

# ED CODE SEPSIS WORKFLOW

## Code Sepsis Triage Criteria:

- 1) Two SIRS criteria OR ANY hypotension\* AND
- 2) A symptom or sign that suggests infection\*\*

### \*Triage SIRS criteria OR hypotension:

- HR > 90
- T > 100.4F
- RR > 20
- WBC > 12,000 (not usually available at triage)
- SBP < 90 or MAP < 65

### • Symptoms that may suggest a source of infection:

- Fever / Rigors
- Dysuria
- Cough
- Abdominal pain / Diarrhea
- Rash / Soft tissue infection
- Altered mental status

This symptom list is NOT intended to be exclusive, and the Triage RN can activate for any clinical suspicion of a bacterial illness.

## Code Sepsis Activation Phone Numbers

RIH - Medcomm: 401-444-7600

TMH - Phone call to the receiving unit / Team secretary.

Also notify charge:  
401-413-5328 (7a-11p)  
401-413-8267 (11p-7a)

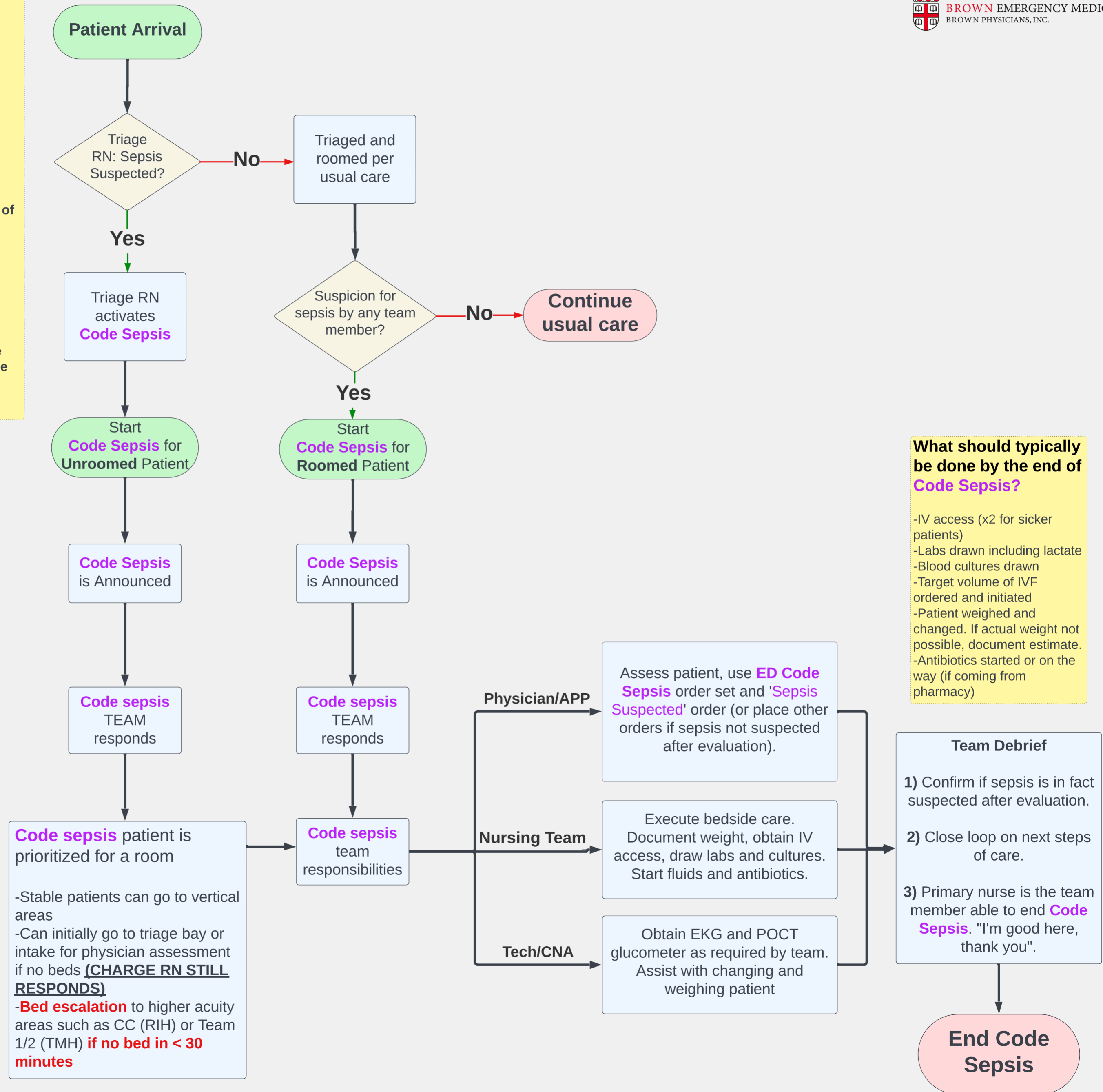
## Code Sepsis TEAM

- 1) Physician or APP\*\*\*
- 2) Charge nurse (or RN designee)
- 3) Primary RN (if one in care area)
- 4) Tech/CNA from current care area

## \*\*\*Code Sepsis - Responsible Physician / APP

RIH:  
Public: PIT physician or B pod overnight  
Ambulance: A pod team  
Critical care: CC Medical team

TMH:  
Public (daytime): PIT physician  
Activations to Team 1/2/4:  
Provider in care area



## What should typically be done by the end of Code Sepsis?

- IV access (x2 for sicker patients)
- Labs drawn including lactate
- Blood cultures drawn
- Target volume of IVF ordered and initiated
- Patient weighed and changed. If actual weight not possible, document estimate.
- Antibiotics started or on the way (if coming from pharmacy)

## Team Debrief

- 1) Confirm if sepsis is in fact suspected after evaluation.
- 2) Close loop on next steps of care.
- 3) Primary nurse is the team member able to end Code Sepsis. "I'm good here, thank you".

**End Code Sepsis**