Sepsis is defined as a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Recent studies regarding the mortality rate due to sepsis have necessitated a change in the pre-hospital approach to these patients. When assessing the patient suffering from suspected sepsis, the most critical element in subsequent treatment is the early recognition of the condition and aggressive management.

General Care

EMR/BLS

1. Initial Assessment/Care **Protocol 1**.

2. Any patient with any one (1) of the following suspected conditions:

    a. Flu like symptoms, pneumonia or respiratory infection (cough/thick mucus)
    b. Urinary tract infection
    c. Blood stream/catheter related infection
    d. Abdominal pain and/or diarrhea or known abdominal infection
    e. Wound infection
    f. Skin/soft tissue infection

    AND

3. Any three (3) of the following conditions will be considered a suspected sepsis patient:

    a. Hyperthermia (> 101° F or > 38° C)
    b. Respiratory rate > 22 breaths per minute
    c. Heart rate > 90 BPM
    d. Signs of poor perfusion or systolic BP $\leq$ 100 mmHg
    e. Altered Mental Status

4. The term “Suspected Sepsis Patient” will be documented in the narrative section on the patient care report.

5. The patient will be transported ALS to the most appropriate facility by MDFR and treated as indicated below.

6. The unit OIC will notify the appropriate receiving facility that the patient is a “Suspected Sepsis Patient” prior to arrival at the hospital.

ALS

7. Monitor cardiac rhythm and and perform a 12-Lead ECG.

8. Establish vascular access via IV/IO.

9. Assess and manage all underlying emergencies according to the most appropriate protocols.

10. Administer **fluid bolus up to 1000 mL of NS.** Monitor B/P and lungs sounds often.