Sepsis Screening Tool
Screening Objectives

- Early identification of patients for SEVERE Sepsis
- Initiate early resuscitation and implementation of Severe Sepsis Order Set
- Increase survival rates with early detection and treatment
- Decrease patient LOS
- Decrease healthcare costs related to Severe Sepsis
Guidelines for Screenings

- Sepsis Screenings are to be done upon patient admission, at every 12 hour shift and PRN depending on patient condition.

- If a patient is placed on the Severe Sepsis Order Set, then no screening is required for 72 hours after this screen.

- Sepsis Screenings are NOT to be done on patients that are Comfort Measures Only.

- The electronic tool incorporates the latest available patient vitals, labs, and assessment data as part of the sepsis screening in order to make the tool more accurate and less time consuming for the nurse.

- A call to the patient’s Managing Practitioner must be placed for EVERY positive screening tool result, unless the patient has already been medically diagnosed with Sepsis and is actively being treated.

- Critical thinking and final responsibility to complete the tool, validate its findings and carry out orders pertaining to these results still remains with the bedside nurse.
Sepsis Screening in Net Access eCharting
Login to Net Access, select your patient. Next, click on eCharting, Chart, then Assessments, and from the Create New Assessment Type drop down click on Sepsis Screening. Then click on Begin.
Directions on when to complete a screening are given at the top of the screen; as well as, the **DATE** and **TIME** of when the patient last screened **POSITIVE** for Severe Sepsis. If the patient has not screened positive previously or has had no screenings done then no data will display.
If the Patient is on **Comfort Measures Only**, select **Yes** to the required question. Note, you are instructed to click on **RN Review** and then **Update/Complete** as screenings are not necessary for these patients.
If the patient is not CMO, click **No** to the required question in order to begin the screening process. Note, that once the No is selected, **Section 1** of the tool for SIRS (Systemic Inflammatory Response Syndrome) opens and is pre-populated with the most current vital sign and lab data available for the patient that meets each of the individual qualifying indicators used in the screening tool.
When any particular data element of the screening is found to be a qualifying indicator for that section, the checkbox for that item will automatically populate and the corresponding value will be displayed; along with the date and time of that result.

*NOTE: Any checkbox that is pre-populated by the sepsis screening tool itself can **NOT** be deselected by the nurse.
A display button to allow the Nurse to see all the screening values used for current sepsis screening tool they are working on can be done by clicking the button that says **All Screening Values**. Checkboxes will only be placed for qualifying indicators as per the evidence based criteria for SIRS, Sepsis or Severe Sepsis.
Here all values can be viewed. Once all values have been checked, click on **Close** to return to the Sepsis Screening form.

<table>
<thead>
<tr>
<th>eCharting Values</th>
<th>eCare Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature 95</td>
<td>Temperature</td>
</tr>
<tr>
<td>Pulse 40</td>
<td>Pulse</td>
</tr>
<tr>
<td>Respirations 10</td>
<td>Respirations</td>
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<tr>
<td>Pulse Ox 70</td>
<td>Pulse Ox</td>
</tr>
<tr>
<td>BP1 Systolic 70</td>
<td>Invasive BP Systolic</td>
</tr>
<tr>
<td>BP2 Systolic</td>
<td>Non-Invasive BP Systolic</td>
</tr>
<tr>
<td>BP3 Systolic</td>
<td>Invasive BP MAP</td>
</tr>
<tr>
<td>BP4 Systolic</td>
<td>Non-Invasive BP MAP</td>
</tr>
<tr>
<td>BP1 MAP 43.3</td>
<td></td>
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<tr>
<td>BP2 MAP</td>
<td></td>
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<tr>
<td>BP3 MAP</td>
<td></td>
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<tr>
<td>BP4 MAP</td>
<td></td>
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<tr>
<td>Glasgow - Admission 5</td>
<td>Glasgow - Shift 1203</td>
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<tr>
<td>Glasgow - Shift</td>
<td></td>
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<tr>
<td>Glasgow - NeuroCheck</td>
<td></td>
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<tr>
<td>Severe Sepsis Screening Positive</td>
<td></td>
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<tr>
<td>Severe Sepsis Orderset Started</td>
<td></td>
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<tr>
<td>Active DVTX of Sepsis/Infection</td>
<td></td>
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<tr>
<td>Lab Values</td>
<td></td>
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<tr>
<td>WBC 2.0</td>
<td></td>
</tr>
<tr>
<td>Bands</td>
<td></td>
</tr>
<tr>
<td>Lactic Acid - Respiratory 8.0</td>
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<tr>
<td>Lactic Acid</td>
<td></td>
</tr>
<tr>
<td>INR 0.5</td>
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<tr>
<td>PTT 20.0</td>
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<tr>
<td>Platelet Count 70</td>
<td></td>
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<tr>
<td>Total Bilirubin 0.1</td>
<td></td>
</tr>
<tr>
<td>ALT (SGPT) 10</td>
<td></td>
</tr>
<tr>
<td>AST (SGOT) 6</td>
<td></td>
</tr>
<tr>
<td>Alk Phosphatase 30</td>
<td></td>
</tr>
</tbody>
</table>
The screening tool will keep track of how many indicators have been met and show a total on the right hand side of each section. Once (2) or more indicators in Section 1 are met, **Section 2 for Sepsis** opens for the nurse to continue with the screen.
With **Section 2** now open to continue the sepsis screening, the nurse must fill in all corresponding information for their patient. If in any section, the patient does not meet the number of indicators needed to screen positive for that section, the nurse should click on **RN Review** and then **Update/Complete** to finish the screening.
Otherwise, the nurse should fill in all corresponding information for their patient with regards to **Infection**, **Suspected Infection** and **Non-prophylactic Antibiotic Therapy**.

Examples of suspected infection sources are provided on the form, but are not limited to what the nurse may perceive as a possible infection source. Remember, all yellow fields are required fields and must be completed.

*NOTE: Section 3 will only open if the patient has met a qualifying indicator in Section 2.*
Once one qualifying indicator for Section 2 is met, **Section 3 for Severe Sepsis** opens for the nurse to complete.

Use the scroll bar on the right hand side of the screen to move down to the other sections.
ALL Yes/No questions in Section 3 are required. Answers to these questions will help the tool determine if any qualifying indicators for their respective section is met or not; or if there is found to be a NEW ORGAN DYSFUNCTION for the patient. The tool will automatically select values that meet criteria once the section opens. Note the PaO2/FiO2 ratio calculation below.
As Yes/No questions are answered, areas that were once grayed out, may now be visible to the nurse and have selected qualifying indicators populated for the RN based on vitals, labs or assessment data available for the patient. Please note the Renal section outlined below. Based on these Creatinine results the patient is qualifying for NEW Renal Organ Dysfunction.
Once all required questions are answered and nurse validated indicators have been processed, if any one indicator is flagged in Section 3, then the patient has screened **POSITIVE** for Severe Sepsis.

Note the Date/Time of the Positive Severe Sepsis Screen. Only the **Update/Pending** button is available at this point. Click on this if you need to step away from the screening and complete it at a later time.
The nurse is to document the Managing Practitioner that was notified of the Positive Screen for Severe Sepsis and if the practitioner placed the patient on the Sepsis Resuscitation Order Set by clicking on either Yes or No below.

Remember, all yellow fields are required. Note there is a Comments field for any additional information the nurse may want to document at this time as well.

Once all the necessary information has been documented on the screening, click on RN Review if it has not been selected yet and then click Update/Complete.
If the patient is not placed on the Sepsis Resuscitation Order Set, click **No** and document all other fields accordingly.

Note, that no additional screening is required for the patient for another **24 hours**.

Once all the necessary information has been documented on the screening, click on **RN Review** if it has not been selected yet and then click **Update/Complete**.
If the patient is not placed on the Sepsis Resuscitation Order Set, click No. If the Managing Practitioner notified states this patient is actively being treated for a known infection or sepsis diagnosis, select the checkbox for Documented Diagnosis/Actively Being Treated as per MD.

Note, that no additional screening is required for the patient for another 72 hours.

Once all the necessary information has been documented on the screening, click on RN Review if it has not been selected yet and then click Update/Complete.
Verify that the Update for the patient was complete and that no errors were received during this process. View the message received below for confirmation.
Reminder: If the patient has been placed on the **Severe Sepsis Order Set** based on a positive screening result, **NO** screening is due for another **72 hours**.

NOTE: The message below for the patient that has screened positive, has been placed on the order set and it has been less than 72 hours. Click on **RN Review** and **Update/Complete** to finish the documentation.
Reminder: If the patient already has a *documented medical* diagnosis for sepsis, severe sepsis, etc, **AND** is *actively being treated for this diagnosis* NO further screenings are required for the patient for another 72 hours.

NOTE: The message below for the patient already diagnosed and actively being treated. Click on **RN Review** and **Update/Complete** to finish the documentation.
Revising/Completing a Sepsis Screen
To revise and document a screening after a positive screen for Severe Sepsis has been communicated, click eCharting, Chart, Assessments. Under the Change/Delete/View option select the screening that requires revision, then click Revise/Update.

NOTE: The Status of this assessment will be “P” for Pending.
Once you are in the Sepsis Screening Tool that is to be revised, make the appropriate changes or Complete the screening as necessary. The nurse will only be able to revise fields that were entered by the nurse.

Any pre-populated values CANNOT be changed via the tool.

***If a screening was done based on an incorrect Vital Sign, Lab value or Assessment finding, then that screening should be Marked Erroneous and new screening is to be completed for the patient with the new, correct values.
Scroll down to complete the information of the **Person Notified** of the POSITIVE Severe Sepsis screen along with the **Date/Time** of the notification, as well as if the patient was placed on the **Severe Sepsis Order Set**.

Click on **Update/Complete** when finished.
Viewing a Sepsis Screen in Net Access
To view the Sepsis Screening results, click on eCharting, Display, Sepsis Screening and then find the results for the Date and Time that are to be reviewed.
Scroll down to view more results. Note the entry for the Patient Screens Positive for Severe Sepsis.

Clicking on the paper icon or SEE TEXT to reveal more detail to an individual result. See example below for the saved data in Display for the Screens Positive Severe Sepsis entry for the patient.

Patient screened Positive for SEVERE SEPSIS due to these values:

- Temperature of 104 on 3/19/2010 at 0600
- Heart Rate of 104 on 3/19/2010 at 0600
- WBC count of 13 on 3/17/2010 at 1623
- Bands result of 11 on 3/17/2010 at 1633
- Suspected or documented infection in the last 24 hours: positive cultures
- Antibiotic Therapy (not prophylaxis) - Yes
- SaO2 of 69 on 3/19/2010 at 0600
- Need to initiate BiPAP or a mech vent to support ventilation - Yes

MAP of 53.3 on 3/19/2010 at 0600
Patient on Vasopressors - Yes
Patient on Vasopressors - Yes

Patient has Primary Neuro Dysfunction - No
Acute Change in Mental Status OR Level of Consciousness - Yes
Patient has Primary Renal Failure - No

250 ml in 24 hours - Yes

Patient has Primary Renal Failure - No
Oliguria-Urine Output less than 0.5 ml/kg/hr or less than
Clinical Data Viewer for Sepsis Screening
The Sepsis Screening can also be reviewed from the Clinical Data Viewer link off the Net Access navigator. To view a particular screening, click on **eCharting, Clinical Data Viewer**, then **Assessments**. Select the screening to review from the populated box of existing assessments for the patient and then click on **View**.
All individual items that qualified for the Sepsis Screening will be displayed with a checkbox corresponding next to that field. No items under the Clinical Data Viewer may be modified. This is only a **VIEW**.
Use the Scroll Bar to scroll down to View the rest of the Sepsis Screening.
Click on **Cancel** once the review of the sepsis screening is complete.
Quick Tips
Net Access Sepsis Screening Tool Quick Tips

- Complete an electronic Sepsis Screening Tool in Net Access for every patient that is ADMITTED, then Q Shift and PRN as needed for the patient.

- NO SCREENINGS are to be done on patients that are placed on Comfort Measures Only (CMO).

- If a patient is placed on the Sepsis Resuscitation Order Set or has an already existing diagnosis for Sepsis AND is actively being treated and the Managing Practitioner does not wish to place the patient on the order set, then no screening is required for another 72 hours.

- If the patient screens positive for severe sepsis but is not put on the order set after communication is done, the patient must be screened again after 24 hours.

- The Net Access screening tool is divided into three sections; Section 1- SIRS, Section 2- Sepsis, Section 3- Severe Sepsis.

- The electronic tool will automatically select and display on the screen any Vitals Signs, Lab values or Assessment values that qualify in each of these different sections.

- The tool will guide the nurse through each of the 3 different sections of the tool as each section qualifies accordingly based on defined criteria and qualifying indicators.
Sepsis Screening may be left **PENDING** until someone is notified and their name, date/time of notification and orders provided (if any) are documented.

Use the eCharting, Chart, Assessments **REVISE** feature to enter this information in and then **UPDATE COMPLETE** the sepsis screening for the patient.

A nurse is **ONLY** required to call a Medical Provider/Managing Practitioner if the patient screens **POSITIVE** for **SEVERE SEPSIS (Section 3)**. These calls should be done in a timely fashion and all calls placed to the practitioner should be documented in the patient’s notes.

If a patient already has a medically documented sepsis diagnosis and is actively being treated for sepsis, complete the screening tool as expected. However, at the bottom, the nurse will be able to document this finding and allow for the screening tool to not be required for another 72 hours.

Remember to discuss the sepsis screening tool results during shift to shift handoff, as well as, if any pending phone calls or interventions regarding the Sepsis Screening or Sepsis Resuscitation Order Set are left to be done for your patient.
Sepsis Screening Reminder

If a Sepsis Screening is overdue for the patient, a RED reminder screen will appear when the Nurse is under the Net Access eCharting, Chart, Assessments function and a Sepsis Screening is not selected to be documented. In order to complete a Sepsis Screening, click on Return to Navigator and select to start a new Sepsis Screening assessment from the drop down menu.
CONGRATULATIONS!

You have successfully completed the Net Access Sepsis Screening Tool for Nurses.