Emergency Department

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Section:	Emergency Nursing Guideline

Policy and Procedure Manual

NURSE INITIATED PROTOCOL: SEPSIS -ADULT

Purpose:

To outline a protocol of nurse initiated treatments for adult patients presenting to the emergency department with symptoms of a potential infectious source and fever > 38C (100.4F), altered mental status, hypothermia, tachycardia, hypotension, and/or signs of hypoperfusion.

This protocol addresses the early recognition and management of patients with sepsis presentation. The diagnostic and therapeutic strategies that are recommended are supported by the best available evidence and expert opinion. A fever, defined as a temperature > 38C (100.4F).

Application:

All emergency department patients 18 years and older

Exceptions:

- Patients triaged as ESI level 1
- Patients under the age of 18 years
- Patients who clearly do not have an infection related complaint (i.e. trauma)
- Patients with neutropenia and fever (Refer to Emergency: 26_24_010 _ Fever- Neutropenia Guideline

- Patient known to be acutely septic (Refer to Clinical Care/Patient Rights: 03_00_200 _ Sepsis Protocol
- Pediatric Patients under the age of 21 years (Refer to 26_37_010 _ Nursing Initiated Protocol Acetaminophen And Ibuprofen Administration Pediatric)

Procedure:

Triage Nurse

1. The nurse should promptly assess patient for signs of clinical instability including Systemic Inflammatory Response Syndrome (SIRS) criteria.

   SIRS Criteria is defined as > 2 of the following

   - Altered Mental Status
   - Temperature > 100.4F, or < 96.5 or rigors
   - Heart Rate > 90/min
   - Respiratory Rate > 20/min
   - Oxygen Saturation < 90%
   - Systolic blood pressure (SBP) < 90mmHg

     Or

   - Shock index (HR/Sys BP) > 0.7

2. The nurse should obtain a brief, targeted history with an assessment of current or past history of:
   - Respiratory symptoms
   - Headache, nuchal rigidity, photophobia
   - Chills/rigors
   - Seizures
   - Abdominal pain; Nausea/Vomiting/Diarrhea; Urinary symptoms
   - Pain (flank, abd, head)
   - Rash (petecheal/purpura/vesicular)
   - Immunocompromise (SCD, HIV/AIDS, oncology)
   - Onset of fever (sudden or gradual) and duration of fever (hours/days)
   - Max temperature at home/method (measured or tactile/PO, axillary, rectal, tympanic)
   - Antipyrectic use - dose and time of administration
   - Oral intake and Urine output
   - Sick Contacts, Recent Travel

   Special considerations

   - Patients with risk of communicable illness (varicella, TB, flu, meningococcemia) or, immuno-suppression (organ transplants, oncology

patients, amyloidosis) should be given a mask and placed on appropriate isolation precautions.

2. ED Clinical Area Assignment

All patients being considered for severe sepsis should be brought to a clinical exam area and notify the practitioner.

Triage Nurse:

1. For patients assigned to the waiting room.
   Acetaminophen 650 mg PO X 1 may be administered for a temperature > 100.4 F unless contraindicated.
   Contraindications to Acetaminophen therapy include:
   - Allergy to Acetaminophen
   - Ingestion of acetaminophen with in the previous 4 hours
   - History of liver disease
2. The Nurse should document in the electronic health record (EHR) all nursing assessments and procedures.
3. The Nurse should monitor response to therapy, repeat temperature within 1 hour.
4. As per standard practice, the MD will enter orders for all medications in the EMAR administered per this protocol, and the nurse will document the time and administration of the medication.

Primary Nurse:

1. For patients assigned to clinical exam room the nurse should obtain the appropriate labs, Comprehensive Metabolic panel, CBC with differential, Venous blood gas, Lactate (on VBG), , INR, PTT, UA, Urine culture*, and consider obtaining one Blood culture with initial draw and consult practitioner regarding ordering of blood cultures (2 sets required, peripherally)*.
2. The Nurse should initiate IV saline lock, and notify MD provider for IV fluid orders and antibiotic orders.
3. The Nurse should document in the EHR all nursing assessments and procedures.
4. The Nurse should monitor response to therapy, repeat temperature within 1 hour.
5. As per standard practice, the MD will enter orders for all medications in the EMAR administered per this protocol, and the nurse will document the time and administration of the medication.

*Cultures should not cause significant delay (>45 minutes) in the start of antimicrobial(s) administration

Responsibility:

MD, RN, Pharmacy

Forms:

None

Other Related Policies:

10_03_010 _ Medication Administration

26_24_010 _ Fever- Neutropenia Guideline

26_37_060 _ Nursing Initiated Protocol Fever- Adult

References:

Rhoades, C., Holleran, R., Carpenter, L., & Grissom, C. (2010). Management of the critical care patient in the emergency department. In *Sheehy's Emergency Nursing Principles and Practice 6th edition.* St. Louis: Mosby.

Society of Critical Care Medicine (2012). Surviving Sepsis Campaign 2012 http://www.sccm.org/Documents/SSC-Guidelines.pdf

Bruce HR, Maiden J, Fedullo PF, Kim SC. Impact of nurse-initiated ED sepsis protocol on compliance with sepsis bundles, time to initial antibiotic administration, and in-hospital mortality. J Emerg Nurs. 2015 Mar;41(2):130-7.

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