1. Does patient look sick?

**Tick**

**OR** NEWS ≥3 [Inpatients ≥5 or single parameter ≥3]?

Low risk of sepsis if normal behaviour and no high or moderate risk criteria present. Use standard protocols, consider discharge (approved by senior decision maker) with safety netting.

2. Could this be due to an infection?

Yes, but source unclear at present
- Pneumonia
- Urinary Tract Infection
- Abdominal pain or distension
- Cellulitis/septic arthritis/infected wound
- Device-related infection
- Meningitis
- Other (specify: "")

4. Assess further for possible sepsis

Organize early clinical assessment
- USE SBAR!
- Send bloods (including blood cultures, FBC, U&Es, CRP, LFTs, clotting, VBG)
- Full clinical assessment [Record time clinician attended]
- Consider other investigations (e.g. CXR, urinalysis ± MSU, etc)

**Treat obvious bacterial infections promptly**

3. ANY red flag criteria?

**Tick**

- Objective evidence of new altered mental state
- Heart rate > 130 per minute
- Systolic B.P. ≤ 90 mmHg (or drop >40 from normal)
- Respiratory rate ≥ 25 per minute
- New O₂ requirement to keep SpO₂ ≥92% (88% in COPD)
- Non-blanching rash / mottled / ashen / cyanotic
- Not passed urine in last ~18 h (or U.O. <0.5 ml/kg/hr)
- Lactate ≥2 mmol/l (if available)
- Severe immunosuppression, e.g. suspected neutropaenia

**Treat Urgently for Sepsis NOW (see overleaf)**

This is time critical, immediate action is required.
# Sepsis Six Pathway

To be applied to all adults and young people over 12 years of age with suspected or confirmed Red Flag Sepsis

Make treatment escalation plan; review CPR status
Inform SpR/Consultant (use SBAR) patient has Sepsis

<table>
<thead>
<tr>
<th>Action (complete ALL within 1 hour)</th>
<th>Time complete</th>
<th>Initials</th>
<th>Reason not done/variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Oxygen</strong></td>
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<tr>
<td>Aim to keep saturations 94-98%</td>
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<tr>
<td>(88-92% if at risk of CO₂ retention e.g. COPD)</td>
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<tr>
<td><strong>2. Blood (± other) cultures</strong></td>
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<tr>
<td>At least 1x peripheral blood ± line cultures. CXR &amp; urinalysis (± CSF, urine culture, etc)</td>
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<tr>
<td><em>Source control</em> – call surgeon/radiologist?</td>
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<tr>
<td><strong>3. IV antibiotics</strong></td>
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<tr>
<td>According to Trust protocol</td>
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<tr>
<td>Consider allergies prior to administration</td>
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<td><strong>4. IV fluids</strong></td>
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<tr>
<td>500ml stat if hypotensive / lactate &gt;2mmol/l. Repeat if clinically indicated – max 30ml/kg</td>
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<tr>
<td><strong>5. Check serial lactates</strong></td>
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<tr>
<td>If lactate &gt;4mmol/l consider referral to Critical Care and recheck after each ~10ml/kg challenge</td>
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<tr>
<td><strong>6. Monitor urine output</strong></td>
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<td>Consider if urinary catheter required</td>
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<tr>
<td>Commence hourly fluid balance chart</td>
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</tbody>
</table>

If after delivering Sepsis Six there is:
- further clinical deterioration
- persistent systolic BP <90 mmHg
- lactate not reducing

*or if patient critically ill at any time*

Discuss with Critical Care / Outreach team

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Space available for local short antimicrobial guideline/escalation policy