Severe Sepsis Protocol

**Septic Patient with Hypotension or Lactate ≥ 4**

- Establish Goals of Care
- Curative
- Pan-Cultures, Source Control, and Broad Spectrum Antibiotics
- If lactate was ≥ 4 or pt remains hypotensive
  - Central Venous Access in Internal Jugular or Subclavian using Full Sterile Technique

**Hypoxemia**

- **YES**
  - Intubation* and lung protective ventilation
  - Pain Control and Sedation regimen using sedation scale
- **NO**
  - Volume Status (See 2nd Page)
  - Inadequate
    - 500 ml Isotonic Fluid Bolus
  - Adequate
    - MAP †
      - < 65
        - Titrate Norepinephrine ‡ (1-40 mcg/min)
        - Sterile A-line placement as soon as possible
      - ≥ 65
        - Transfuse 1 unit PRBC (preferably leukoreduced)
  - ≥ 65
    - ScvO2 §
      - < 70
        - HCT
          - < 21
            - Transfuse 1 unit PRBC (preferably leukoreduced)
          - ≥ 21
            - 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

**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

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