SEPSIS SCREENING TOOL ACUTE ASSESSMENT

01 START THIS CHART IF THE PATIENT LOOKS UNWELL OR MEOWS HAS TRIGGERED

RISK FACTORS FOR SEPSIS INCLUDE:

- Impaired immunity (e.g. diabetes, steroids, chemotherapy)
- Recent trauma / surgery / invasive procedure
- Indwelling lines / IVDU / broken skin

02 COULD THIS BE DUE TO AN INFECTION?

LIKELY SOURCE:

- Respiratory
- Breast abscess
- Urine
- Abdominal pain / distension
- Infected caesarean / perineal wound
- Chorioamnionitis / endometritis

03 ANY RED FLAG PRESENT?

- Objective evidence of new or altered mental state
- Systolic BP ≤ 90 mmHg (or drop of >40 from normal)
- Heart rate ≥ 130 per minute
- Respiratory rate ≥ 25 per minute
- Needs O₂ to keep SpO₂ ≥ 92%
- Non-blanching rash / mottled / ashen / cyanotic
- Lactate ≥ 2 mmol/l*
- Not passed urine in 18 hours (<0.5ml/kg/hr if catheterised)

* lactate may be raised in & immediately after normal delivery

04 ANY AMBER FLAG PRESENT?

- Acute deterioration in functional ability
- Respiratory rate 21-24
- Heart rate 100-129 or new dysrhythmia
- Systolic BP 91-100 mmHg
- Has had invasive procedure in last 6 weeks (e.g. CS, forceps delivery, ERC, cerclage, CVs, miscarriage, termination)
- Temperature < 36°C
- Has diabetes or gestational diabetes
- Close contact with GAS
- Prolonged rupture of membranes
- Bleeding / wound infection
- Offensive vaginal discharge
- Non-reassuring CTG / fetal tachycardia >160
- Behavioural / mental status change

FURTHER REVIEW REQUIRED:

- SEND BLOODS AND REVIEW RESULTS
- ENSURE SENIOR CLINICAL REVIEW within 1HR

TIME OF REVIEW:  

ANTIBIOTICS REQUIRED:

- Yes    - No

NO AMBER FLAGS = ROUTINE CARE / CONSIDER OTHER DIAGNOSIS

PATIENT DETAILS:  
DATE:  
NAME:  
DESIGNATION:  
SIGNATURE:  
TIME:
**SEPSIS SCREENING TOOL - THE SEPSIS SIX**

**COMPLETE ALL ACTIONS WITHIN ONE HOUR**

1. **OXYGEN IF REQUIRED**
   - Aim for O₂ saturations of 94-98%

2. **OBTAIN IV / IO ACCESS, TAKE BLOODS**
   - Blood cultures, blood glucose, lactate, FBC, U&Es
   - Lumbar puncture if indicated

3. **GIVE IV ANTIBIOTICS**
   - To local policy, consider allergy status
   - Antivirals may also be required

4. **CONSIDER IV FLUIDS**
   - If lactate is above 2 mmol/L give fluid bolus 20 ml/kg without delay
   - If lactate >4 mmol/L call critical care

5. **SERIAL LACTATE MEASUREMENT**
   - Nice recommends using lactate to guide further fluid therapy

6. **MONITOR URINE OUTPUT +/- CTG**

**RED FLAGS AFTER ONE HOUR – ESCALATE TO CONSULTANT NOW**

**RECORD ADDITIONAL NOTES HERE:**

- e.g. allergy status, arrival of specialist teams, variance from Sepsis Six