



Septic Patient with Hypotension or Lactate ≥ 4

Establish Goals of Care

Stop Protocol

Pan-Cultures, Source Control, and Broad Spectrum Antibiotics

20 cc/kg Isotonic Fluid Bolus

Central Venous Access in Internal Jugular or Subclavian using Full Sterile Technique

Hypoxemia

Intubation* and lung protective ventilation

Pain Control and Sedation regimen using sedation scale

Notes:

- * Ketamine is the preferred induction agent
 - † If MAP > 90 without pressors, titrate nitroglycerin infusion until MAP < 90
 - ‡ If tachycardic, consider phenylephrine 50-400 mcg/min
 - § When sending ScvO₂, send repeat Lactate. If lactate is not normalizing, consider the same therapies as for low ScvO₂
- Revised 11/22/2009

NO

Volume Status (See 2nd Page)

500 ml Isotonic Fluid Bolus

Adequate

MAP[†]

Titrate Norepinephrine[‡] (1-40 mcg/min)

Sterile A-line placement as soon as possible

If MAP < 65 after Norepi > 20 mcg/min: add Hydrocortisone 100 mg IV Q8 & Vasopressin 0.04 units/min

≥ 65

ScvO₂[§]

HCT

Transfuse 1 unit PRBC (preferably leukoreduced)

Severe Sepsis Protocol
Division of Emergency Critical Care
M S S M

Consider **one** of the following

Intubate, if patient not currently (especially in the elderly). Give heavy sedation and pain control.

Inotropes, especially if heart appears hypodynamic
Consider calcium (500-1000 mcg) first if low and then dobutamine (2.5-20 mcg/kg/min)

Additional Fluids, if any of the volume assessments (see page 2) indicate possible volume responsiveness

Transfuse, 1 unit PRBC (preferably leukoreduced) if HCT between 21 and 30. Especially in patients with coronary artery disease