LIBERTYHEALTH

Jersey City Medical Center
Department of Patient Care Services

POLICY: Calling "Activate sepsis Team"

Developed by: Sepsis Collaborative

Approved by: _____
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Approved by: _____
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Effective Date: August 31st, 2009

Distribution: Critical Care Division, Emergency Department; Department of Medicine, Department of Respiratory Therapy, Security

Purpose:

The purpose of calling "Activate Sepsis Team" is to expedite the timely treatment of patients presenting to the emergency department in severe sepsis and septic shock. The goal is to transfer the patient from the emergency department to a critical care bed within 90 minutes of diagnosis.

Policy:

"Activate Sepsis Team" is to be called whenever a patient has been identified to be in severe sepsis and/or septic shock and Lactate $\geq$ 4 or SBP $\leq$ 90mmHg (MAP $\leq$ 65) despite initial 20-30cc/kg NS bolus.

Procedure:

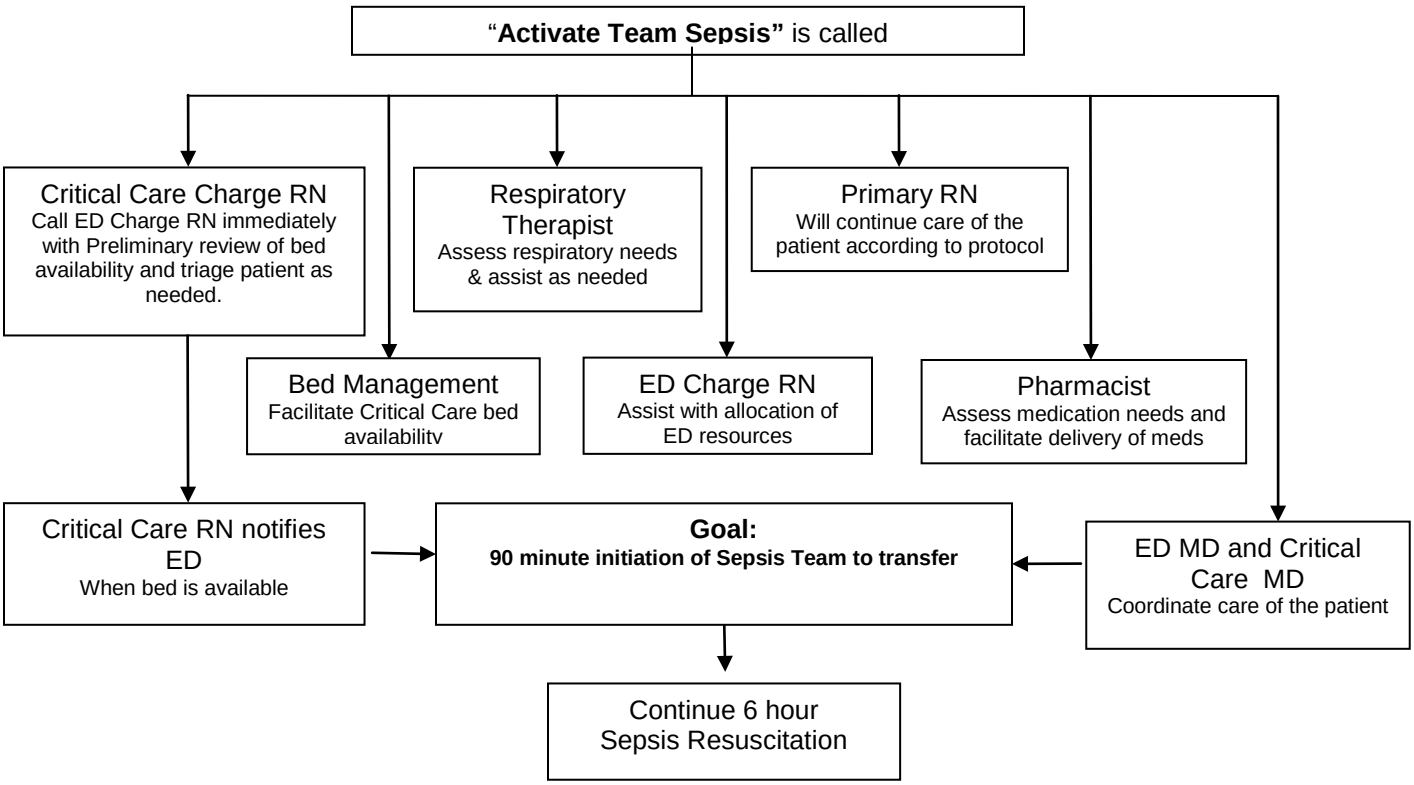
- Nurse will identify patient in severe sepsis and septic shock using established Criteria
- Initial Resuscitation orders for severe sepsis/septic shock will be initiated
- ER RN will immediately notify ER attending
- ER Attending Physician will confirm diagnosis and current treatment
- ED attending physician will direct the ED nurse to initiate "Activate Sepsis Team"
- ED charge nurse will dial 8 and tell the security/central station to announce "Activate Sepsis Team".

The Sepsis team consists of:

- ER Attending
- Critical Care Intensivist
- Critical Care Resident or MOD
- Respiratory therapist
- Primary ED nurse
- Critical Care Transport RN
- ER charge RN
- Nursing Supervisor

Once “Activate Team Sepsis” is called it is expected that the Critical Care resident or MOD, Nursing supervisor, and Respiratory therapist report to the ED immediately. The ED Educator, Clinical Nurse Leader and Critical Care Transport RN will provide a supportive roll and will report to the ED if available. The Critical Care Charge RN is to call the ED Charge RN immediately to discuss bed availability. Critical Care Charge RN will start the triage process with the respective team in order to receive the septic patient. Lactate Level will always be drawn stat and results will be available from lab within 30 minutes from receipt of specimen.

Team Sepsis Response



Picard, M. Donoghue, S. Young-Kershaw, D. Russell, K. Development and Implementation of Multidisciplinary Sepsis Protocol. Critical Care Nurse 2006; 26(3): 43-55

Rivera, C. Every Minute Counts, Nursing Management 2009; 40(5): 34-48

Robson W, Newell J. Assessing treating and managing patients with sepsis. Nursing Standards 2005;19(50):56-64