

SEPSIS KEY: Assessment Finding/Cue	Physiologic Rationale	Nursing Intervention	Reassessment/Expected Improvements
Sepsis	SIRS plus suspected UTI and or pneumonia	Sepsis protocol: administer ordered antibiotics within one hour post any cultures	Resolution of sepsis
Decreased LOC (lethargic/confused)	Decreased tissue perfusion to brain and hypoxia of brain cells due to decreased perfusion /shock.	Reorient, educate, keep day night schedule, assess neuro status frequently	LOC normal for patient
Warm, flushed skin	Massive vasodilation from inflammatory response and increased body temp (fever)	Cover pt. with sheet to prevent shivering	No shivering. Skin warm, dry
Tachycardia	O2 sat 82 showing hypoxia, RR 34 and shallow with cackles	Apply O2, anticipate intubation and mechanical ventilation if does not improve quickly: increased RR will exhaust patient	Sao2, ABG, and RR improving
Tachypnea	Compensation for tissue hypoxia and metabolic acidosis	Provide O2, assess, oral care for dry mouth	RR in normal range
BP <90, MAP 65: remains low post IV fluid bolus; pulses weak and thready	Massive vasodilation and systemic capillary permeability	Anticipate vasopressor and or health care provider to assess fluid status using passive leg raises	Goal: MAP > 65 &/or systolic BP > 90 ; Central venous pressure 8 to 12 (filling pressure of right ventricle)
Fever	Bacterial infection, sepsis	Give antibiotic, antipyretics, use aseptic technique to prevent further infection	Temp in normal range
Oliguria	Inadequate renal perfusion and possible kidney injury/failure	Anticipate administering normal saline 30 mL/kg. Monitor hourly U.O. Monitor BUN, CRT	Goal for U.O. 30 mL/hr or 0.5 mg/kg/hr.
Elevated blood glucose of 200	Stress can cause liver to break down sugars, insulin resistance can occur in septic patient	Keep BG around 140 or less with ordered insulin	BG in acceptable range
Lactate 2.2	hypoperfusion	Fluids and then vasopressor	Lactate decreasing
Metabolic Acidosis ABG	Hypoperfusion	Fluids and then vasopressor	Acidosis improving/resolving
MODS starting	Cardiovascular - decreased BP, tachycardia, need for vasopressors; Neuro - confused, lethargic; Endocrine - hyperglycemia; renal - oliguria; metabolic: metabolic acidosis, elevated lactate	Close assessment, administration of antibiotics on time, fluids as ordered, hourly VS, U,O; monitor labs. Administer vasopressors per order. Notify MD ASAP of changes. Prevention of end organ failure & MODS: organize care, decrease stimuli, anticipate intubation & IV sedation to help decrease O2 demand & increase O2 to tissues; ? early nutrition viaNGT	Signs of improving perfusion: normalizing BP, MAP, U.O. , capillary refill, absence of mottling, Lactate decreasing/returning to normal. All labs returning to a more normal range