Patient presents to the ED with concern for infection and/or temperature abnormality (in the ED or within 4 hrs of presentation)?

Exclude from shock triage tool. Continue routine triage process.

Continue assessment at triage.

General assessment: Is patient critically ill?

NO

YES

Transfer patient to a resuscitation room and immediately alert physician / resuscitation team.

Continue shock triage tool

- Obtain a full set of vital signs including blood pressure and temperature
- Perform a brief history and physical exam assessing mental status, skin, pulses and capillary refill/perfusion
- Is the patient a high-risk patient? (see Table 1)

Septic Shock Checklist

- Temperature abnormality (Table 2) ______________°C
- Hypotension (Table 2) ___________________mmHg
- Tachycardia (Table 2) ____________________bpm
- Tachypnea (Table 2) ____________________bpm
- Capillary refill abnormality (Table 3) ____________
- Mental status abnormality (Table 3) _____________________
- Pulse abnormality (Table 3) ____________________
- Skin abnormality (Table 3) ______________________

Is patient hypotensive?

NO

YES

Initiate/continue the Septic Shock protocol /pathway using the Septic Shock Order Set, and mobilize resources.

Does patient meet 3 or more of the 8 clinical criteria, OR
Does high-risk patient meet 2 or more of the 8 clinical criteria?

NO

YES

Continue routine triage process.

Identify the patient as meeting septic shock triage criteria, transfer to a room immediately and alert physician.

Does physician assessment concur with triage assessment?

NO

YES

Continue routine care.

Table 1. High Risk Conditions

- Malignancy
- Asplenia (including SCD)
- Bone marrow transplant
- Central or indwelling line/catheter
- Solid organ transplant
- Severe MR/CP
- Immunodeficiency, immunocompromise or immunosuppression

Table 2. Vital Signs (PALS)

<table>
<thead>
<tr>
<th>Age</th>
<th>Heart Rate</th>
<th>Resp Rate</th>
<th>Systolic BP</th>
<th>Temp (°C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 d – 1 m</td>
<td>&gt; 205</td>
<td>&gt; 60</td>
<td>&lt; 60</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>≥ 1 m – 3 m</td>
<td>&gt; 205</td>
<td>&gt; 60</td>
<td>&lt; 70</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>≥ 3 m – 1 r</td>
<td>&gt; 190</td>
<td>&gt; 60</td>
<td>&lt; 70</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>≥ 1 y – 2 y</td>
<td>&gt; 190</td>
<td>&gt; 40</td>
<td>&lt; 70 + (age in yr × 2)</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>≥ 2 y – 4 y</td>
<td>&gt; 140</td>
<td>&gt; 40</td>
<td>&lt; 70 + (age in yr × 2)</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>≥ 4 y – 6 y</td>
<td>&gt; 140</td>
<td>&gt; 34</td>
<td>&lt; 70 + (age in yr × 2)</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>≥6 y – 10 y</td>
<td>&gt; 140</td>
<td>&gt; 30</td>
<td>&lt; 70 + (age in yr × 2)</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>≥ 10 y – 13 y</td>
<td>&gt; 100</td>
<td>&gt; 30</td>
<td>&lt; 90</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>&gt; 13 y</td>
<td>&gt; 100</td>
<td>&gt; 16</td>
<td>&lt; 90</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
</tbody>
</table>

Table 3. Exam Abnormalities

<table>
<thead>
<tr>
<th></th>
<th>Cold Shock</th>
<th>Warm Shock</th>
<th>Non-specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulses (central vs. peripheral)</td>
<td>Decreased or weak</td>
<td>Bounding</td>
<td></td>
</tr>
<tr>
<td>Capillary refill (central vs. peripheral)</td>
<td>≥ 3 sec</td>
<td>Flash (&lt; 1 sec)</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>Mottled, cool</td>
<td>Flushed, ruddy, erythroderma (other than face)</td>
<td>Petechiae below the nipple, any purpura</td>
</tr>
<tr>
<td>Mental status</td>
<td>Decreased, irritability, confusion, inappropriate crying or drowsiness, poor interaction with parents, lethargy, diminished arousability, obtundation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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