Sepsis Core Measure Checklist

Date of Admission: _____ (Time Zero= Time at which infection is identified/documented + 2 SIRS present with 6 hours of one another)

ED Team_____ **ED Team**_____ **ED Team**_____

Inpt Team_____ **Inpt Team**_____ **__Inpt Team**_____

☐ Infection identified/documented in ED with relevant Sepsis orders initiated.
☐ Lactate Result (not order) IF >2.0 mmol/l ☐ Documentation calling this Severe Sepsis ☐ Repeat Lactate result (order 2 hrs after prior draw time through "Infection" Order Set)
☐ Blood Cultures drawn (not ordered) prior to ATB ☐ Broad Spectrum (IV) ATB initiated (not ordered) within 3 hrs of Time Zero, *Selection from Empiric Broad Spectrum ATB List (on Green Sheet)*
☐ SIRS Template used in note: ☐ SIRS criteria indicated, ☐ Suspected Site(s) Indicated, ☐ In-hospital concurrent diagnosis indicated, ☐ Culture indicated, ☐ 30mL/kg Target documented, ☐ ATB/Medications indicated
☐ Assessment secondary to Organ Dysfunction indicating Severe Sepsis ***(****Lactate >2.0 mmol/l, INR >1.5, PTT > 60 sec, Platelet <100,000, Billirubin >2, Creatinine >2, Urine output < 0.5 mL/kg/hr for 2 hrs, SBP <90, MAP <65, SBP decrease by 40 from previous "normal"****)***-but not when chronic or due to medications
IF Severe Sepsis: ☐ Consider 30 mL/kg Crystalloid Fluid Bolus (0.9% NS or LR), ☐ Repeat Lactate result (order 2 hrs after prior draw time through "Infection" Order Set) which will order 2 additional Lactates.
IF Septic Shock: = Lactate **≥** 4.0 and/or Sepsis induced hypotension (SBP < 90 mmHg, MAP < 65 mmHg, or SBP decrease by 40 from previous "normal"**)**-but not when chronic or due to medications
☐ Documentation calling this "Septic Shock with Severe Sepsis" ☐ 30 mL/kg Crystalloid Fluid Bolus (0.9% NS or LR) for hypotension or Lactate **≥** 4.0 > 125 mL hr, ☐ 30 mL/kg Target Achieved within 6 hrs of Time Zero of Lactate **≥** 4.0 and/or Sepsis induced hypotension
☐ **Vasopressors** (Norepinephrine 1st choice unless compelling reason for alternative) ☐ Within 6 hrs of Time Zero of Lactate **≥** 4.0 and/or Sepsis Induced hypotension ☐ Repeat Volume Status and Tissue Perfusion Assessment Note consisting of including Vital Signs, Cardiopulmonary, Capillary Refill, Pulse and Skin findings *(you may write the note after 6 hrs so long as you document the time you examined the patient which must be > 6 hrs)*
☐ Examination within 6 hrs of Time Zero of Lactate **≥** 4.0 and/or Sepsis Induced hypotension

Top Issues of Focus

☐ Broad Spectrum ATB AND Delivered within 3 hrs.	☐ ED Provider not thinking/documenting/acting upon Sepsis treatment plan.
☐ Infection/Sepsis Screen not suspected while in ED.	☐ 30 mL/kg ordered as one target volume based upon weight rather than small repeated boluses.
☐ Inpatient delay in timing of ATB administration from time ordered in Iatric.	☐ Communication from Inpatient provider to ED team on additional Sepsis orders on admission.
☐ Blood Cultures within 3 hrs.	☐ Lack of 6 hr Repeat Assessment note.

Reviewer Signature _____ **Date**_____**Time**_____

Reviewed With Signature_____ **Date**_____**Time**_____

Patient Label

INFECTION-SEPSIS SPECTRUM (ISS) CHECKLIST

AS DEFINED BY JOHNSON MEMORIAL HOSPITAL SEPSIS COMMITTEE:

Time Zero = *Time at which Infection is suspected/diagnosed + 2 or more SIRS present within 6 hours of one another*

SEPSIS = *Suspicion/diagnosis of infection + 2 or more SIRS (that cannot be excluded as due to the infection)*

SEVERE SEPSIS = *Suspicion/diagnosis of infection + 2 or more SIRS + organ dysfunction* ***(including Lactate >2.0)***

Date:_____**TIME ZERO:** _____

ALL of the following within (3) Hours of Time Zero				
☐ **Lactate result (not order)**	Draw Time:	Result Time:	Result:	Print Name
☐ **Blood Cultures drawn (prior to ATB) (not ordered)**		1st Set Time:	2nd Set Time:	Print Name
☐ **IV Antibiotic (ATB) initiated (not ordered)**		Time:		Print Name
AND within (3) Hours of Time Zero				
☐ **30 mL/kg Crystalloid Fluid Bolus (0.9% NS** *or* **LR) for Hypotension or Lactate ≥4 (consider for Severe Sepsis)** **Weight kg**_____ **X 30 =** _____ **mL predicted**		*Total volume given over 4-5 hours* **Target time to complete 30mL/kg:** **Amount infused in ED:**		Print Name
AND within (6) Hours of Time Zero				
☐ **Repeat Lactate result if initial is > 2.0 mmol/L (order 2hrs after prior draw time)**	Draw Time:	Result Time:	Result:	Print Name

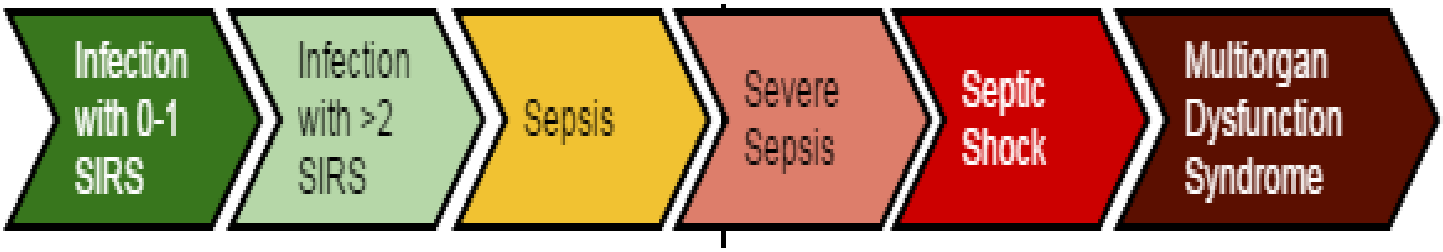
SEVERE SEPSIS WITH SEPTIC SHOCK CHECKLIST

(all of the above measures plus the following)

SEPTIC SHOCK = ***Lactate ≥ 4.0 and/or*** *Sepsis-induced* ***hypotension*** *(****SBP*** *less than* ***90*** *mmHg,* ***MAP*** *less than* ***65*** *mmHg, or* ***SBP*** *decrease greater than* ***40*** *mmHg from* ***baseline****) in the hour after fluid resuscitation (30mL/kg)* **for ≥ 2 consecutive BP readings**

Date:_____**SEPTIC SHOCK CLOCK:** _____

Within (6) Hours of Septic Shock Clock		
☐ **Vasopressors**	Time:	Print Name
Within (6) Hours of Septic Shock Clock		
☐ **Repeat Volume Status and Tissue Perfusion Assessment Note (written by NP/PA/MD/DO) consisting of including vital signs, cardiopulmonary, capillary refill, pulse, and skin findings**		
This form to remain in front of patient's chart until after six hour beyond time zero, and then forward it to Gina Croxford in the Quality Department. Not a part of the permanent medical record, DO NOT SCAN.		



Sepsis: Empiric Antibiotic Selection Pathway

Early initiation of appropriate therapy is associated with improved outcomes in severe sepsis and septic shock and these guidelines are intended for use in patients with these syndromes only. All patients with suspected sepsis should have appropriate cultures obtained, although antimicrobial therapy should not be unduly delayed for this. Delays in initiating active therapy have been associated with worsened clinical outcomes and so antimicrobials should be initiated as rapidly as possible. The addition of a second antimicrobial agent can expand the empiric coverage for resistant Gram-negative pathogens. This combination therapy has been advocated by international consensus guidelines (Surviving Sepsis Campaign) in critically ill patients in severe sepsis or septic shock given delays to active therapy in this population has been associated with an increased mortality. Despite the clear mortality benefit of initially active therapy in critically ill patients, combination therapy remains controversial. The addition of a second agent has not been definitively associated with improved outcomes and depending on the severity of illness and patient population may be associated with worsened outcomes. Therefore, the addition of a second agent (e.g. tobramycin added to anti-pseudomonal betalactam) should be based on patient severity of illness, the likelihood of isolating resistant Gram-negative pathogens, and the potential adverse effects of additional therapy. Antibiotic therapy should be narrowed to target the isolated pathogen when culture results become available. Patients who have milder forms of infection may be more appropriately treated with narrow spectrum agents and antibiotic choices in these patients should be based upon current guidelines and clinical judgment. De-escalation to a single active agent is **strongly** recommended when culture and susceptibility results return.

EIAD: extended interval aminoglycoside dosing panel

+/- denotes that the drug is optional and use should be based on assessment of severity of infection and likelihood of resistance or isolation of the pathogen the agent targets

Suspected Source of Infection	Suggested Antibiotics
Unknown (includes catheter related blood stream infection) ‡	Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **OR** Cefepime 1 gm IV q6hr **PLUS** Vancomycin IV per pharmacy consult (initial 25mg/kg loading dose) **+/-** Tobramycin 7 mg/kg IV EIAD *Severe beta-lactam allergy (anaphylaxis, hives):* Aztreonam 2 gm IV q8h **PLUS** Vancomycin IV per pharmacy consult (initial 25mg/kg loading dose) **+/-** Tobramycin 7 mg/kg IV EIAD ‡Consider Micafungin 100mg IV qday in patients at high risk for invasive candidiasis. Major risk factors predicting candidemia at TNMC include: 1) Broad-spectrum antibiotics, 2) Central venous catheter, 3) Receipt of TPN, 4) Abdominal surgery, and 5) Steroid use. Presence of 2 or fewer of the risk factors suggests a 99.4% chance of **not** developing candidemia, while patients with >2 risk factors have a 4.7% risk of developing candidemia.
Urinary Tract **Patients should be assessed for risk of multi-drug resistant pathogens.** Suggested risk factors for resistant pathogens: 1) Residence in long-term care facility (LTCF) 2) Recent receipt of broad spectrum antibiotics 3) History of MDR urinary pathogen 4) History of recurrent UTI 5) Nosocomial UTI	**Not at risk for multi-drug resistant organisms** Ceftriaxone 1g IV q24h (2 grams if >80kg) **+/-** Gentamicin 7 mg/kg EIAD *Severe beta-lactam allergy (anaphylaxis, hives):* Aztreonam 2 gm IV q8hr **+/-** Gentamicin 7 mg/kg IV EIAD **At risk for multi-drug resistant organisms** Cefepime 1 gm IV q6hr **OR** Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **+/-** Gentamicin 7 mg/kg IV EIAD **+/-** Vancomycin per pharmacy consult (initial 25mg/kg loading dose) *Severe beta-lactam allergy (anaphylaxis, hives):* Aztreonam 2 gm IV q8h **PLUS** Gentamicin 7 mg/kg IV EIAD **PLUS** Vancomycin per pharmacy consult (initial 25mg/kg loading dose)
Skin/Soft Tissue:	Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **PLUS** Vancomycin Preferred (initial loading dose of 25mg/kg) OR Daptomycin 6 mg/kg IV **+/-** Clindamycin 900mg IV Q8H
Necrotizing Skin/Soft Tissue: Gas Gangrene or Necrotizing Fasciitis **(Add Clindamycin if Streptococci suspected or evidence of toxic shock syndrome present)**	*Severe beta-lactam allergy (anaphylaxis, hives):* Aztreonam 2 gm IV q8h **PLUS** Vancomycin IV per pharmacy consult (initial 25mg/kg loading dose) **+/-** Clindamycin 900mg IV Q8H
Intra-abdominal Source	Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **OR** Cefepime 1g q6h hours **PLUS** Metronidazole 500 mg IV q8h **+/-** Gentamicin **OR** Tobramycin 7 mg/kg IV EIAD **+/-** Vancomycin per pharmacy consult (initial 25mg/kg loading dose) *Severe beta-lactam allergy (anaphylaxis, hives):* Aztreonam 2gm IV q8h **PLUS** Metronidazole 500 mg IV q8h **PLUS** Vancomycin per pharmacy consult (initial 25mg/kg loading dose) **+/-** Gentamicin **OR** Tobramycin 7 mg/kg IV EIAD
Community Acquired Pneumonia – No Pseudomonas Risk Factors Excludes nursing home patients.	Ceftriaxone 1 gram (2 grams if > 80 kg) IV q24h **PLUS** Azithromycin 500 mg IV q24h *Severe beta-lactam allergy (anaphylaxis, hives):* Levofloxacin 750 mg IV q24h
Community Acquired Pneumonia – Pseudomonas Risk Factors (structural lung disease, >10mg prednisone/day, malnutrition) **Excludes nursing home patients.**	1) Cefepime 1 gm IV q6hr **OR** Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **PLUS** Levofloxacin 750 mg IV q24h 2) Cefepime 1 gm IV q6hr **OR** Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **PLUS** Tobramycin 7 mg/kg IV EIAD **PLUS** Azithromycin 500 mg IV q24h **OR** Levofloxacin 750 mg IV q24h *Severe beta-lactam allergy (anaphylaxis, hives):* Aztreonam 2 g IV q8h **PLUS** Levofloxacin 750 mg IV q24h **PLUS** Tobramycin 7 mg/kg IV EIAD

Nosocomial Pneumonia: healthcare-associated pneumonia (HCAP), hospital-acquired pneumonia (HAP), ventilator-associated pneumonia (VAP) **Classification as healthcare associated pneumonia:** • Antimicrobial therapy in preceding 90 d • Hospitalization for >2d in preceding 90 d • Residence in a nursing home or extended care facility • Home wound care • Home infusion therapy (including antibiotics) • Chronic dialysis within 30 d • Immunosuppressive disease and/or therapy **Add azithromycin if requiring coverage of atypical pathogens (e.g. *Legionella sp.*)** **Add Levofloxacin if evidence/suspic of *S. pneumoniae* infection** **Add clindamycin in patients with beta-lactam allergy if requiring coverage for aspiration pneumonia/anaerobes**	1) Cefepime 1 gm IV q6hr **OR** Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **OR** Meropenem 1 gm IV q8hr **PLUS** Azithromycin 500 mg IV q24h **PLUS** Vancomycin IV per pharmacy consult (initial 25mg/kg loading dose) (Linezolid is also an option) 2) Cefepime 1 gm IV q6hr **OR** Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **OR** Meropenem 1 gm IV q8hr **PLUS** Levofloxacin 750 mg IV q24h **PLUS** Vancomycin IV per pharmacy consult (initial 25mg/kg loading dose) (Linezolid is also an option) 3) Cefepime 1 gm IV q6hr **OR** Piperacillin/tazobactam 4.5g IV q8h, infused over 4 hours **OR** Meropenem 1 gm IV q8hr **PLUS** Tobramycin 7 mg/kg IV EIAD **PLUS** Azithromycin 500 mg IV q24h **OR** Levofloxacin 750 mg IV q24h **PLUS** Vancomycin IV per pharmacy consult (initial 25mg/kg loading dose) (Linezolid is also an option) *Severe beta-lactam allergy (anaphylaxis, hives):* Aztreonam 2 gm IV q8h **PLUS** Tobramycin 7 mg/kg IV EIAD **PLUS** Azithromycin 500 mg IV q24h **OR** Levofloxacin 750 mg IV q24h **PLUS** Vancomycin IV per pharmacy consult (initial 25mg/kg loading dose) (Linezolid is also an option) **+/-** Clindamycin 600 mg IV q8h

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(all of the above measures plus the following)

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Within (6) Hours of Septic Shock Clock		
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+/- denotes that the drug is optional and use should be based on assessment of severity of infection and likelihood of resistance or isolation of the pathogen the agent targets

Suspected Source of Infection	Suggested Antibiotics
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Date:_____ TIME ZERO: _____

ALL of the following within (3) Hours of Time Zero

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☐ IV Antibiotic (ATB) initiated (not ordered)		Time:		Print Name

AND within (3) Hours of Time Zero

☐ 30 mL/kg Crystalloid Fluid Bolus (0.9% NS or LR) for Hypotension or Lactate ≥4 (consider for Severe Sepsis) Weight kg_____ X 30 = _____ mL predicted	*Total volume given over 4-5 hours* **Target time to complete 30mL/kg:** **Amount infused in ED:**	Print Name

AND within (6) Hours of Time Zero

☐ Repeat Lactate result if initial is > 2.0 mmol/L (order 2hrs after prior draw time)	Draw Time:	Result Time:	Result:	Print Name

SEVERE SEPSIS WITH SEPTIC SHOCK CHECKLIST

(all of the above measures plus the following)

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Date:_____ SEPTIC SHOCK CLOCK: _____

Within (6) Hours of Septic Shock Clock

☐ Vasopressors	Time:	Print Name

Within (6) Hours of Septic Shock Clock

☐ **Repeat Volume Status and Tissue Perfusion Assessment Note (written by NP/PA/MD/DO) consisting of including vital signs, cardiopulmonary, capillary refill, pulse, and skin findings**

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