

Waterford: Antimicrobial Guidelines - Antimicrobial Guideline: Sepsis Screening Tools

Sepsis Screening Tool for Adults



**ACUTE HOSPITALS ONLY
(NON MATERNITY) ≥16 YRS**

Addressograph

SEPSIS SCREENING TOOL FOR ADULTS
THIS FORM DOES NOT REPLACE CLINICAL JUDGEMENT

Any Healthcare Professional (HCP) should start this tool if **CONFIRMED** or **SUSPECTED INFECTION** present PLUS presence of ≥1 of the triggers listed below

Patient looks sick

Emergency Dept. Manchester Triage Category 2

Elevated EMEWS or INEWS (INEWS ≥ 4 or ≥5 if on O₂)

Patient/Family/Carer/Clinician Concern

GP/ Ambulance personnel queries sepsis

Score:

YES *Time Zero: : : :

*When the patient 1st triggers for sepsis screen

Name

NMBI/MCRN

Grade

DATE: / /

REQUEST MEDICAL REVIEW AS PER ESCALATION AND RESPONSE PROTOCOLS TO RISK ASSESS PATIENT USING ISBAR

Is any ONE RED FLAG present?

Signs of Shock

Systolic Blood Pressure < 90mmHg (or drop of > 40mmHg below normal +/- Point of care lactate > 2mmols/L)

OR

Risk of Neutropenia

Recent chemotherapy/radiotherapy

OR

Evidence of New Organ Dysfunction
(any one of the following)

New Acutely altered Mental Status

Respiratory Rate > 30 bpm

Heart rate > 130 bpm

Not passed urine in 12 hours or urine output < 0.5mls/kg/hr

Non blanching rash

New or increased need for O₂ to achieve SpO₂ >90%

Pallor/mottling with central CRT > 3 seconds

Other organ dysfunction

NO RED FLAGS - CHECK FOR AMBER FLAGS

≥ 2 Systemic Inflammatory Responses (SIRS) that are sustained PLUS ≥ 1 Comorbidity.

SIRS (check for 2 or more listed below)

Respiratory rate ≥ 20 bpm

Heart rate 91 - 130 bpm

Temperature < 36 or > 38.3 °C

Blood glucose level > 7.7 mmol/l (in absence of diabetes mellitus)

WCC < 4 or > 12 x 10⁹ /L

AND

≥ 1 Comorbidity (listed below)

Aged ≥ 75 years

Frailty

Diabetes Mellitus

COPD

Cancer

Chronic Renal Disease

Chronic Liver Disease

Recent Surgery /Trauma (past 6 weeks)

Immunosuppression (due to medication or disease)

PROBABLE SEPSIS

IMMEDIATE ACTION IS REQUIRED

POSSIBLE SEPSIS

SITE OF INFECTION (IF KNOWN)

START SEPSIS 6 NOW

INFORM SENIOR DECISION MAKER

See overleaf

NEGATIVE SCREEN SEPSIS UNLIKELY AT THIS TIME

EXIT PATHWAY

Sign

MCRN / NMBI (ANP)

Treat as per diagnosis and continue to monitor. Rescreen if deteriorates

Is there an End-of-Life Pathway in place? Yes No Is escalation clinically appropriate? Yes No

If Sepsis 6 is not clinically appropriate, exit the sepsis pathway.

Doctor Signature MCRN



**SEPSIS TREATMENT PROTOCOL FOR ADULTS
(NON MATERNITY) ≥16 YRS
SEPSIS 6 BUNDLE
- COMPLETE WITHIN 1 HOUR**

Addressograph

TAKE 3	1 TAKE BLOOD CULTURES 2 sets of peripheral blood cultures (aseptic technique) prior to giving antimicrobials unless this leads to a delay >45mins. If patient has CVAD, take line cultures at the same time. Other cultures as indicated by history and examination.	Time Taken: □□:□□
	2 TAKE BLOOD TESTS FBC, Renal and Liver profile, point of care lactate, CRP +/- coagulation screen. If initial lactate elevated > 2mmols/L, repeat lactate after sepsis 6 bundle to assess response.	Time Taken: □□:□□
	3 URINARY OUTPUT ASSESSMENT Assess urinary output as part of volume/perfusion status assessment. For patients with sepsis/septic shock start fluid balance charts. Catheterisation and hourly measurements may be required.	Time: □□:□□ Fluid balance chart commenced <input type="checkbox"/>
GIVE 3	4 IV ANTIMICROBIALS (if appropriate), THINK SOURCE CONTROL. Consider Microbiology review Red Flags (PROBABLE SEPSIS) IV Antimicrobials within 1 HOUR Amber Flags (POSSIBLE SEPSIS) Review test results to identify infectious vs non-infectious causes of acute illness. If infection confirmed, administer IV antimicrobials within 3 HOURS . Note: If infection with new onset organ dysfunction present (e.g. AKI, thrombocytopenia or hyperlactatemia etc.) administer antimicrobials immediately. TIME GIVEN □□:□□ <input type="checkbox"/> Patient already on appropriate antimicrobials <input type="checkbox"/> This patient does not require antimicrobials at this time	TIME GIVEN □□:□□
	5 GIVE IV FLUID BOLUS IF REQUIRED For patients with hypotension or hypoperfusion give a 250 - 500mls IV fluid bolus of balanced crystalloid. Administer a total volume of fluid resuscitation up to 30ml/kg within the first 3 hours unless fluid intolerant or the patients clinical condition requires earlier referral to critical care for consideration of inotropes/vasopressors. Reassess response to fluid resuscitation frequently. Refer to fluid resuscitation algorithm.	Time Given: □□:□□ or N/A <input type="checkbox"/>
	6 GIVE OXYGEN IF REQUIRED Titrate supplementary oxygen to maintain oxygen saturations 94-96% (88-92% for patients with chronic lung disease).	Time Given: □□:□□ or N/A <input type="checkbox"/>
Reassess vital signs at least every 30 minutes. IF CONDITION WORSENING / NOT IMPROVING, ESCALATE TO CONSULTANT. Consider SEPTIC SHOCK if MAP less than 65mmHg DESPITE FLUID RESUSCITATION and escalate to critical care.		
<input type="checkbox"/> Sepsis UNLIKELY at this time, treat as per working diagnosis, continue to monitor. Rescreen if deteriorates <input type="checkbox"/> This is likely to be SEPSIS at this time <input type="checkbox"/> Senior Clinician informed		
Signature _____		MCRN / NMBI (ANP) _____
Print _____		Date: ___/___/___ Time □□:□□

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Sepsis Screening Tool for Maternity Patients (up to 42 days post-partum)



This form does not replace clinical judgement

SEPSIS SCREENING TOOL FOR MATERNITY PATIENTS (UP TO 42 DAYS POST-PARTUM) ACUTE HOSPITALS ONLY

Woman's Name: _____
 Date of Birth: _____
 Healthcare Record No: _____
 Addressograph _____

Obstetric History
 Para: _____ Gestation: _____ Days post-natal: _____ Delivery type: _____ Recent pregnancy loss? _____

Any Healthcare Professional (HCP) should start this tool if CONFIRMED or SUSPECTED INFECTION present PLUS presence of ≥1 of the triggers listed below

Site of Infection (If known) _____

Patient looks sick
 Elevated IMEWS ≥2 yellows or ≥1 pink
 In an Adult Emergency Department - Manchester Triage Category 2
 Patient/Family/Carer/Clinician Concern
 GP/Ambulance personnel queries sepsis

YES *Time Zero: : Name _____ Grade _____
 When the patient first triggers for sepsis screen NMBI/MCRN _____ DATE: / /

REQUEST MEDICAL REVIEW AS PER ESCALATION AND RESPONSE PROTOCOLS TO RISK ASSESS PATIENT USING ISBAR

Is any **ONE RED FLAG** present?

Signs of Shock

Systolic Blood Pressure < 90mmHg (or drop of > 40mmHg below normal +/- Point of care lactate > 2mmol/L).
 Rule Out PPH

OR

Evidence of New Organ Dysfunction
 (any one of the following)

Acutely altered Mental Status
 Respiratory Rate > 30 bpm
 Heart rate >130 bpm
 Not passed urine in 12 hours or urine output < 0.5mls/kg/hr
 Non blanching rash
 New or increased need for O₂ to achieve SpO₂ >90%
 Pallor/mottling with central CRT > 3 seconds
 Other organ dysfunction

OR

Risk of Neutropenia

Recent chemotherapy/radiotherapy/autoimmune disorder

NO RED FLAGS - CHECK FOR AMBER FLAGS

≥ 2 Systemic Inflammatory Responses (SIRS) that are sustained not transient WITH/WITHOUT Risk Factors.

Respiratory rate ≥ 20 bpm
 Heart rate ≥ 100 and ≤ 130 bpm
 Temperature < 36 or ≥ 38.0 °C
 Blood glucose level > 7.7 mmol/L (in absence of diabetes mellitus)
 WCC < 4 or > 16.9 x 10⁹ /L
 Fetal HR >160bpm

Risk factors

Pregnancy related	Non-pregnancy related
<input type="checkbox"/> Caesare	<input type="checkbox"/> Age > 35 years
<input type="checkbox"/> Pre-term/prolonged rupture of membranes	<input type="checkbox"/> Minority ethnic group
<input type="checkbox"/> Retained products	<input type="checkbox"/> Vulnerable socio-economic background
<input type="checkbox"/> History pelvic infection	<input type="checkbox"/> Obesity
<input type="checkbox"/> Group A Strep. infection in close contact	<input type="checkbox"/> Diabetes, including gestational diabetes
<input type="checkbox"/> Recent amniocentesis	<input type="checkbox"/> Recent surgery
	<input type="checkbox"/> Symptoms of infection in the past week
	<input type="checkbox"/> Immunocompromised e.g. Systemic Lupus
	<input type="checkbox"/> Chronic renal failure
	<input type="checkbox"/> Chronic liver failure
	<input type="checkbox"/> Chronic heart failure

YES

PROBABLE SEPSIS
 IMMEDIATE ACTION IS REQUIRED

NO

POSSIBLE SEPSIS

YES

NO

NEGATIVE SCREEN SEPSIS UNLIKELY AT THIS TIME

EXIT PATHWAY

Sign _____
 MCRN / NMBI (AN/MP) _____

Treat as per diagnosis and continue to monitor. Rescreen if deteriorates

SITE OF INFECTION (IF KNOWN) _____

START SEPSIS 6+1 NOW
 INFORM SENIOR DECISION MAKER
 See overleaf



SEPSIS TREATMENT PROTOCOL FOR MATERNITY PATIENTS (UP TO 42 DAYS POST-PARTUM)
SEPSIS 6+1 BUNDLE
- COMPLETE WITHIN 1 HOUR

Addressograph

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	2 TAKE BLOOD TESTS FBC, Renal and Liver profile, point of care lactate, CRP +/- coagulation screen. If initial lactate elevated > 2mmol/L, repeat lactate after sepsis 6 bundle to assess response.	Time Taken: □□:□□
	3 URINARY OUTPUT ASSESSMENT Assess urinary output as part of volume/perfusion status assessment. For patients with sepsis/septic shock start fluid balance charts. Catheterisation and hourly measurements may be required.	Time: □□:□□ Fluid balance chart commenced <input type="checkbox"/>
	+1 IF PREGNANT ASSESS FETAL WELLBEING	Time Completed: □□:□□ N/A <input type="checkbox"/>
GIVE 3	4 IV ANTIMICROBIALS (if appropriate), THINK SOURCE CONTROL. Consider Microbiology review	
	Red Flags (PROBABLE SEPSIS)	Amber Flags (POSSIBLE SEPSIS)
	IV Antimicrobials within 1 HOUR TIME GIVEN □□:□□ <input type="checkbox"/> Patient already on appropriate antimicrobials <input type="checkbox"/> This patient does not require antimicrobials at this time	Review test results to identify infectious vs non-infectious causes of acute illness. If infection confirmed, administer IV antimicrobials within 3 HOURS . Note: If infection with new onset organ dysfunction present (e.g. AKI, thrombocytopenia or hyperlactatemia etc.) administer antimicrobials immediately. TIME GIVEN □□:□□
5 GIVE IV FLUID BOLUS IF REQUIRED For patients with hypotension or hypoperfusion give a 250 - 500mls IV fluid bolus of balanced crystalloid. Administer a total volume of fluid resuscitation up to 30ml/kg within the first 3 hours unless fluid intolerant or the patients clinical condition requires earlier referral to critical care for consideration of inotropes/vasopressors. Reassess response to fluid resuscitation frequently. Refer to fluid resuscitation algorithm. Caution in pre-eclampsia.	Time Given: □□:□□ or N/A <input type="checkbox"/>	
6 GIVE OXYGEN IF REQUIRED Titrate supplementary oxygen to maintain oxygen saturations 94-98% (98-92% for patients with chronic lung disease).	Time Given: □□:□□ or N/A <input type="checkbox"/>	
Reassess vital signs at least every 30 minutes. IF CONDITION WORSENING / NOT IMPROVING, ESCALATE TO CONSULTANT. Consider SEPTIC SHOCK if MAP less than 65mmHg DESPITE FLUID RESUSCITATION and escalate to critical care.		
THIS IS LIKELY TO BE SEPSIS <input type="checkbox"/> OR SEPTIC SHOCK <input type="checkbox"/> AT THIS TIME		
<input type="checkbox"/> Senior Clinician Informed Time: □□:□□		
<input type="checkbox"/> Sepsis UNLIKELY at this time		
Signature <input type="text"/>		MCRN / NMBI (A/N/MP) <input type="text"/>
Print Name <input type="text"/>		Date: <input type="text"/> Time: □□:□□

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