Sepsis FAQ

Sepsis Coordinator

1. **What is the role of the sepsis coordinator?**
   Every regional health ministry in Trinity Health has a sepsis coordinator. At Loyola University Medical Center, this role reports to the Center for Clinical Excellence. The sepsis coordinator focuses on reviewing the care that we have provided in the first six hours after the patient meets the criteria for severe sepsis or septic shock including identifying missed opportunities in the three and six hour bundles, providing follow up to nurse managers and unit medical directors on unit performance related to sepsis, and ensuring that physicians have signed orders related to the sepsis order set/protocol. This role is also a liaison to Trinity Health for work related to sepsis.

Clinical Care

1. **Are nurses working within their scope of practice by initiating the sepsis order set/protocol?**
   Yes. The initial response to sepsis order set and protocol falls under the framework of emergency protocols since sepsis is a medical emergency. Under the emergency framework, nurses who initiate the initial response to sepsis order set/protocol are working within their scope of practice. Additionally, it has been vetted with legal, Trinity Health, and regulatory personnel. The Initial Response to Sepsis Protocol has also been approved by the Medical Executive Committee.

2. **What happens if a physician does not co-sign the orders initiated by the nurse?**
   The sepsis coordinator will review all patients who have had an initial sepsis order and will identify any patients for whom this order set remains unsigned 72 hours after being placed by the nurse. The sepsis coordinator will reach out to the physician of record requesting co-signature. If necessary, the concern will be escalated to the department chair and Associate Chief Medical Officer for Quality & Safety.

3. **If the patient has had a sepsis clock stopped, should a clock be started again with the next positive sepsis screen?**
   Yes! The sepsis screening tool has been designed to be a sensitive tool in order to avoid missing potential cases of severe sepsis and septic shock. As a result, it is
possible that a patient may screen positive (start the clock) and then have a provider determine that the patient does not yet meet the full criteria for severe sepsis or septic shock (“Stop the Clock”). It is in the patient’s best interest to carefully investigate every positive sepsis screening to rule out severe sepsis or septic shock. A patient who continues to trigger positive sepsis screens and cannot be ruled out for severe sepsis or septic shock requires emergent attention.

4. **If there is a physician at the bedside, is the nurse still required to initiate the initial response to sepsis order set/protocol?**
   - There should always be a dialogue between the nurse and physician about next steps for the patient. Ideally, the LIP should initiate the initial response to sepsis order set/protocol and the nurse should perform the ordered interventions.

5. **When the MEWS 5+ BPA is triggered, should the bedside nurse call the Rapid Response Team first, or fill out the sepsis screen first?**
   - It is recommended to initiate the rapid response first and then complete the sepsis screen after.

6. **Do blood cultures need to be drawn if they were already drawn within the last 24 hours?**
   - The orders are pre-checked to create standardization. If the physician is at the bedside, have a dialogue about the blood cultures being drawn. If the physician is not at the bedside, then the blood cultures should be drawn, since you will also need to draw a lactate level as well.

7. **Are comfort care and/or hospice patients excluded from the initial response to sepsis order set/protocol?**
   - Yes. If the patient has a comfort care order or is a hospice patient, they are excluded from the sepsis protocol.

8. **What happens if the ER starts the sepsis clock and initiates the initial response to sepsis order set but the admitting team does not agree that the patient has severe sepsis or septic shock? Is it OK to not complete the 3 and/or 6 hour bundle?**
   - If the admitting service does not agree the patient meets clinical criteria for severe sepsis or septic shock, they should speak to the ED physician to understand their rationale. If the admitting service still does not agree, then documentation must be present in the progress note that states the patient is not severe sepsis or septic shock. If documentation does not appear in the progress notes, the 3 and 6 hour bundles must be completed.

9. **A patient is treated with the initial response to sepsis order set in the ED and is transferred to a bed. Upon arrival to the floor, the MEWS BPA fires. What should the nurse do?**
If a MEWS of 4 BPA fires, the nurse should fill out the sepsis screening tool and if it is positive, should call an RRT. If a MEWS of 5 BPA fires, the nurse should call an RRT. The rationale for this is that the patient condition may change from the time the patient was treated for sepsis in the ED.

10. Does stopping the sepsis clock discontinue the Initial Response to Sepsis Orders?
No, any orders that the LIP does not want to be completed must be discontinued in EPIC.

11. What if my patient has an active or suspected infection, but I know the MEWS elevated due to another disease process, unrelated to the infection?
If the MEWS is high and the patient has a positive sepsis screen, the sepsis clock should be started. If the LIP determines the patient does not have severe sepsis or septic shock, the LIP should stop the clock. The rationale for this is that the patient may have deteriorated or had a change in status since the prior MEWS BPA.

12. As an LIP, can I verbally discontinue sepsis care if I believe the patient does not have severe sepsis once the RN has started the sepsis clock?
Only an LIP can stop the sepsis clock. Therefore if you determine the patient does not have severe sepsis or septic shock, you should stop the sepsis clock via the sepsis navigator within 3 hours of sepsis clock start time. Every sepsis clock start time must be followed by either a completed 3 hour sepsis bundle or a sepsis clock stop.

Antibiotics

1. How were the antibiotics chosen to be in the sepsis order set/protocol?
The antibiotics were chosen based on national recommendations for the treatment of sepsis. The infectious disease service, pharmacy, and sepsis committee members were involved in the selection process. The goal of the selection was to ensure rapid ordering of an antibiotic by limiting decision making to reviewing a known drug allergy to Penicillin.

2. How quickly do the antibiotics need to be administered?
When treating sepsis, every hour that this initial dose of antibiotic is delayed increases mortality. As a result, antibiotics in the sepsis order sets are “stat” medications. “Stat” medications should be administered within 30 minutes of the order being placed.

3. Whose responsibility is it to administer the antibiotic?
After an order is placed for a patient, any nurse can administer the medication. When a rapid response is called, the Rapid Response Team nurse assesses the
patient, determines whether the patient needs to be moved to a higher level of
care, and initiates the Initial Response to Sepsis Order Set/Protocol. The bedside
nurse should administer the antibiotic while the Rapid Response Team nurse
coordinates care for the patient.

4. **What happens if a patient has an allergic reaction to the antibiotic that is
administered from the sepsis order set/protocol?**
   It is the responsibility of the nurse initiating the Initial Response to Sepsis Order
   Set/Protocol to review the current patient allergies documented in the medical
   record prior to selecting the antibiotic from the Initial Response to Sepsis Order
   Set/Protocol. If an allergic reaction occurs related to the antibiotics from the sepsis
   order set/protocol, the primary service should be notified for immediate action.

5. **What antibiotic should be chosen if the patient’s allergies is “unknown” and we
   cannot verify with the patient because they are obtunded?**
   In this case, choosing the penicillin allergic option would be safest.

6. **What should we do if the patient is allergic to all three antibiotic choices?**
   This should be very rare, but in this case, the nurse is outside of the protocol and
   the nurse should contact the physician to choose another antibiotic through the IP
   sepsis order set.

**Rapid Response**

1. **Will Rapid Response calls increase due to this initiative?**
   The Rapid Response Team has responded to calls related to sepsis since May 2016.
   However, due to increase awareness about sepsis and increased screening, calls may
   increase. However, the majority of our severe sepsis and septic shock patients are
   served in the Emergency Department and Intensive Care Units, which are not served
   by the Rapid Response Team.

2. **Should an RRT be called for every positive sepsis screen?**
   Yes, the intervention for a positive sepsis screen on a non-ICU unit is to call a rapid
   response.

3. **Can the floor nurse assist in the RRT by placing the initial response to sepsis
   orders?**
   Yes. Any nurse can follow the emergency protocol for sepsis, including a floor
   nurse, Intensive Care unit nurse, or Rapid Response Team nurse. Therefore, the
   floor nurse can place the sepsis orders into Epic. This process would be similar to
   the current RRT orders that may be placed during an RRT.
4. **If the physician is at the bedside of the RRT, do they have to use the initial response to sepsis order set?**
   Yes. Although, if the physician decides that there is clinical justification for another antibiotic choice, then this initial response to sepsis order set would not be used, but the IP sepsis order set must be used. However, we will follow-up with that physician to understand why the initial response to sepsis order set was not used, but if there is clinical justification, then it is acceptable.

5. **Is it mandatory for MICU residents to attend a rapid response?**
   The rapid response team consists of an ICU nurse and respiratory therapist. It is advantageous for the MICU resident to attend an RRT as the likelihood of the patient being transferred to the MICU is great, although attendance is not a mandatory requirement.