PICU

Patient Responder (sepsis score 0-4)
OR
Secondary sepsis screen > 4 and ODS ≤ 2

Observe for 30 minutes. Vital signs Q15 min x2.
Look for signs of OD (i.e., poor perfusion, altered mental status, decreased urinary output)

Patient Responder

1- Maintain patient location.
2- Vital signs every 1 hour x3.
3- Rescreen every 12 hours and with change in status

Patient Non-responder
Transfer to PICU immediately.

Patient Non-Responder (sepsis score 5-18) AND ODS >2

Severe Sepsis Protocol
All non-responders transfer to PICU.
Tasks completed within 1 hour and to be done in PICU.
May start on unit if waiting to transfer.

1- In the event of hypotension and/or serum lactate > 2 mmol/L, deliver a minimum of an additional 20 ml/kg of isotonic solution to maintain normal SBP for age.
2- Vital signs at least every 5 minutes.
3- Insert Foley catheter. Obtain UA and urine culture.
4- Apply vasopressors for hypotension not responding to fluid bolus.

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