Franciscan ALLIANCE

Franciscan Stewardship Initiative – Clinical Operations
Franciscan Sepsis Care Map,Target LOS: 5.1 Days

DEFINITIONS:

SIRS: Temp > 38 or < 36, HR > 90, RR > 20 or $PaCO_2$ <32, WBC > 12K or < 4K or Bands > 10%
SEPSIS: 2 or more SIRS criteria + Known or Suspected Infection
SEVERE SEPSIS: SEPSIS + ≥ 1 Acute Organ Dysfunction
**** SEPTIC SHOCK:** SEVERE SEPSIS + Refractory Hypotension (SBP < 90 or MAP < 70 or SBP decrease ≥40 mmHg after 30 mL/kg fluid bolus)

***ORGAN DYSFUNCTION:**

Acutely Altered Mental Status
SBP < 90 or MAP < 70 or SBP ↓ > 40 mmHg
PaO2/FiO2 < 300 or SpO2 < 92% or ↑ FiO2 by > 2L/Min
Creatinine > 2.0 or ↑ 0.5 from baseline
U.O < 0.5 mL/kg/hr for > 2 hrs or < 750 mL/24 hrs
Bilirubin > 2.0 or AST > 90 or ALT > 90
Coagulopathy (INR > 1.5 or aPTT > 60 sec or Platelet Count < 100K)
Lactate > 2.2 Severe Sepsis; > 4.0 Septic Shock

	Early Recognition (ED or Inpatients)	Resuscitation (Early Intervention) Target: To be completed within 1-6hr hours of recognition/diagnosis	Management Target: Begin with 6 hour resuscitation	Maintenance Target LOS: 1-3 days	Discharge/Transition Off Sepsis Care Map Day 3-5
Order Set	Use Order Set 1336 GEN ED OR IP SEPSIS ADULT INITIAL RESUSCITATION FOCUSED	If patient is being admitted use order set 1219 CRITICAL CARE MANAGEMENT ADMISSION TEMPLATE	Use order set 1046 GEN IP SESIS ONGOING MANAGEMENT FOCUSED		
Medical Milestones/ Discharge Criteria	**Immediate Recognition/Diagnosis** **SEPSIS:** 1) Signs, symptoms and risk factors for infection SIRS criteria as stated above for ED and Inpatient, respectively **SEVERE SEPSIS/SEPTIC SHOCK:** 2) Organ Dysfunction* 3) Septic Shock** 4) Call Rapid Response Team	1) Antibiotic administration within 1 hour of recognition 2) Fluid Bolus 30mL/kg over an hour or less, if tolerated 3) Central access, if appropriate 4) BP: MAP > 65 or SBP > 90 5) Lactate (normal) < 2.2 mmol/L 6) CVP: 8 – 12 7) ScvO2 Normal (>70%), if appropriate 8) Stroke volume optimized, if appropriate 9) SpO2 > 92%	1) Vent Management Tidal Volume (TV) ≤ 6mL/kg (Improving Oxygenation) 2) Wean O2, if appropriate 3) Continue decreasing Vasopressor 4) Normalizing White Blood Cell Count 5) Improving urine output (> 0.5 mL/kg/hr)	1) Weaning from O2/Ventilatory Support/Spontaneous breathing trial 2) Demonstrates Stable BP off vasopressors 3) Infection resolved/resolving 4) Antibiotic de-escalation/adjust regimen based on cultures 5) Discontinue central lines and urinary catheters as appropriate	1) When procalcitonin normalizes, convert to oral antibiotics or discontinue. Afebrile 2) Functional Status at baseline or improving (*Functional Status corresponds to including but not limited to: patient's mental health, ambulatory state, and nutrition needs)*
Assessment and Testing	Vital Signs Assess with SIRS Screen at least every change in shift, floor, status change, and change of provider, use Sepsis screening tool on initial assessment Physical Exam: Signs of Infection Labs: CBC, Chemistry, Lactate, Procalcitonin, 2 sets of blood cultures drawn before antibiotics initiated, UA and reflex culture if needed, sputum, Coags when indicated. Chest X-Ray IV Access	O2/Ventilatory Support for mechanically ventilated: Aim for CVP 12-15 Re-check Vital Sign and Labs BP Support Urine Output Monitoring Consider invasive vs. non-invasive means to measure fluid resuscitation (e.g. monitor CVP, stroke volume, or consider ultrasonography, esophageal Doppler) Identify source of infection	Titration of O2/Ventilatory Support Vital Sign Monitoring Fluid Status Assessment Consider repeating Lactate Ongoing monitoring for SIRS/Sepsis Infection source control	Ongoing monitoring for SIRS/Sepsis Check vital signs or per department policy Consider repeat Procalcitonin (day 3)	Assessment of new baseline functional status
Medication	IV Fluids (Crystalloids): 30 mL/kg bolus to run over an hour or less Begin broad-spectrum antibiotic therapy within 1 hour of time zero (first triage or first positive screen), choose antibiotic based on most likely source(s) of sepsis Consider antipyretics	IV Fluids (consider re-bolus if refractory hypotension) Continue broad spectrum antibiotics If vasopressors/inotropes, use central access, preferably in Internal Jugular site Consider initiating Steroids (if refractory to fluid resuscitation and requiring vasopressors)	Prophylaxis: Stress Ulcer and VTE Glycemic Control per protocol Continue empiric antibiotics, adjust regimen based on culture results Consider: Tapering Steroids Consider: Weaning Vasopressors/Inotropes	De-escalation of antibiotics, evaluate clinical criteria for change to PO antibiotic Sedation weaning, if mechanically ventilated Transition from IV to PO meds Consider: Tapering Steroids Nutrition Assessment: Enteral vs. Parenteral	Determine duration of therapy for antibiotics based on source of infection and final cultures PO antibiotics (arrange for IV antibiotics, if needed) – assess adequacy of oral intake and discontinue IV hydration
Consults	Consider: Internal Medicine Critical Care ICU Transfer	Consider: Critical Care Palliative Care – recommended if advanced malignancy, recurrent sepsis, etc. Infectious Disease (ID) - Immunocompromised - Complicated Infection (Endocarditis, Osteomyelitis) - History of Multidrug Resistant Organisms - Multiple antibiotic allergies Surgical Services/Interventional Radiology - Abscesses, etc.	Consider: ID (include Sepsis in comments), recommended if source of infection is unclear, patient is immunosuppressed, diabetic or meets criteria for severe sepsis/septic shock Palliative Care, recommended if advanced malignancy, recurrent sepsis Social Work/Case Management Nutrition PT/OT Evaluation Speech/Swallow Evaluation	Consider: Social Work/Case Management SNF/LTAC/Home Health Rehab Services for Trach/PEG Diabetes Education	Consider: Transition Coach Social Work/Case Management: ongoing social work involvement in discharge planning, equipment needs, medication needs Rehab
Discharge Prep/ Education	Review code status/advance directive with patient Establish goals of care	Provide patient and family with basic information about sepsis/treatment plan and advanced directive	Address social issues	Make sure patient and family understand signs and symptoms of sepsis, review advanced directive, complete outpatient resuscitation orders, e.g. POST or POLST, as appropriate Medication teaching	Sepsis discharge education Review discharge paperwork
Activity	Bed Rest	Bed Rest	Bed Rest or Progressive Upright Mobility/Early Mobilization protocol	Continue Progressive Upright Mobility/Early Mobilization protocol, advance activity to out of bed	Advance activity to out of bed and ambulation to baseline
Other	Reference High Risk Diagnosis List Communication with Interdisciplinary Care Team				Establish follow-up appointments, labs