

## **Skilled Nursing Facility Sepsis Care Kit**













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## A Look at Sepsis<sup>1</sup>

#### What is sepsis?

The Centers for Disease Control and Prevention (CDC) defines sepsis as the body's extreme response to an infection. It is a life-threatening medical emergency.

Sepsis happens when an infection you already have—in your skin, lungs, urinary tract, or elsewhere—triggers a chain reaction throughout your body.

Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death.<sup>1</sup>

#### Who is at risk?

While anyone can get sepsis, certain populations are more at risk than others, including:

- Adults 65 and older.
- People with chronic medical conditions.
- People with weakened immune systems.
- Children younger than one.

Whereas most skilled nursing facility (SNF) residents meet at least one of the abovementioned criteria, it is imperative that SNF residents be screened routinely for sepsis.

#### What symptoms should I look for?

Sepsis may not look the same in every person. Symptoms can include:

- Confusion or disorientation.
- Fever/shivering/feeling cold.
- Shortness of breath.
- High heart rate.
- Extreme pain or discomfort.
- Clammy/sweaty skin.

If a person has two or more Systemic Inflammatory Response Syndrome (SIRS) criteria and has a confirmed or suspected infection, he or she has screened positive for sepsis. Utilize the tools included in this care kit to act immediately for your residents!

<sup>&</sup>lt;sup>1</sup> Centers for Disease Control and Prevention (CDC) What Is Sepsis? (2019). https://www.cdc.gov/sepsis/what-is-sepsis.html.

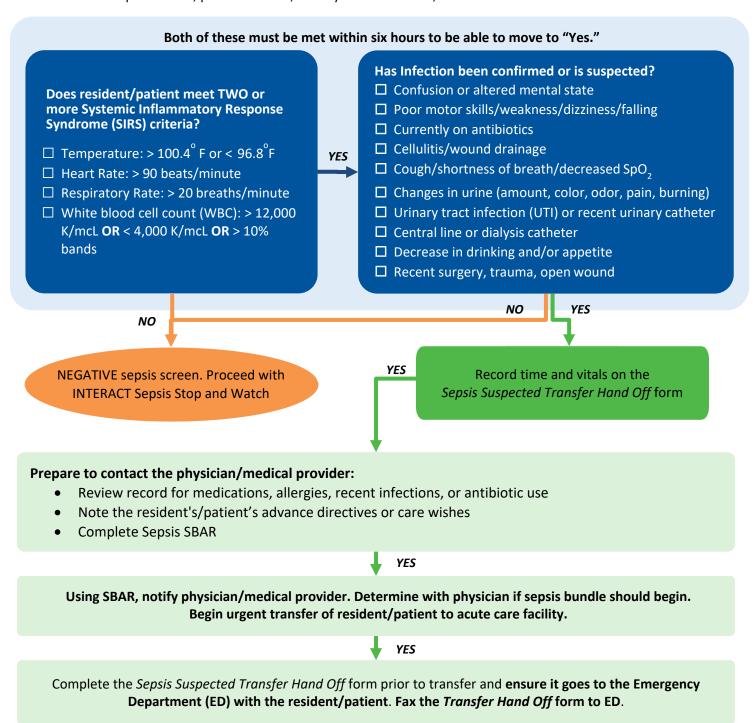






## Sepsis Care Pathway for Skilled Nursing Facilities<sup>2</sup>

**Anyone who has an infection is at high risk for sepsis.** Potential causes of infection that can lead to sepsis include: pneumonia, pressure ulcers, urinary tract infections, and other chronic conditions.



<sup>&</sup>lt;sup>2</sup> CDC. Vital signs and clinical tools. https://www.cdc.gov/vitalsigns/pdf/2016-08-vitalsigns.pdf, https://www.cdc.gov/sepsis/clinicaltools/, https://www.cdc.gov/sepsis/pdfs/factsheet-longterm-care-sepsis-nurses-508.pdf
Stop and Watch: https://pathway-interact.com/wp-content/uploads/2021/08/12-INTERACT-Stop-and-Watch-Early-Warning-Tool-2021.pdf





## **Skilled Nursing Facility Sepsis Screening Tool**<sup>3</sup>

Re	sident/Patient Name:		DOB:			
Nu	Nurse Completing Screening: Date/Time:		Date/Time:			
1.	Does resident/patient meet any of TWO of the Temperature: > 100.4° F or < 96.8 ☐ Heart rate: > 90 beats/minute ☐ Respiratory rate: > 20 breaths/min ☐ White blood cell count (WBC): > 1	o F				
2.	TWO SIRS criteria met?  ☐ Yes (move to question 3) ☐ No (so	creening complete)				
	Does resident/patient have a confirmed OR  ☐ Confusion or altered mental state ☐ Poor motor skills/weakness/dizziness/ ☐ Currently on antibiotics ☐ Cellulitis/wound drainage ☐ Cough/shortness of breath/decreased ☐ Change in urine (amount, color, odor,	falling cat  Ce  De  SpO <sub>2</sub>	inary tract infection (UTI) or recent urinary theter ntral line or dialysis catheter crease in drinking and/or appetite cent surgery, trauma, open wound her:			
3. 4.	If NO—Stop (screening complete) —> Conti If 2 and 3 are YES, then resident/patient has so Continue to screen for severe sepsis below.	•				
5.	Are ANY of the following organ dysfunction criteria present that are NOT a chronic condition?					
	<ul><li>Neurological:</li><li>ANY change in mental status</li></ul>	<ul><li>■ Metabolic:</li><li>• Serum lactate&gt; 2.0 mmol/L</li></ul>	<ul> <li>Pulmonary:</li> <li>RR &gt; 20 OR need to increase O<sub>2</sub> to maintain SpO<sub>2</sub> &gt; 90%</li> </ul>			
	<ul> <li>□ Cardiac:         <ul> <li>Systolic blood pressure (SBP) &lt; 90mmHg</li> <li>Mean arterial pressure (MAP) &lt; 60 mmHg</li> <li>&gt; 40 mmHg decrease in SBP from baseline</li> <li>Capillary refill &gt; 3 seconds</li> </ul> </li> </ul>	<ul> <li>□ Renal:</li> <li>Urine Output &lt; 0.5ml/kg/l hours (or &lt; 30 ml/hr for 2</li> <li>Serum creatinine increase by 0.3gm/dl in past 48 hours</li> </ul>	hours) • Diarrhea			
	<ul><li>☐ Hematologic:</li><li>• Platelet count &lt;100,000</li><li>• INR &gt; 1.5 or PTT &gt; 60 seconds</li></ul>	<ul><li>☐ Hepatologic:</li><li>Total bilirubin &gt; 4mg/d</li></ul>				

- 6. If NO, then complete Sepsis SBAR, and call MD to inform of positive sepsis screening and implement sepsis guidelines. Continue to assess/monitor for severe sepsis.
- 7. If YES, the resident/patient has screened POSITIVE for SEVERE SEPSIS. Complete Sepsis SBAR and call MD to inform of positive severe sepsis screening and prepare for transfer to acute care setting.

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<sup>&</sup>lt;sup>3</sup> Gyang E, Shieh L, et al. A Nurse-Driven Screening Tool for the Early Identification of Sepsis in an Intermediate Care Unit Setting. J Hosp Med, 2015, Feb. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4816455/
INTERACT. https://pathway-interact.com/wp-content/uploads/2021/08/15-INTERACT-SBAR-Communication-Form-2021.pdf









## **Skilled Nursing Facility (SNF)**

## Situation-Background-Assessment-Recommendation (SBAR) for Sepsis<sup>4</sup>

Communicate immediately with attending provider when a resident/patient screens positive for sepsis.

SITUATION:				
		•		s/she has met two or more of the following
Systemic Inflammatory Resp	onse Syndrome (SIRS)	criteria and has a co	onfirme	d or suspected source of infection.
Two or more SIRS criteria	met (check all that ap	pply):		
☐ Temperature: > 100	).4° F or < 96.8° F			
☐ Heart rate: > 90 bea	ats/minute			
☐ Respiratory rate: > 3				
☐ White blood cell co	unt (WBC): > 12,000 K/	mcL <b>OR</b> < 4,000 K/i	ncL <mark>OR</mark>	> 10% bands
Infection is confirmed or	suspected (check all th	nat apply):		
☐ Confusion or altere	d mental state		Urina	ary tract infection (UTI) or recent urinary
☐ Poor motor skills/w	eakness/dizziness/falli	ng	cath	eter
☐ Currently on antibio	otics		Cent	ral line or dialysis catheter
☐ Cellulitis/wound dra	ainage		Decr	ease in drinking and/or appetite
☐ Cough/shortness of	breath/decreased SpC	$_{ m D_2}$	Rece	nt surgery, trauma, open wound
$\square$ Change in urine (an	nount, color, odor, pair	n)	Othe	er:
BACKGROUND:				
Resident/patient was a	dmitted to SNF with:			
Allergies:				
Pertinent lab values: _				
Advance directives:				
ASSESSMENT:				
Resident's/patient's me	ntal status compared t	to baseline is: norm	al/abno	ormal
Temperature:	Pulse:	Respiration:_		Blood Pressure:
SpO <sub>2</sub> :	Urine output:	mL/hour or		mL over the last 8 hours
Most recent weight:		kg		
RECOMMENDATIONS:				

- 1. Request STAT orders for lactate level and blood cultures (x2).
- 2. Request orders for broad spectrum antibiotic(s) and 30mL/kg of normal saline or lactated ringers with rapid infusion.
- 3. Consider transfer to an acute care facility based on resident/patient presentation and response to interventions.
  - a. Complete SNF to Emergency Department (ED) Transfer Form.

Dellinger RP, Levy MM, Rhodes A, et al. Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2012. Critical Care medicine. 2013;41(2): 580-637.

Dinger M, Deutschman, CS Seymour CW, et al. The third international consensus definitions for sepsis and septic shock: 2016. JAMA. 2016;315(8): 801-810.doi:10.1001/jama.2016.0287.









## **SEPSIS SUSPECTED**

# Skilled Nursing Facility (SNF) to Emergency Department (ED) Transfer Handoff Form<sup>5</sup>

SNF/Facility:	Date:
SNF Contact Person:	Time First Criteria Met:
Patient Name:	DOB:
Advance Directive:	
Comorbidities:	
Check all that apply: Two or more Systematic Inflammatory Response Syndro 6-hour window	me (SIRS) criteria AND infection confirmed/suspected within
Two or more SIRS criteria have been met:  ☐ Temperature: > 100.4° F or < 96.8°F  ☐ Heart Rate: > 90 beats/minute  ☐ Respiratory Rate: > 20 breaths/minute  ☐ White blood cell count (WBC): > 12,000 K/mcL OR	R < 4,000 K/mcL <b>OR</b> > 10% bands
Infection is confirmed or suspected:  ☐ Confusion or altered mental state ☐ Poor motor skills/weakness/dizziness/falling ☐ Currently on antibiotics ☐ Cellulitis/wound drainage ☐ Cough/shortness of breath/decreased SpO₂ ☐ Change in urine (amount, color, odor, pain)	<ul> <li>□ Urinary tract infection (UTI) or recent urinary catheter</li> <li>□ Central line or dialysis catheter</li> <li>□ Decrease in drinking and/or appetite</li> <li>□ Recent surgery, trauma, open wound</li> <li>□ Other:</li> </ul>
Fluids and/or Antibioti	cs Started at SNF
FLUIDS	ANTIBIOTICS
Type of fluid:	Antibiotics given:
Time started:	Time given:
Amount given:	
Other pertinent information:	

<sup>&</sup>lt;sup>5</sup> CDC. Vital signs and clinical tools. https://www.cdc.gov/vitalsigns/pdf/2016-08-vitalsigns.pdf, https://www.cdc.gov/sepsis/clinicaltools/, https://www.cdc.gov/sepsis/pdfs/factsheet-longterm-care-sepsis-nurses-508.pdf Cleveland Clinic. Sepsis Warning Transfer Log.









## My Plan to Identify Infection and/or Sepsis

Name \_\_\_\_\_ Date \_\_\_\_\_

### **Green Zone: No Signs of Infection**

- My heartbeat and breathing feel normal for me.
- ✓ I don't have chills or feel cold.
- ✓ My energy level is normal.
- ✓ I can think clearly.
- ✓ Any wound or IV site I have is healing well.



#### **Green Means I Should:**

- ✓ Watch every day for signs of infection.
- Continue to take my medicine as ordered, especially if I'm recovering from an infection or illness.
- ✓ Keep my doctor and other appointments.
- ✓ Follow instructions if I'm caring for a wound or IV site.
- ✓ Wash my hands and avoid anyone who is ill.

#### **Yellow Zone: Caution**

- ✓ My heartbeat feels faster than usual.
- ✓ My breathing is fast, or I'm coughing
- ✓ I have a fever between 100.0°F and 101.4°F.
- ✓ I feel cold and am shivering—I can't get warm.
- ✓ My thinking is slow—my head is "fuzzy."
- ✓ I don't feel well—I'm too tired to do things.
- ✓ I haven't urinated in 5 hours or it's painful or burning when I do.
- ✓ Any wound or IV site I have looks different.



#### Yellow Means I Should:

- Contact my doctor, especially if I've recently been ill or had surgery.
- ✓ Ask if I might have an infection or sepsis.

Physician Contac		Į	l	•	
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Doctor:	

Phone:

### **Red Zone: Medical Alert!**

- ✓ I feel sick, very tired, weak, and achy.
- My heartbeat or breathing is very fast.
- ✓ My temperature is 101.5°F or greater.
- ✓ My temperature is below 96.8°F.
- ✓ My fingernails are pale or blue.
- ✓ People say I'm not making sense.
- My wound or IV site is painful, red, smells, or has pus.



#### **Red Means I Must:**

- ✓ Act fast ... Sepsis is serious!
- ✓ **Call 9-1-1** and say, "I need to be evaluated immediately. I'm concerned about sepsis."

Journal of the American Medical Association (JAMA) Network, JAMA Patient Page: Sepsis. October 2010. Available at: https://jamanetwork.com/journals/jama/fullarticle/186795. Accessed on June 8. 2018.

Centers for Disease Control and Prevention. Sepsis. Basic Information. How Can I Get Ahead of Sepsis? Available at: https://www.cdc.gov/sepsis/basic/index.html. Accessed on June 8, 2018. Mayo Clinic. Mayo Foundation for Medical Education and Research: Disease Conditions Information: Sepsis. Available at: https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214?p=1. Accessed on June 8, 2018. The Sepsis Alliance. General Information and Resources. Sepsis Symptoms. Available at: https://www.sepsis.org. Accessed on June 8, 2018.

 $Adapted from \ {\it ``Evaluation'} for Severe Sepsis Screening Tool \ {\it '`https://www.journalofhospital medicine.com/jhospmed/article/128173/severe-sepsis-screening-tool \ {\it '`https://www.jo$ 









#### **Additional Resources**

#### **Centers for Disease Control and Prevention: Sepsis?**

- https://www.cdc.gov/sepsis/what-is-sepsis.html
- <a href="https://www.cdc.gov/sepsis/pdfs/factsheet-longterm-care-sepsis-nurses-508.pdf">https://www.cdc.gov/sepsis/pdfs/factsheet-longterm-care-sepsis-nurses-508.pdf</a>
- https://www.cdc.gov/sepsis/clinicaltools/
- https://www.cdc.gov/vitalsigns/pdf/2016-08-vitalsigns.pdf

#### **Centers for Disease Control and Prevention: Nursing Homes and Assisted Living Resources**

https://www.cdc.gov/longtermcare/index.html

#### **INTERACT** (Interventions to Reduce Acute Care Transfers)

- <a href="https://pathway-interact.com/wp-content/uploads/2021/08/12-INTERACT-Stop-and-Watch-Early-Warning-Tool-2021.pdf">https://pathway-interact.com/wp-content/uploads/2021/08/12-INTERACT-Stop-and-Watch-Early-Warning-Tool-2021.pdf</a>
- <a href="https://pathway-interact.com/wp-content/uploads/2021/08/15-INTERACT-SBAR-Communication-Form-2021.pdf">https://pathway-interact.com/wp-content/uploads/2021/08/15-INTERACT-SBAR-Communication-Form-2021.pdf</a>

#### **Merck Manual**

• <a href="https://www.merckmanuals.com/professional/critical-care-medicine/sepsis-and-septic-shock/sepsis-shock/sepsis-and-septic-shock/sepsis-and-septic-shock/sepsis-and-septic-shock/sepsis-shock/sepsis-shock/sepsis-shock/sepsis-shock/sepsis-shock/sepsis-shock/sepsis-shock/sepsis-shock/sepsi

#### Minnesota Hospital Association—Seeing Sepsis Tools

• <a href="https://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-improvement-topics/sepsis#/videos/list">https://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-improvement-topics/sepsis#/videos/list</a>

#### **Surviving Sepsis Campaign**

http://survivingsepsis.org/Pages/default.aspx

#### **Sepsis Alliance**

https://www.sepsis.org/