**SEPSIS STABILIZATION**

The following clinical recommendations have been developed to aid in the early identification and management of suspected sepsis. A patient may screen positive for infection and receive treatment while other diagnoses are considered or managed. This guideline is in the interest of initiating stabilization and facilitating safe and expeditious transfer, while maximizing the chance for survival. Please use your clinical judgment; these are only recommendations. UW physicians are available for consultation through the Transfer Center.

### Step 1 – Infection Suspected

**Source (if known):**
- Abdominal
- Blood Stream
- Central Nervous System
- Device Related
- Endocarditis
- Epidemic
- Respiratory
- Travel Associate
- Urinary
- Wound/Soft Tissue
- Other

### Step 2 – Screen for Sepsis-Defining Organ Dysfunction

**qSOFA ≥2** (worth 1 point each)
- Hypotension (SBP < 100)
- Altered Mental Status (GCS < 15)
- Respiratory Rate ≥22

**Organ Dysfunction:**
- Lactate >2
- Elevated bilirubin, creatinine
- Coagulopathy
- Altered Mental Status
- Hypotension (SBP<90 or map <65)
- Decreased urine output
- New or increased O2 need

### Sepsis

Concern for infection + Evidence of life-threatening acute organ dysfunction

### Septic Shock

Sepsis + Persistent Hypotension
(SBP <90, or lactate >4)

### Begin Emergency Treatment

- **Airway, Breathing, Circulation**
- **Begin Bundle** (See below)
- **Administer Broad Spectrum Abx**
  - Initiate Fastest infusing meds first
  - See ABX reference sheet below
  - Do Not Delay antibiotics for cultures
- **Begin Fluid Resuscitation:**
  - 30 ml/kg IF Lactate ≥ 4, SBP < 90, MAP < 65, or pt tachycardic with no s/s fluid overload

### Reassess

- Lactate if initial lactate > 2
- Exam c/w hypoperfusion
- Passive leg raise
- Bedside ultrasound
- MAP < 65 mmhg

### Respond

- Consider adding 10ml/kg fluid boluses if bedside ultrasound or passive leg raise suggests fluid responsiveness
- Initiate Norepinephrine for persistent hypotension
- Consider adding Vasopressin if MAP remains ≤ 65, despite norepinephrine
- Consider adding Epinephrine for persistent shock
- Consider Corticosteroids if patient on chronic steroid therapy
## CMS BUNDLE CHECKLIST

<table>
<thead>
<tr>
<th>3 Hour Bundle Requirement</th>
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</thead>
<tbody>
<tr>
<td>□ Initial Lactate measurement</td>
</tr>
<tr>
<td>□ Blood cultures, culture other potential sources</td>
</tr>
<tr>
<td>□ Broad Spectrum Antibiotics <em>(goal &lt; 1 hr., give fastest infusing med 1st)</em></td>
</tr>
<tr>
<td>□ IV Fluids (30 ml/kg if SBP &lt; 90, or lactate ≥ 4)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>6 Hour Bundle Requirement</th>
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<tbody>
<tr>
<td>□ Complete 30 mg/kg fluid bolus</td>
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<tr>
<td>□ Repeat Lactate if initial lactate is ≥ 2</td>
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<tr>
<td>□ Initiate Vasopressors <em>(if pt remains hypotensive (SBP &lt; 90, or MAP &lt; 65 after fluid bolus))</em></td>
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<tr>
<td>□ Documentation of Shock Re-assessment</td>
</tr>
</tbody>
</table>

### Antibiotic Therapy for Severe Sepsis/Septic Shock

ABX choice should be based on site of infection and risk factors for drug resistant organisms (prior abx, SNF, LTACH, h/o MDROs)

**Single drug therapy options:**

- Ceftriaxone
- Cefepime
- Piperacillin/Tazobactam

*(ADD VANCOMYCIN if risk factors for MRSA present)*

**For patients with severe beta-lactam allergy:**

- Aztreonam OR Ciprofloxacin OR Aminoglycoside
- PLUS Vancomycin regardless of risk factors for MRSA

Contact Infectious Disease Consult or Antimicrobial Stewardship with questions

Reviewed 2021 HMC Sepsis Committee