

SEPSIS HYPOPERFUSION PATHWAY

Use in conjunction with EWS chart & Sepsis Six screening and action tool

Patient Label

Name: _____

NHI: _____ or patient details DOB: _____
dd/mm/yy

Address: _____

ADULT PATIENT WITH SUSPECTED SEPTIC SHOCK

Signs of infection and hypotension and/or raised lactate

Signs of hypoperfusion after **SEPSIS SIX** bundle completed
Remains hypotensive SBP <90, RR>25, decreased level of consciousness,
lactate not falling

MAY NEED ICU & VASOACTIVE SUPPORT

Inform relevant senior clinician

1. Ensure escalation remains appropriate
2. Commence phenylephrine or metaraminol (as below) by peripheral infusion to achieve MAP >65
3. Arrange urgent source control if required (discuss with relevant surgical team)
4. Discuss with Intensive Care Team
5. Arrange definitive care

If in a peripheral hospital and accepted for ICU:

- Commence supportive therapies in consultation with ICU team.
- Arrange insertion of arterial & central venous catheters then transition to noradrenaline (as below).
- Consider local skilled resources to assist (eg. onsite anaesthetist).

Arrange transport to appropriate ICU facility with accepting team approval. Critical Care retrieval may be appropriate

If in a hospital with Critical Care capability:

- Commence supportive therapies in consultation with ICU team.
- Arrange transfer to ICU as soon as possible.

Maintain vigilance and re-assess patient regularly to achieve:

- MAP >65mmHg, SpO₂ >94%, lactate reducing and acceptable urine output
- Continue all supportive care and re-consider source control

Phenylephrine: 10mg diluted into 100mL of D5W creates 100microg/mL solution.
Run at 0-30mL/hr via secure peripheral IV

Metaraminol: 10mg diluted to 20mL of H₂O creates 0.5mg/mL solution. Run at 0-30mL/hr via secure peripheral IV

Noradrenaline: 4mg diluted into 50mL of D5W creates 80microg/mL solution. Run at 0-30mL/hr via central venous catheter

NOTE: arterial monitoring is considered mandatory if noradrenaline is used.