

UW MEDICINE SEPSIS STATEMENT

6/2023

- Treatment of infection should never be delayed until a patient meets sepsis criteria. When infection is suspected, treatment should be started without delay.
- Sepsis and septic shock represent medical emergencies and should be treated emergently.
- Evaluation and treatment of sepsis should be done in a manner consistent with the Medicare Sep-1 Quality Metric. This care includes obtaining blood cultures, evaluation of markers of organ dysfunction (including lactate), early initiation of empiric anti-infective agents, and volume resuscitation. With ongoing signs and symptoms of sepsis, especially septic shock, early initiation of vasopressors, re-assessment of hemodynamics, and repeat lactate levels are appropriate interventions.

- The UW Medicine Sepsis Team supports the [Sepsis-3 definition of sepsis](#) as: "...life threatening organ dysfunction caused by a dysregulated host response to infection."¹ Organ dysfunction is defined as the temporary or permanent abnormal functioning of an organ system that is thought to be related to infection. (i.e. elevated lactate, abnormal kidney function, respiratory failure, etc.)
- The UW Medicine Sepsis Team acknowledges the [Sepsis-3 definition of septic shock](#) as: "...a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality..". However, we do not believe that this population is limited to patients with both hypotension AND hyperlactatemia. This patient population can be defined by persistent hypotension and/or significant hyperlactatemia, both of which are associated with significantly increased mortality.
- Normal lactate does not exclude infection or sepsis.
- There are a variety of screening tools that can be used to help identify patients that might have sepsis and/or severe infection without sepsis. These tools include SIRS criteria, SOFA, qSOFA, MEWS and NEWS. While any of these tools may help identify a septic patient, none are perfectly sensitive or specific for sepsis. All patients with suspected sepsis require a clinical evaluation that may lead to appropriate testing and treatment.
- All providers treating a septic patient are responsible for appropriate documentation of this diagnosis.
 - One key element of this documentation is linking the relevant organ dysfunction to the sepsis diagnosis.
 - Example: "Pneumonia with sepsis – Patient presents with chest x-ray and clinical presentation consistent with severe pneumonia and sepsis. Accompanying hyperlactatemia and acute kidney injury are due to hypoperfusion resulting from sepsis."

SEPSIS CLINICAL TOOL

	Indicators	Order & Implement
<div>Sepsis Screening Criteria</div>	SIRS <u>Vitals & Clinical Presentation</u> HR > 90 RR > 20 WBC <4k or >12k Temp <36c or >38.3c Altered Mental Status Hypotension SBP <100, MAP <65 RR >22 + Suspicion of Infection	<div> Labs CBC CMP PT/INR Lactate Blood Cultures x2 UA with reflex culture </div> <div> Meds & Interventions Peripheral IV x2 IV Antibiotics Frequent VS Measure Weight </div>
<div>Sepsis</div>	ONE OR MORE <u>ORGAN DYSFUNCTION</u> AMS, Lactate > 2 Hypotension (SBP <90, MAP <65) Bilirubin, Creatinine > 2 Coagulopathy (INR > 1.5) Worsening Respiratory Status Platelets < 100k Urine Output <0.5mL/kg/H for >2H	30 mL/kg bolus NS or LR If bolus withheld, document clinical reason (.SEPSISFLUIDEXCEPTIONS) If initial lactate >2 repeat within 6 hours Increased monitoring
<div>Septic Shock</div>	ONE OR MORE Lactate ≥ 4 Persistent hypotension despite adequate IVF resuscitation (SBP < 90, MAP <65)	Vasopressors Target MAP >65 VS q5min until BP stable Septic Shock Reassessment (.SEPTICSHOCKREASSESS)