T Technology
H Healthy Communities
R Responsive
I Including everyone
V Valuing our people
E Efficient and effective

NHS
Leicestershire Partnership
NHS Trust

LPT Management of Sepsis in Adults Policy

This policy sets out to advise staff in relation to best practice for the assessment and early identification of possible sepsis and the expected actions to be taken when red flag sepsis is suspected in both community and inpatient settings. Sharing supportive tools and processes

Key words: SEPSIS, Infection

Version: Version 1

Approved by:

Ratified By: DPRG; PSIG ; Safety Forum

Date this version was ratified: DPRG 18.12.24; PSIG 21.5.25; Safety Forum16.7.2025

Date issued for publication: 20.8.25

Review date: 1 March 2028

Expiry date: 30 September 2028

Type of policy: Clinical

Contents

SUMMARY & AIM

This document provides guidance to staff on the recognition and treatment of ADULT patients (aged 18 and over and in an adult clinical environment inpatient and community) with sepsis and septic shock.

The purpose of this document is to describe the recommended practice for identification and management of sepsis in a timely manner.

KEY REQUIREMENTS

Sepsis Pathways, Deteriorating Patient Policy

TARGET AUDIENCE:

This guideline applies to all medical, registered nursing and allied health professional staff employed by LPT, including bank, agency, and locum staff.

TRAINING

- Local training for process and awareness is available for all clinical staff on Ulearn.
- All clinical staff are to complete the electronic learning package available on ULearn (e-LfH) This is a one-off role essential module.
- All new doctors receive basic instruction on the sepsis screening tool at trust and local induction.
- Essential to role ILS' training & BLS Training includes care of the deteriorating patient (including sepsis) occurs annually for all nursing and medical staff. BLS for HCSW and Therapy staff.
- Any additional local training for process and awareness delivered to staff by practice development teams- must use agreed standardised training packages for each area and approved by DPRG
- When a new policy is authorised, or when an existing policy is revised staff should take time to read and fully understand the policy and relevant documents, ensuring that they are able to implement the policy when required. If clarification is needed, then staff should approach their line

manager who will decide if additional training is required and that the training is documented in their training record.

1.0 Quick look summary

This document provides guidance to staff on the recognition and treatment of ADULT patients (aged 18 and over and in an adult clinical environment inpatient and community) with sepsis and septic shock.

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
1	August 2025	New Policy

For Further Information Contact:

1.2 Key individuals involved in developing and consulting on the document

- Jacqueline Moore – DMH Physical Health Matron
- Karen Plowman – CHS ACP Virtual Wards
- Dr Rebecca Hall – DMH Medical Lead
- Sue Arnold – Patient Safety
- Rebecca Fowler –DHoN FYPC LDA
- Gemma Clarke – LDA Quality Team Lead
- Emily Jarvis - LDA
- Laura Browne – LDA Community Physical Health Lead
- DPRG Committee
- Simon Guild- DHoN MHSOP
- Lynn MacDiarmid – CHS Community Hospitals Advanced Nurse Practitioner
- Virtual Policy Group

1.3 Governance

Level 2 or 3 approving delivery group – Sepsis Working group; Trust Deteriorating Patient Resuscitation Group

Level 1 Committee to ratify policy – Quality and Safety PSIG

Level 2 Quality Forum

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It considers the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

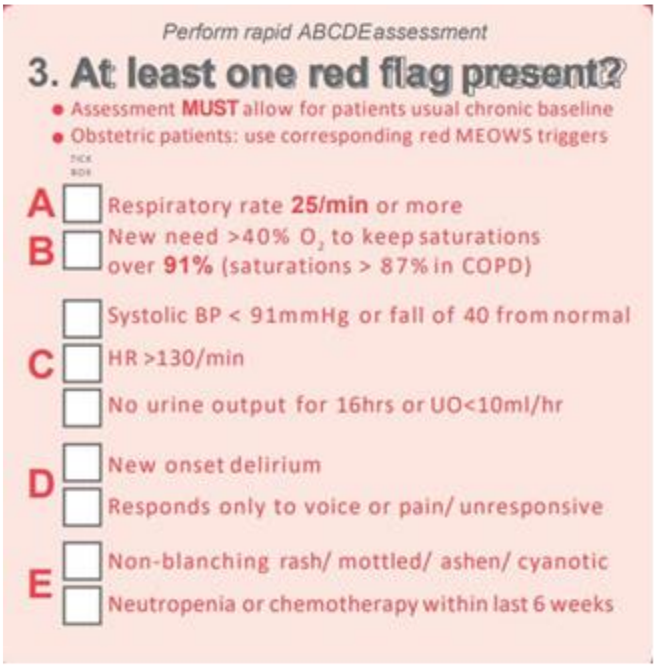
- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 8) of this policy

1.6 Definitions that apply to this policy.

Definitions as per NICE Sepsis Guidelines 2024:

- Sepsis/ Septicaemia: Sepsis is a syndrome defined as life threatening organ disfunction due to a dysregulated host response to an infection. Septicaemia or sepsis is the clinical name for blood poisoning by bacteria. It is the body's most extreme response to an infection. Sepsis that processes to septic shock has a death rate as high as 50%, depending on the type of organism involved.
- Septic shock: Septic shock is a subset of sepsis, which describes circulatory, cellular, and metabolic abnormalities that are associated with a greater risk of mortality than sepsis alone.
- Red Flag Sepsis: Systolic B.P 91-100mmHg; Heart rate 91-130 or new dysrhythmia; Not passed urine in the last 12-18 hours; Temperature < 36 Celsius; Clinical signs of wound, device, or skin infection.


Perform rapid ABCDE assessment

3. At least one red flag present?

- Assessment **MUST** allow for patients usual chronic baseline
- Obstetric patients: use corresponding red MEOWS triggers

TICK BOX

A ☐ Respiratory rate **25/min** or more

B ☐ New need >40% O_2 to keep saturations over **91%** (saturations > 87% in COPD)

C ☐ Systolic BP < 91mmHg or fall of 40 from normal
☐ HR >130/min
☐ No urine output for 16hrs or UO<10ml/hr

D ☐ New onset delirium
☐ Responds only to voice or pain/ unresponsive

E ☐ Non-blanching rash/ mottled/ ashen/ cyanotic
☐ Neutropenia or chemotherapy within last 6 weeks

- **Amber Flag Sepsis:** term used to describe the presence of any one or more Amber Flag criterion from the UK Sepsis Trust tools.
- **Sepsis 6 bundle**:
- **The National Early Warning Score (NEWS2)** is a system for scoring the physiological measurements that are recorded at the patient's bedside. It is an aggregate severity of illness score (0-20) for adults with points ascribed to increasing physiological abnormalities (respiratory rate, pulse oximetry-measured oxygen saturation, requirement for supplemental oxygen, systolic blood pressure, heart rate, level of consciousness, temperature). Its purpose is to recognise deterioration and identify acutely ill patients, including those with sepsis.

DPRG	Deteriorating Patient and Resuscitation Group
e-LfH	eLearning for Healthcare
LPT	Leicestershire Partnership Trust
BMHU	Bradgate Mental Health Unit
COHO	Community Hospitals (part of community health service directorate)
CHS	Community Health Services – directorate which includes COHO and all district nursing teams

FYPCLDA	Families & Young People, Childrens and Learning Disabilities & Autism Services (Directorate)
ILS	Immediate Life Support
BLS	Basic Life Support

Consent: a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to make the particular decision.
- have received sufficient information to make it and not be acting under duress.

Due Regard: Having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

2.0 Purpose and Introduction

2.1 Introduction

This document provides guidance to staff on the recognition, diagnosis, and early management/treatment of ADULT patients (aged 18yrs and over and who are not pregnant in an adult clinical environment inpatient and community) with sepsis and septic shock.

Sepsis is a common, time dependent medical emergency that can affect a person of any age irrespective of underlying health and concurrent medical conditions. There are approximately 300 cases of sepsis per 100,000 of population per and a UK National Confidential Enquiry into Patient Outcome and Death - Just Say Sepsis! (NCEPOD, 2015) highlighted sepsis as being a leading cause of avoidable death that kills more people than breast, bowel and prostate cancer combined.
It is now estimated that given that there are at least 200,000 cases of sepsis every year, that sepsis costs the NHS between £1.5 and £2 billion each year, and our wider economy at least £11 billion and possibly as high as £15.6 billion. (The UK Sepsis Trust 2024)

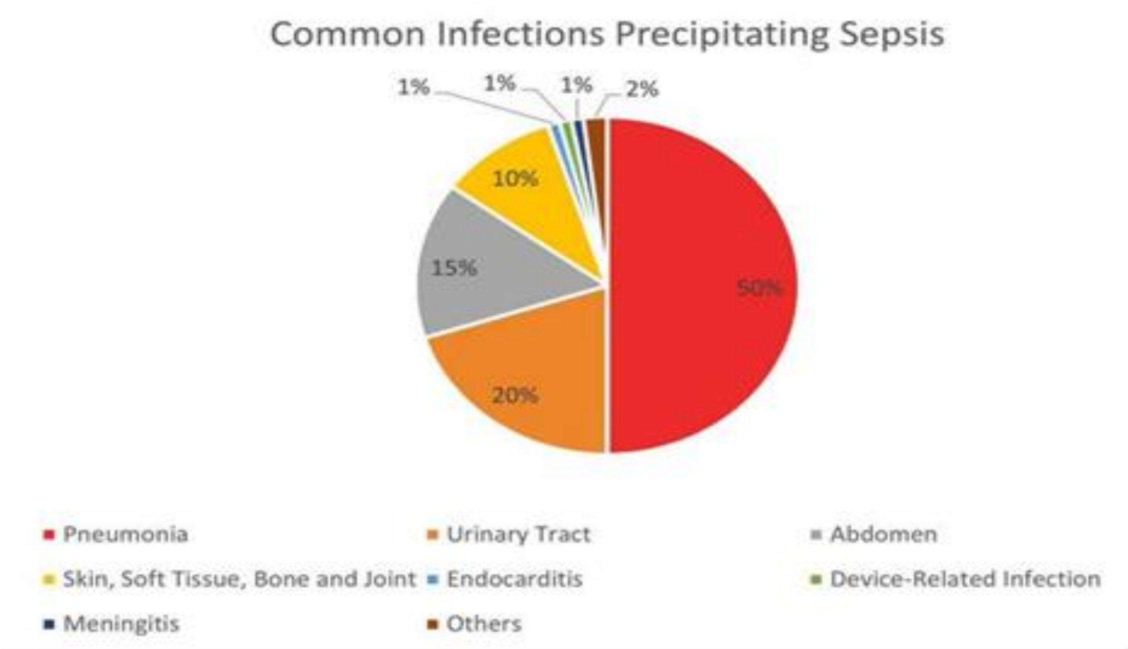
Sepsis is often difficult to diagnose and although people with sepsis may have a history of infection, fever is not present in all cases. The signs and symptoms of sepsis can be very non-specific and can be missed if clinicians do not think **'could this be sepsis?'**. Simple interventions like the administration of antibiotics within 1 hour of diagnosis have been demonstrated to save lives and reduce hospital length of stay.

Some patients may be admitted or transferred from other healthcare providers to LPT care with pre-existing medical conditions that could increase their vulnerability to sepsis. These conditions include (The UK Sepsis Trust 2024):

- Patients over 75yrs of age or people who are very frail
- Patients who have impaired immune systems because of illness or drugs, including:
    - those having treatment for cancer with chemotherapy.
    - those who have impaired immune function (for example, people with diabetes, people
    - who have had a splenectomy, or people with sickle cell disease)
    - those taking long-term steroids.
    - those taking immunosuppressant drugs to treat non-malignant disorders such as rheumatoid arthritis.
- Patients who have had surgery, or other invasive procedures, in the past 6 weeks.
- people with any breach of skin integrity (for example, cuts, burns, blisters, or skin infections).
- Patients who misuse drugs intravenously.
- Patients with indwelling lines or catheters.

Although for us here at LPT it is rare to have a pregnant persons in our inpatient care or on the community caseload, we do also need to consider those who are pregnant or have given birth, or, had a termination of pregnancy or miscarriage in the past 6 weeks are also in a high-risk group for sepsis.
If there are people in our care that meet these criteria, the responsible clinician must seek specialist advice about monitoring (referrals can be made to maternity/ Obstetrics for management). The detection and assessment of possible red flag sepsis remain the same.

Common infections precipitating Sepsis:



Source: 2024 The UK Sepsis Trust The Sepsis Manual 7th Edition. United Kingdom Sepsis Trust

3.0 Process

- The screening tools are available to guide staff, however they do not override the clinical judgement and should alternate actions be taken this must be clearly documented within the patients record and a clear plan of care must be logged and communicated to staff with continued care responsibilities.

- The LPT Sepsis Screening and Action Tools (appendices 1-3) are to be used on all patients who have either: A new early warning score (EWS) of 3 in one parameter or scoring 5 or more; look unwell or if there is concern regarding an acute change in mental state.

- The tools are available on SystmOne, Brigid inpatient systems (which link directly to SystmOne) and a hard copy can be obtained from this policy or directly from staff net for business continuity.

- The LPT Sepsis Screening and Action Tools provide details of the patient care, monitoring and interventions that are required to recognise and treat sepsis / red flag sepsis / septic shock and must be initiated as soon as a patient has clinical evidence of sepsis or the healthcare professional caring for the patient has concerns about their risk of developing sepsis.

- The LPT Sepsis Screening and Action Tools provide detailed interventions and timescales that must be adhered to, to improve mortality from sepsis. Calling the 2222 or/and 9999 is an important action for patients suspected to have red flag sepsis.

- In the event of potential red flag sepsis clinical staff who have access to a sepsis box, are expected to use the sepsis box (details of the contents of the sepsis box can be found in appendix 4) to manage the patient until the ambulance arrives.

- Staff are advised to work within their remit and scope of practice - for example nursing staff in DMH inpatient areas are usually unable to manage an IV antibiotic or to insert a cannula, whilst in CHS inpatient wards the nursing staff would carry out this element of the sepsis six bundle. In DMH areas, with access to a sepsis box, the medical teams would be the lead for IV access and administration of the antibiotics and fluids and should do so within their own scope of practice.

- Community staff that have concerns regarding possible sepsis or red flag sepsis can access the Community Sepsis Screening tools (appendix 2 & 3). The tools are available to support clinical decision making for staff that can facilitate physiological vital signs (appendix 3) and those that can observe only – soft signs (appendix 2). The tools are used by staff within their own remit.

- Staff must be aware of the processes available for their specific area of work and refer to the processes in Appendix 5.

4.0 Process of management of sepsis boxes

- Boxes are NOT supplied or managed by pharmacy.
- Pharmacy will supply the antibiotic bundle to be held inside of each box.
- Sepsis boxes will contain the meropenem (as part of the antibiotic bundle) & essential items for managing the sepsis 6 bundle – excluding lactate monitoring (see appendix 4 For sepsis box insert for guidance)
- A laminated ‘sepsis box insert’ will be held within each box this provides staff with additional guidance for the sepsis 6 process and the order of the actions required: the process for managing the reconstitution and administration of the antibiotic and details for the box contents. This should be returned to the box after use (if a replacement is required this can be found in appendix 4)
- Weekly checks of the sealed box and logging expiry dates (as part of the emergency trolley checking). Staff must request or replace items prior to their expiry date and log the actions taken.

- Following the use of the box staff must **replenish all items**:
    - requesting replacement antibiotic bundle from pharmacy.
    - using ward stock for all other items and
    - ensuring blood culture packs are replaced.
        - For DMH at BMHU/Bennion there is a small supply held in the physical health team's office & these can also be obtained from GGH pathology lab using the order form
        - All other areas to use their usual ordering process
- Actions to refill the box must be completed as soon after the event as possible, by the team using the box, prior to returning them to the ward/area that it is stored.

  For DMH BMHU and Bennion/Evington: If there are any issues with replenishing the box staff can contact the CDM for advice and/or contact the physical health team. **It remains the wards responsibility to refill the box.**

5.0 Policy Requirements

Details of the principles and core standards to be used in the development and management of policies.

6.0 Duties within the Organisation

Policy Author

- Jacqueline Moore – DMH Physical Health Matron
- Karen Plowman – CHS ACP Virtual Wards
- Dr Rebecca Hall – DMH Medical Lead
- Sue Arnold – Patient Safety

Lead Director

Chief Executive, Medical and Nursing & AHP Directors are responsible for ensuring the safe and effective delivery of services; this includes securing and directing resources to support the implementation of this policy.

Directors, Heads of Service

Directors, Heads of Service are responsible for ensuring the safe and effective delivery of services they manage; this includes securing and directing resources to support the implementation and monitoring of this policy.

Ensuring that all staff are aware of their responsibility to adhere to the policy.

Ensure appropriate resources are in place to facilitate adherence to the policy.

Senior Managers, Matrons and Team Leads

Senior Managers, Matrons and Ward Managers/ Team Leaders will ensure that all staff carry out patient observations using the appropriate scoring NEWS2 and SBAR tools, and that adequate staff training is undertaken within their area including compliance with resuscitation and sepsis training.

Ensuring the clinical staff, they are responsible for are aware of and apply this policy into clinical practice**.**

Ensuring sepsis box checks are completed daily within ward areas that have them.

Responsibility of Clinical Staff

All staff members must ensure that they understand the relevant NEWS2 and SBAR and the implications of their use and are up to date with their mandatory resuscitation and early warning scoring and sepsis training specific to their roles and skill set.

All staff must ensure that they follow the NEWS2 guidance, triggers, and have access the Sepsis pathways to support appropriate escalation and action. They are responsible for documenting this in the patient's record. Specific to their area of work and remit.

- It is the responsibility of the attending clinical team (nursing and medical) to initiate the Adult Sepsis Screening and Immediate Action Tool and document all care (Appendix 1-3)
- Consider and act on the signs and symptoms of sepsis/red flag sepsis, be able to distinguish between the two and to escalate care quickly for emergency support.
- Consider the use of Sepsis box in the event of potential red flag sepsis if available in the incident.
- Instigate early supportive management using the Resuscitation Council UK (2021) Guidelines and treatment of Sepsis pathway Appendix 3.
- Staff must always work within their clinical competence and role expectation and in line with training provided by LPT.
- Carry / have access to the sepsis pathways and associated equipment when considering if someone could have suspected sepsis appropriate to the role and environment in which they work.
- Report incidents of all suspected Sepsis in accordance with the LPT Incident Reporting
- For areas that hold a Sepsis Box- staff must ensure they ensure the box is replenished.

See Appendix 5 for all processes for LPT areas that this Policy refers to.

Responsibilities of Deteriorating Patient Resuscitation Group (DPRG)

- Oversight of policy implementation and compliance
- Incidents related to Sepsis will be reviewed within the Trust DPRG and learning will be feedback to directorates.

7.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

8.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
Training	Monthly	Sepsis training compliance reports from Ulearn	Sepsis training compliance reports must be	DPRG

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
			reviewed at directorate service level and submitted to DPRG.	
6	A quarterly report to DPRG	1.Training compliance as detailed in Trust Training Flash reports 2.NEWS/Sepsis audits via AMaT	DPRG	
8	Monthly/Bi monthly	Incidents related to Sepsis will be reviewed within the Trust DPRG (via agreed working groups) and learning will be feedback to directorates.	DPRG	

9.0 References and Bibliography

- LPT Deteriorating Patient Policy (2024)
- Sepsis and Septic Shock (Includes UHL and Kettering Sepsis Pathway) UHL Guideline Latest version approved by the Policy and Guideline Committee Sepsis and Septic Shock (Includes UHL and Kettering Sepsis Pathway) UHL Guideline Trust ref: B11/2014. (n.d.). Available at: https://secure.library.leicestershospitals.nhs.uk/PAGL/Shared%20Documents/Sepsis%20and%20Septic%20Shock%20(Includes%20UHL%20and%20Kettering%20Sepsis%20Pathway)%20UHL%20Guideline.pdf.

- NICE (2024). Suspected sepsis: recognition, diagnosis and early management NICE Guideline NG51
- Just Say Sepsis! A review of the process of care received by patients with sepsis Improving the quality of healthcare. (n.d.). Available at: https://www.ncepod.org.uk/2015report2/downloads/JustSaySepsis_FullReport.pdf.
- The UK Sepsis Trust (2024). *THE SEPSIS MANUAL*. [online] Available at: https://sepsistrust.org/wp-content/uploads/2024/07/Sepsis-Manual-7th-Edition-2024-V1.0.pdf.
- Society of Critical Care Medicine (2021). *Surviving sepsis campaign guidelines 2021*. [online] Society of Critical Care Medicine (SCCM). Available at: https://www.sccm.org/Clinical-Resources/Guidelines/Guidelines/Surviving-Sepsis-Guidelines-2021.

10.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery, and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

11. Appendices

No.	Title	Page Number/s
Appendix 1	LPT Sepsis Screening and Action Tool – Inpatient	17-18
Appendix 2	LPT Sepsis Screening and Action Tool – Community (without observations)	19-20

Appendix 1:LPT Sepsis Screening and Action tool – Inpatient

In-Patient Sepsis Screening and Flow Chart

Complete and file in medical record

NHS

Name:

Date of Birth:

Hospital Number:

Affix Hospital Label if available

SOS 6 Suspicion Of Sepsis

Better Together services provided by:

Leicestershire Partnership NHS Trust

1. At least one of the following present?

TICK BOX

- [ ] Early Warning Score 5 or more **OR**
- [ ] Patient looks unwell **OR**
- [ ] Concern regarding acute change in mental state

N (TICK BOX) → **Low Risk of Sepsis**

Consider other diagnoses.
Review if patient deteriorates.

TICK BOX

Y ↓

2. Is the clinical picture suggestive of an infection? YES

If there is a high probability of a non-infective explanation for clinical features (eg AMI, PE, liver failure, pancreatitis or stroke) then manage as low risk of sepsis

- [ ] Chest
- [ ] Urinary Tract
- [ ] Cellulitis, necrotizing fasciitis
- [ ] Abdominal
- [ ] Bone or joint
- [ ] Meningitis
- [ ] Device related (eg catheter, line)
- [ ] Other, state:
- [ ] Yes, but source unclear

N (TICK BOX)

Y ↓

Perform rapid ABCDE assessment

3. At least one red flag present?

- Assessment **MUST** allow for patients usual chronic baseline
- Obstetric patients: use corresponding red MEOWS triggers

TICK BOX

- A [ ] Respiratory rate **25/min** or more
- B [ ] New need for **>40% O_2** to keep saturations over 91% (saturations > 87% in COPD)
- [ ] Systolic BP < 91mmHg or fall of 40 from normal
- C [ ] HR >130/min
- [ ] No urine output for 16hrs or UO<10ml/hr
- [ ] New onset delirium
- D [ ] Responds only to voice or pain / unresponsive
- [ ] Non-blanching rash/ mottled / ashen / cyanotic
- E [ ] Neutropenia or chemotherapy within last 6 weeks

N (TICK BOX) → **Moderate Risk of SEPSIS**

Sepsis likely / Present

TICK BOX

Inform clinician / ANP / OOH's / treating Dr.

- Consider Sepsis Six interventions (see overleaf)
- Begin at least hourly observations.
- Act on early warning score triggers
- Send appropriate microbiological samples (including blood culture)
- Send blood samples for FBC, CRP, U&E, LFT coagulation, Blood gas (venous or arterial) Glucose, ensure results are reviewed.
- Source specific antimicrobial prescribing based on local policy (e.g., 4hr CAP bundle)

Y (TICK BOX) → **HIGH Risk of SEPSIS**

Red Flag Sepsis

TICK BOX

This is a time critical condition, immediate action is required!

Start Sepsis 6 bundle NOW (see overleaf)

TICK BOX

- [ ] **Inform most senior clinician on site**
- [ ] **In hours : discuss with Consultant or Geriatrician on call, urgently**
- [ ] **Out of hours : call 999 if ceiling of care has not been agreed**

Delivery of Sepsis Six by junior staff must not be delayed. This process can be de-escalated as agreed in joint discussion with consultant or the responsible clinician:

TICK BOX

- [ ] Patient is End of Life
- [ ] Patient low suspicion of infection
- [ ] Red Flag due to chronic disease

STOP

SURNAME & GRADE	SIGNATURE	DATE & TIME

PRINT NAME: Title: Date: Time:

NB: Paper copies of this document may not be most recent version.
The definitive version with be held on Leicester Partnership Trust Esource

Leicester Partnership Sepsis Pathway adopted from Sepsis UK Trust www.sepsisuk.org

In-Patient LPT106b V2 May 2024 review Jan 2025

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Sepsis Six Bundle

Complete in one hour.

Actions should be carried out simultaneously.

Use sepsis box / pack to support delivery of sepsis six

THE UK SEPSIS TRUST

Supporting Resources

Sepsis
Frequently Asked Questions

How to:
Take a blood culture
Draw up meropenem
Use a sepsis box

1 Administer supplementary oxygen (if required)

- Aim to keep saturations > 94%

COPD: Adjust target saturations to 88-92%

Time Started	Name	Reason not administered

2 Blood Culture & Source Management

- **Take blood cultures (before IV antibiotic)**
- Think source confirmation and control!
- Consider also sputum, urine, CSF, line culture/removal
- **involve appropriate surgical team / radiologist as indicated**
- **For Community Acquired Pneumonia start 4 hr CAP Bundle**

Time Taken	Name	Reason not taken

3 Give IV antibiotics

PRESCRIBE STAT (TIMED). GIVE YOURSELF OR MAKE SURE SOMEONE DOES

- **Red Flag Sepsis: Meropenem IV 1g stat (+/- second dose at 8hrs) and review at first inpatient consultant assessment (microbiology advice may be needed at this stage)**
- **Sepsis**: According to local antimicrobial policy

Time Given	Name	Reason for departure from prescribing guidance

4 Give a fluid challenge

Check and monitor response

If SBP <90mmHg or Lactate >2

- Give 500mls 0.9% NaCl over 15 mins, repeat once if necessary
- Senior resident clinician review to exclude other causes of shock before giving up to 30ml/kg

If SBP >90mmHg and Lactate <2 consider IV fluids

Time Given	Name	Reason not given

5 Measure lactate (Not appropriate for LPT)

- Obtain blood gas - venous or arterial
- If lactate >4mmol/L refer to critical care
- Ensure samples are sent for FBC, CRP, U+E, LFT, coag screen
- Repeat lactate after fluid challenge

LPT Action

- Ensure samples are sent for FBC, CRP, UE, LFT, Coag screen

Time Taken	Name	Reason not done

6 Measure urine output

- Ensure hourly fluid balance chart commenced
- Consider catheter if AKI / SBP <90 / Lactate >2
- Monitor Vital Signs at 15-30mins intervals until EWS below 3

Time Started	Name	Reason not started

NB: Paper copies of this document may not be most recent version.
The definitive version with be held on Leicester Partnership Trust eSource

Leicester Partnership Sepsis Pathway adopted from Sepsis UK Trust www.sepsisuk.org

In-Patient
LPT106b Dec 2024 DPRG

Appendix 2: LPT Sepsis Screening and Action Tool – Community(soft signs)

THE UK SEPSIS TRUST

NHS Leicestershire Partnership NHS Trust

Sepsis Screening and Action Tool (Community)

This form is to be used by ALL staff as an initial sepsis screening tool.
The Sepsis Recognition and Flowchart (Community and Outpatients) should be used by all clinicians with the necessary skill set.

1. Are you worried your patient is sick?

e.g.

	Tick
High or low temperature to central touch	☐
Sudden deterioration	☐
Unusually drowsy, confused or delirious	☐
Carer concern about mental state and behaviour	☐

N → Low risk of sepsis

Y ↓

2. Are there any new infections?

e.g.

	Tick
Yes, patient has a fever, feels very cold	☐
Chesty cough / breathing sounds rattly	☐
Frequency, painful to pass urine	☐
Abdomen very painful or swollen	☐
Skin, joints or wounds swollen, red or pus visible	☐
Peripheral lines / catheter painful	☐

N → Low risk of sepsis

Y ↓

3. Is ONE Red Flag present?

e.g.

	Tick
Patient much more confused than normal	☐
Patient has collapsed or can't wake patient	☐
Unable to feel a pulse at the wrist	☐
Breathing very fast (more than one breath every two seconds)	☐
Has blue lips	☐
Has new red or purple rash all over, or mottled Skin	☐
Hasn't passed urine in last 18 hours	☐
Recent chemotherapy (within last 6 weeks)	☐

N → 4. Is there cause for concerns?

Y ↓ RED Flag Sepsis!

4. Is there cause for concerns?

e.g.

	Tick
Relatives worried about mental state/behaviour	☐
Patient not able to do what they normally can	☐
Patient takes steroid tablets (e.g. prednisolone)	☐
Has had injury or been in hospital in last 6 weeks	☐
Breathing harder work than normal	☐
Hasn't passed urine in last 12 – 18 hours	☐
Feels very cold to the touch	☐
Skin, joints or wounds swollen, red or pus visible	☐

N ↑ Low risk of sepsis

Y ↓ At risk of sepsis

Low risk of sepsis. Consider other diagnosis . Review routinely if condition changes

At risk of sepsis

1. Inform co-ordinator/GP/111 using SBAR
2. Clearly state that the person might have sepsis
3. Ensure the same day medical assessment by appropriate clinician as per local policy
4. May require hospital referral or assessment by GP (follow usual protocol)

RED Flag Sepsis! This is a time critical condition, immediate action is required.

1. **If appropriate * dial 999, state patient has 'Red Flag Sepsis'. Complete SBAR overleaf**
2. **Inform next of kin**
3. **Get an up-to-date list of patient's medication and allergies to give to ambulance crew**

*Consider individuals advanced plan

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Leicestershire Partnership NHS Trust

Time of call to 9999:	
Call reference number:	
Time crew arrived:	
Location patient transferred to:	

Brief Outline of Patients History

S — **Situation:**
I am (name), a nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned about XX
(e.g. BP is low/high, pulse is XX, temperature is XX.
Early Warning Score is XX)

B — **Background:**
Patient (X) was admitted on (XX date) with (e.g. MI/Chest infection)
They have had (X operation / procedure / investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of Obs. Were (XX)
Patient (X)'s normal condition is ....
(e.g. alert / drowsy / confused / pain free)

A — **Assessment:**
I think the problem is (XXX)
And I have .... (e.g. given 02 / analgesia / stopped the infusion
OR
I am not sure what the problem is but Patient (X) is deteriorating
OR
I don't know what's wrong but I am really worried

R — **Recommendation:**
I need you to ....
Come and see the patient in the next (XX) mins
AND
Is there anything I need to do in the meantime? (e.g. stop the fluid / repeat the Obs.)

Ask receiver to repeat key information to ensure understanding

The SBAR Tool originated from the US Navy and was adapted for use in healthcare by Dr. M Leonard and colleagues from Kaiser Permanente, Colorado, USA

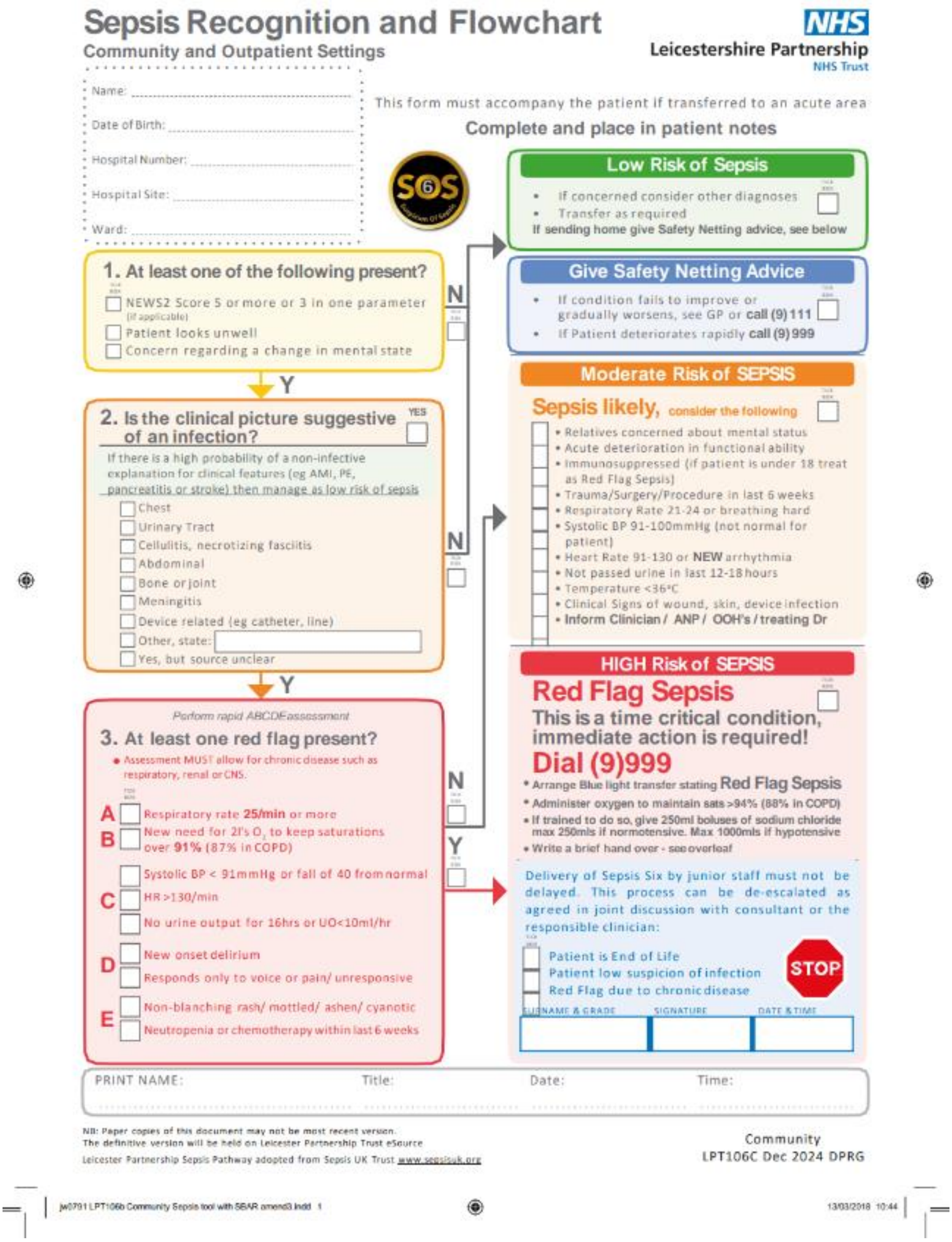
Brief Outline of Patients Current Condition

Print name:	Title:	Date:	Time

NB: Paper copies of this document may not be most recent version.
The definitive version will be held on Leicester Partnership Trust eSource
Leicester Partnership Sepsis Pathway adopted from Sepsis UK Trust www.sepsisuk.org

Community
LPT106C Feb 2018

Appendix 3: LPT Sepsis recognition and flowchart – Community (with vital signs)



Sepsis Recognition and Flowchart

Community and Outpatient Settings

NHS Leicestershire Partnership NHS Trust

Name:

Date of Birth:

Hospital Number:

Hospital Site:

Ward:

This form must accompany the patient if transferred to an acute area

Complete and place in patient notes

SOS 6 Suspicion of Sepsis

1. At least one of the following present?

- NEWS2 Score 5 or more or 3 in one parameter (if applicable)
- Patient looks unwell
- Concern regarding a change in mental state

N → Low Risk of Sepsis / Y ↓

2. Is the clinical picture suggestive of an infection? YES

If there is a high probability of a non-infective explanation for clinical features (eg AMI, PE, pancreatitis or stroke) then manage as low risk of sepsis

- Chest
- Urinary Tract
- Cellulitis, necrotizing fasciitis
- Abdominal
- Bone or joint
- Meningitis
- Device related (eg catheter, line)
- Other, state:
- Yes, but source unclear

N → Moderate Risk of SEPSIS / Y ↓

Perform rapid ABCDE assessment

3. At least one red flag present?

- Assessment MUST allow for chronic disease such as respiratory, renal or CNS.

A
- Respiratory rate **25/min** or more

B
- New need for 2l's O_2 to keep saturations over **91%** (87% in COPD)

C
- Systolic BP < 91mmHg or fall of 40 from normal
- HR >130/min
- No urine output for 16hrs or UO<10ml/hr

D
- New onset delirium
- Responds only to voice or pain/ unresponsive

E
- Non-blanching rash/ mottled/ ashen/ cyanotic
- Neutropenia or chemotherapy within last 6 weeks

N → Moderate Risk of SEPSIS / Y → HIGH Risk of SEPSIS

Low Risk of Sepsis

- If concerned consider other diagnoses
- Transfer as required

If sending home give Safety Netting advice, see below

Give Safety Netting Advice

- If condition fails to improve or gradually worsens, see GP or **call (9) 111**
- If Patient deteriorates rapidly **call (9) 999**

Moderate Risk of SEPSIS

Sepsis likely, consider the following

- Relatives concerned about mental status
- Acute deterioration in functional ability
- Immunosuppressed (if patient is under 18 treat as Red Flag Sepsis)
- Trauma/Surgery/Procedure in last 6 weeks
- Respiratory Rate 21-24 or breathing hard
- Systolic BP 91-100mmHg (not normal for patient)
- Heart Rate 91-130 or **NEW** arrhythmia
- Not passed urine in last 12-18 hours
- Temperature <36°C
- Clinical Signs of wound, skin, device infection
- **Inform Clinician / ANP / OOH's / treating Dr**

HIGH Risk of SEPSIS

Red Flag Sepsis

This is a time critical condition, immediate action is required!

Dial (9)999

- Arrange Blue light transfer stating **Red Flag Sepsis**
- Administer oxygen to maintain sats >94% (88% in COPD)
- If trained to do so, give 250ml boluses of sodium chloride max 250mls if normotensive. Max 1000mls if hypotensive
- Write a brief hand over - see overleaf

Delivery of Sepsis Six by junior staff must not be delayed. This process can be de-escalated as agreed in joint discussion with consultant or the responsible clinician:

- Patient is End of Life
- Patient low suspicion of infection
- Red Flag due to chronic disease

STOP

SURNAME & GRADE	SIGNATURE	DATE & TIME

PRINT NAME: Title: Date: Time:

NB: Paper copies of this document may not be most recent version.
The definitive version will be held on Leicester Partnership Trust eSource

Leicester Partnership Sepsis Pathway adopted from Sepsis UK Trust www.sepsisuk.org

Community
LPT106C Dec 2024 DPRG

jw0791 LPT106b Community Sepsis tool with SBAR amend3.indd 1 13/03/2018 10:44

Time of call to 9999:	
Call reference number:	
Time crew arrived:	
Location patient transferred to:	

NHS Leicestershire Partnership NHS Trust

THE UK SEPSIS TRUST

SOS Suspicion of Sepsis

EWS OBSERVATIONS	Date:				Repeat every 15 minutes					
	Obs.	Time	Obs.	Time	Obs.	Time	Obs.	Time	Obs.	Time
RR										
SpO_2										
BP										
HR										
UO										
AVPU										
EWSTotal										

Brief Outline of Patients History

S Situation:

I am calling because I am concerned that ...
I am (name), a nurse on ward (X)
I am calling about (patient X)

(e.g. BP is low /high, pulse is XX, temperature is XX, Early Warning Score is XX)

B Background:

Patient (X) was admitted on (XX date) with

(e.g. MI/Chest infection)
They have had (X operation /procedure /investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of obs. were (XX)
Patient (X)'s normal condition is ... (e.g. alert / drowsy / confused, pain free)

A Assessment:

I think the problem is (XXX)
And I have...
(e.g. given O_2 /analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X) is deteriorating
OR
I don't know what's wrong but I am really worried

R Recommendation:

I need you to ...
Come to see the patient in the next (XX mins)
AND
Is there anything I need to do in the meantime?
(e.g. stop the fluid /repeat the obs)

Ask receiver to repeat key information to ensure understanding

The SBAR Tool originated from the US Navy and was adapted for use in healthcare by Dr. M Leonard and colleagues from Kaiser Permanente, Colorado, USA

Brief Outline of Patients Current Condition

Print name:	Title:	Date:	Time:

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Leicester Partnership Sepsis Pathway adopted from Sepsis UK Trust www.sepsisuk.org

Community
LPT106C Dec 2024 DPRG

jw0791 LPT106b Community Sepsis tool with SBAR amend3.indd 2 13/03/2018 10:44

Appendix 4: Trust Sepsis box Insert (reverse is DMH only)

SEPSIS BOX

Contents of Box

- Blood Culture Pack
- 1L 0.9% Saline
- IVI giving set
- x 1 Cannula pack (pink)
- Dressing pack
- x 2 20 ml syringes
- x 2 Green needles
- X2 10ml Water for injection
- x 2 Sterile Swab
- Blood bottles & needle (red, brown, green)
- 2 X 10ml 0.9% Normal Saline
- Octopus connectors x 1

Sepsis 6

1. Give high-flow oxygen

- these patients are exempt from BTS O2 Guidelines
- may not be needed if SpO2 >98%

Seek expert help if severe COPD or used for >4h

2.Take blood cultures (before IV antibiotic)

- *Unless already taken today*
- Consider also sputum, urine, CSF, line culture/removal
- Consider imaging for source, contrast-enhanced CT abdomen
- For Community Acquired Pneumonia, start UHL 4hr CAP Bundle

3. Give IV antibiotics (allergy history?)

- *Don't just prescribe: give yourself or make sure someone does*

Sepsis: According to UHL antimicrobial policy

Severe Sepsis: consider meropenem IV 1g stat. (BMHU send to A&E) A second 1g dose of meropenem to be given at an appropriate interval depending on renal functions (see dose chart). Thereafter meropenem will require an authorisation code. Such patients must be discussed with a microbiologist during the working day (including Saturday and Sunday mornings) to review clinical findings.

4. Give a fluid challenge

- And check/monitor response, consider repeat dose

Sepsis: At least 500ml/0.9% Saline

Severe Sepsis with SBP <90 :
Stat 20ml/kg 0.9ml% saline

5. Measure Urine Output

Sepsis: Start fluid balance chart, T&T at 30 minute intervals

Severe Sepsis : Consider catheter, start fluid balance, T&T/NEWS at 15minute intervals until T&T below 4 /NEWS 5

SOS 6 Suspicion Of Sepsis

NHS Leicestershire Partnership NHS Trust

Meropenem 1g - For SEVERE SEPSIS Administration Only (Adults)

Presentation	Vials containing meropenem, 1g powder for reconstitution (as trihydrate)
Contraindications	• **Anaphylactic reaction to penicillin contact Microbiology** • Hypersensitivity to the active substance or to any of the excipients • Hypersensitivity to any other carbapenem antibacterial agent. • Severe hypersensitivity (e.g. anaphylactic reaction, severe skin reaction) to any other type of betalactam antibacterial agent (e.g.penicillins or cephalosporins) • The concominant use of meropenem and valporic acid/sodium valproate is not recommended. As it may cause the valporic acid concentrations to drop below the therapeutic range, increasing he risk of breakthrough seizures
Dose	1g given initially. A second 1g dose to be given at 8 hours (normal renal function). Further doses of meropenem require microbiology authorisation (see box 3 opposite). IV Injection: Give by slow IV Injection over 5 minutes
Reconstitution	**Reconstitute each 1g vial with 20ml Water for Injection to give a concentration of 50mg/ml. Shake reconstituted solution until clear and all powder dissolved.**
Flush	With sodium chloride 0.9% or glucose 5%
Adverse Effects	Local site reactions, inflammation, thrombophlebitis, pain at injection site, rash, pruritus, paraesthesia, urticarial, anaphylaxis, angioedema, convulsions. Apnoea also reported. Discontinue immediately at the first appearance of rash or other signs of hypersensitivity, and administer appropriate treatment
Comments	When giving by IV INJECTION do not administer via an infusion containing a medicine additive without first stopping the running infusion and flushing the line both before and after administration of the IV injection Vials are for single use only

Renal Failure (Dose)

GFR (ml/min)	Dose
26-50	Sepsis 1g every 12 hours, or normal dose every 12 hours (usually max 1g every 12 hours, 2g every 12hours may be used in severe infection such as meningitis)
10-25	Sepsis 1g every 12 hours, or 50% of normal dose every 12
<10	Sepsis 1g every 24 hours, max 1g od

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REFILLING THE SEPSIS BOX:

Information for staff at BMHU, Belvoir and MHSOP Bennion (only):

If you have used the sepsis box on your ward please refill the box following the contents list on the front of this sheet.

- **The main supplies for the box can be taken from ward stock and their are additional supplies to refill the box held in the physical health teams managers office (main reception BMHU) this includes blood culture packs.** OOH please request the CDM to support access to the office.
- **Request replacement antibiotics bundle (if used) from the pharmacy to be delivered straight away to refill the box**
- Return the newly filled box to the storage area on Watermead ward—The staff on Watermead need to be made aware so they can update their checklist
- Kirby and Belvoir are to replenish and check their own boxes.
- **Between use :** Staff on Watermead, Belvoir and Kirby and Langley ward will check the sealed box daily
- If the box on Belvoir is used please refill the box and checks as per protocol. Supplies can also be obtained as detailed above
- **Bennion Centre MHSOP: Kirby & Langley hold their own sepsis box**

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Appendix 5: Sepsis box Process Flow charts: BMHU; MHSOP; CHS; FYPCLDA Community and Inpatients

Sepsis Box Process Belvoir, Kirby, Langley & Welford

(2222 & 9999. Resus Trolley, Inpatient NEWS2 escalations and Inpatient Sepsis Pathway (Eating Disorders (ED) – may have adapted assessment tools/parameters for their speciality))

Location of boxes	Each ward area has their own sepsis box located in the clinic room (this may be on the resus trolley)
Red flag sepsis is suspected	If red flag sepsis is suspected during assessment with NEWS2 and sepsis pathway – request the box , the meropenem antibiotic will be in the box
Monitoring	Ward clinical team can commence oxygen as indicated & continue to monitor as per NEWS2 – continue throughout until EMAS arrive. Consider any ceiling of care/ReSPECT forms during assessments
Medics are required to manage the Sepsis 6 Bundle	Guided by the Sepsis Pathway. Canulation. Manage the IV fluids and antibiotic administration, if this is within the HCP remit- note there is not always a suitably skilled staff member to facilitate the bundle so staff are required to offer what they can safely e.g. oxygen, vital signs and call 9999 any bloods/cultures to be taken directly to GGH as urgent.
Logging actions	Clinical team to log all actions taken for the sepsis 6 bundle on the sepsis pathway – all details should be offered to the EMAS team, clearly stating what elements of the bundle have been commenced. Complete an EIRF
Refill & Replace	Following the incident replace all items and return to ward clinics/resus trolley. Update the check sheet with new expiry dates Request replacement meropenem.

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Sepsis Box Process Evington Centre: Coleman & Gwendolen wards

(9999 only. Resus Trolley & Sepsis Box, Inpatient NEWS2 escalations and Inpatient Sepsis Pathway)

Location of boxes	Each ward area has their own sepsis box located in the clinic room (this may be on the resus trolley)
Red flag sepsis is suspected	If red flag sepsis is suspected during assessment with NEWS2 and sepsis pathway – request the box , the meropenem antibiotic will be in the box
Monitoring	Ward clinical team can commence oxygen as indicated & continue to monitor as per NEWS2 – CALL 9999 as per NEWS2/Sepsis escalation and state 'Possible RED FLAG Sepsis' continue vital signs until EMAS review and transfer if indicated. Consider any ceiling of care/ReSPECT forms during assessments
Medics are required to manage the Sepsis 6 Bundle	Guided by the Sepsis Pathway. Canulation. Manage the IV fluids and antibiotic administration if this is within the HCP remit- note there is not always a suitably skilled staff member to facilitate the bundle so staff are required to offer what they can safely e.g. oxygen, vital signs and call 9999 any bloods/cultures to be taken directly to LGH as urgent.
Logging actions	Clinical team to log all actions taken for the sepsis 6 bundle on the sepsis pathway – all details should be offered to the EMAS team, clearly stating what elements of the bundle have been commenced. Complete an EIRF
Refill & Replace	Following the incident replace all items and return to ward clinics/resus trolley. Update the check sheet with new expiry dates Request replacement meropenem.

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Sepsis Process DMH Rehab Wards, Step Down, Mill Lodge & HPC

(No sepsis box, 9999. Resus Trolley, Inpatient NEWS2 escalations and Inpatient Sepsis Pathway)

Boxes are NOT available	These areas do NOT have a sepsis box. There is potential for these areas not to have any medical attendance- if medics are on site they will access the equipment within the resus trolley (oxygen, fluids, cannulas, blood bottles).
Red flag sepsis is suspected	If red flag sepsis is suspected – request the resus trolley
Monitoring	Ward clinical team can commence oxygen as indicated & continue to monitor as per NEWS2 – CALL 9999 as per NEWS2/Sepsis escalation and state 'Possible RED FLAG Sepsis' continue vital signs until EMAS review and transfer if indicated. Consider any ceiling of care/ReSPECT forms during assessments
Manage the Sepsis 6 Bundle	EMAS Team will manage the bundle in these areas. Guided by the Sepsis Pathway. Staff in these areas can provide the elements of the bundle that are available to the area within the resus trolley e.g. Canulation, fluids as per skills/remit of staff available on site. CALL 999 as per NEWS2/Sepsis escalation and state 'Possible RED FLAG Sepsis'
Logging actions	Clinical team to log all actions taken for the sepsis 6 bundle on the sepsis pathway – all details should be offered to the EMAS team, clearly stating what elements of the bundle have been commenced. Complete an EIRF
Refill & Replace	Following the incident replace all items to the resus trolley, update the check sheet with expiry dates

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Sepsis Process LDA Inpatients Agnes Unit

- (No sepsis box, 9999. Resus Trolley, Inpatient NEWS2 escalations and Inpatient Sepsis Pathway)

Boxes are NOT available	These areas do NOT have a sepsis box. There is potential for these areas not to have any medical attendance - if medics are on site they will access the equipment within the resus trolley (oxygen, fluids, cannulas, blood bottles).
Red flag sepsis is suspected	If red flag sepsis is suspected – request the resus trolley
Monitoring	Ward clinical team can commence oxygen as indicated & continue to monitor as per NEWS2 – CALL 9999 as per NEWS2/Sepsis escalation and state 'Possible RED FLAG Sepsis' continue vital signs until EMAS review and transfer if indicated. Consider any ceiling of care/ReSPECT forms during assessments
Manage the Sepsis 6 Bundle	EMAS Team will manage the bundle in these areas. Guided by the Sepsis Pathway. Staff in these areas can provide the elements of the bundle that are available to the area within the resus trolley e.g. Canulation, fluids as per skills/remit of staff available on site. CALL 9999 as per NEWS2/Sepsis escalation and state 'Possible RED FLAG Sepsis'
Logging actions	Clinical team to log all actions taken- a copy should be offered to the EMAS team if being transferred. Ensure relevant NOK are informed. Log actions on sepsis pathway on S1 and physical health template. Complete EIRF
Refill & Replace	Following the incident replace all items to the resus trolley, update the check sheet with expiry dates

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Sepsis Process LDA : Respite Short Breaks

(No sepsis box, 9999. Resus Bag, Inpatient NEWS2 escalations and Sepsis Pathway)

The Sepsis Screening Tool for community has been designed for staff who do not have the skills, knowledge, or equipment to record clinical observations. Staff can identify 'soft signs'/non-contact observation of deterioration and escalate as per the tool.

The Community Sepsis pathway is to be used by all staff who have the knowledge and skills to record clinical observations, escalating clinical concern as per pathway.

Boxes are NOT available	These areas do NOT have a sepsis box. There is potential for these areas not to have a registered nurse on duty
Red flag sepsis is suspected	If red flag sepsis is suspected – call 9999 request as per your NEWS2 escalation and state, 'possible RED FLAG SEPSIS' and obtain the resus bag (manage the elements of the resus situation that you are trained to support with). Consider the ceiling of care; advanced care plans; ReSPect forms at this point (see below)
Ceiling of care/ ReSPECT status	For those with a ceiling of community-based care, advanced care plan or similar or refusal to go to acute care despite risks – clinician must request an urgent medical review and contact senior on-call support. Ensure the plan of care is followed and contact NOK
Monitoring	Continue NEWS2 assessments until EMAS review and transfer if indicated. Prepare all essential documentation & care plans ready for transfer. Follow the individual plan of care for those with a advanced care plan/ReSPECT form.
Logging actions	Clinical team to log all actions taken on the patient record

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Sepsis Box Process CHS Community Hospitals inpatient wards

Location of boxes	All wards have a sepsis box located on the resus trolley
Red flag sepsis is suspected	If red flag sepsis is suspected – request the box and collect the meropenem(antibiotic) from the medication cupboard at the same time
Monitoring	Ward clinical team can commence oxygen as indicated & continue to monitor as per NEWS2 – continue throughout until medical/ANP review Discussion about ceiling of care and ability to manage safely on site and or EMAS transfer if indicated.
Manage the Sepsis 6 Bundle	Guided by the Sepsis Pathway. Canulation Manage the IV fluids and antibiotic administration
Logging actions	Clinical team to log all actions taken for the sepsis 6 bundle on the sepsis pathway – a copy should be offered to the EMAS team if being transferred
Refill & Replace	Following the incident replace all items and return to resus trolley, update the check sheet with expiry dates Request replacement meropenem.

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Sepsis Process CHS Community Teams

The Sepsis Screening Tool for community has been designed for staff who do not have the skills, knowledge, or equipment to record clinical observations. Staff can identify 'soft signs' using non-contact observation of deterioration and escalate as per the tool.
The Community Sepsis pathway is to be used by all staff who have the knowledge and skills to record clinical observations, escalating clinical concern as per pathway..

Identified concern	During you visit you are concerned the patient is unwell or they advise you they feel unwell. Consider possible causes
Carry out vital signs/soft signs	Carry out vital sign/soft signs as indicated within your service area during routine visits: community NEWS2/ Non-contact observations. Ensure this is recorded following your visit
Sepsis Screening Tools	Utilise the appropriate Sepsis Screening tool to support with clinical decision making and guide on action to take; taking into consideration the presence of or possible infection or other causes. Those patient's not requiring hospital transfer the Sepsis Screening/Pathway are available on S1 for completion
Suspected Red Flag Sepsis	For those patients who trigger for Red Flag Sepsis and require transfer to acute care, the clinician should stay with the patient until an ambulance arrives, and/or care is transferred safely. (unless there is a responsible adult that can manage the situation. Staff are advised to contact their senior in the event of delays and requesting support)
Ceiling of care/refusals	For those with a ceiling of community-based care, advanced care plan or similar or refusal to go to acute care despite risks – clinician must request an urgent medical review and contact the ENAS,GP, DHM or the Frailty Virtual Ward should be contacted
Communication /Documentation	All actions and interventions to be handed over to the EMAS team using SBAR. Documentation to be completed on Systmone as per record keeping standards

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Sepsis Process DMH, LDA, & ED Community Teams

The Sepsis Screening Tool for community has been designed for staff who do not have the skills, knowledge, or equipment to record clinical observations. Staff can identify 'soft signs'/non-contact observation of deterioration and escalate as per the tool.
The Community Sepsis pathway is to be used by all staff who have the knowledge and skills to record clinical observations, escalating clinical concern as per pathway. (Eating Disorders (ED) – may have adapted assessment tools/parameters for their speciality)

Identified concern	During your visit you are concerned the patient is unwell or they advise you they feel unwell. Consider possible causes
Soft signs	Carry out vital sign/soft signs/non-contact observations as indicated within your service area during routine visits & own remit
Sepsis Screening Tools	Utilise the appropriate Soft Signs Sepsis Screening tool /non-contact observations to support with clinical decision making and guide on action to take; taking into consideration the presence of or possible infection or other causes.
Suspected Red Flag Sepsis	For those patients who trigger for possible Red Flag Sepsis and require transfer to acute care, advise the patient to call 999 ; if you are not confident the patient(carer/relative) will act themselves, seek 999 advice yourself - the clinician should stay with the patient until an ambulance arrives, and/or care is transferred safely (unless there is a responsible adult that can manage the situation. Staff are advised to contact their senior in the event of delays and requesting support)
Not red flag sepsis/refusals	If safe to do so signpost the patient to their GP; 111 for further advice; if you are concerned that this may not happen or the patient refuses, follow up with a call to the GP to raise your concern; consider and log capacity
Communication /Documentation	The assessments, conversations & actions must be recorded on EPR

Appendix 6: Training Needs Analysis

<table>
<tr><td colspan="1">Training topic/title:</td><td colspan="3">1. Sepsis in Adults
2. Resus Level 2 (BLS)
3. Resus Level 3 (ILS)</td></tr>
<tr><td>Type of training:
(see Mandatory and Role Essential Training policy for descriptions)</td><td colspan="3">☐ Not required
2+3 YES-Mandatory (must be on mandatory training register)
1. YES-Role Essential (must be on the role essential training register)
☐ Desirable or Developmental</td></tr>
<tr><td>Directorate to which the training is applicable:</td><td colspan="3">Yes - Directorate of Mental Health
Yes - Community Health Services
☐ Enabling Services
☐ Estates and Facilities
☐ Families, Young People, Children, Learning Disability and Autism
Yes - Hosted Services</td></tr>
<tr><td>Staff groups who require the training: (consider bank /agency/volunteers/medical)</td><td colspan="3">Medical, Nursing, Bank, Agency and Locum</td></tr>
<tr><td>Governance group who has approved this training:</td><td>Deteriorating Patient Resus Group</td><td>Date approved:</td><td>Nov 24</td></tr>
<tr><td>Named lead or team who is responsible for this training:</td><td colspan="3">Learning and Development</td></tr>
<tr><td>Delivery mode of training: elearning/virtual/classroom/ informal/adhoc</td><td colspan="3">eLearning and classroom</td></tr>
<tr><td>Has a training plan been agreed?</td><td colspan="3">Yes</td></tr>
<tr><td>Where will completion of this training be recorded?</td><td colspan="3">Yes - uLearn
Yes - Other locally held for local training</td></tr>
<tr><td>How is this training going to be quality assured and completions monitored?</td><td colspan="3">Compliance monthly reports to DPRG and Training Education and Development Group</td></tr>
<tr><td>Signed by Learning and Development Approval name and date</td><td>A O'Donnell.
ALISON O'DONNELL.</td><td colspan="2">Date:
18th Nov 24</td></tr>
</table>

Appendix 7: The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers   Answer yes/no to all

Respond to different needs of different sectors of the population yes

Work continuously to improve quality services and to minimise errors yes

Support and value its staff yes

Work together with others to ensure a seamless service for patients yes

Help keep people healthy and work to reduce health inequalities yes

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance yes

Appendix 8: Due Regard Screening Template

Section 1	
Name of activity/proposal	LPT Management of Sepsis Policy
Date Screening commenced	January 2024
Directorate / Service carrying out the assessment	Sepsis Workstream: CHS and DMH Physical Health Matron
Name and role of person undertaking this Due Regard (Equality Analysis)	Jacqueline Moore DMH Physical Health Matron
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The aim of this Policy is it provide staff with the best practice principles in the assessment, identification, and immediate intervention of a patient with suspected sepsis/ Red Flag Sepsis. Supporting the Trust Deteriorating Patient Policy	
OBJECTIVES: To improve patient outcomes by ensuring early identification, clinical assessment and intervention for patients with physical deterioration when a possible infection is identified that could support the identification of possible red flag sepsis.	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	Positive Impact: acknowledgment that people aged 75years or that are very frail have increased risk factors
Disability	Positive impact – Use of non-contact observations for patients with learning disabilities and communication difficulties
Gender reassignment	No impact
Marriage & Civil Partnership	No impact
Pregnancy & Maternity	Although rare, LPT may have people who are prenatal or postnatal and this policy would apply to them with the acknowledged considerations
Race	No impact
Religion and Belief	No impact
Sex	No impact
Sexual Orientation	No impact
Other equality groups?	Positive impact – Use of non-contact observations for patients with learning disabilities and communication difficulties. (i+ncluding those with SMI, Organic diagnosis)

Section 3
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.

<table>
<tr><td colspan="2">Yes</td><td colspan="2">No</td></tr>
<tr><td colspan="2">High risk: Complete a full EIA starting click here to proceed to Part B</td><td colspan="2">Low risk: Go to Section 4.</td></tr>
<tr><td colspan="4">Section 4</td></tr>
<tr><td colspan="4">If this proposal is low risk please give evidence or justification for how you reached this decision:</td></tr>
<tr><td colspan="4">This is a low risk Policy that takes into consideration a number of protected characteristics including age and disability and has bespoke tools to support clinicians in practice.</td></tr>
<tr><td>Signed by reviewer/assessor</td><td>Jackie Moore</td><td>Date</td><td>July 2025</td></tr>
<tr><td colspan="4">Sign off that this proposal is low risk and does not require a full Equality Analysis</td></tr>
<tr><td>Head of Service Signed</td><td>Sarah Latham</td><td>Date</td><td>July 2025</td></tr>
</table>

Appendix 9: Data Privacy Impact Assessment Screening

<table>
<tr><td colspan="4">Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.</td></tr>
<tr><td>Name of Document:</td><td colspan="3">Management of Sepsis Policy</td></tr>
<tr><td>Completed by:</td><td colspan="3">Jacqueline Moore and Karen Plowman</td></tr>
<tr><td>Job title</td><td colspan="2"></td><td>Date</td></tr>
<tr><td colspan="2">Screening Questions</td><td>Yes / No</td><td>Explanatory Note</td></tr>
<tr><td colspan="2">1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.</td><td>No</td><td></td></tr>
<tr><td colspan="2">2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.</td><td>No</td><td></td></tr>
<tr><td colspan="2">3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?</td><td>No</td><td></td></tr>
<tr><td colspan="2">4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?</td><td>No</td><td></td></tr>
<tr><td colspan="2">5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.</td><td>No</td><td></td></tr>
<tr><td colspan="2">6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?</td><td>No</td><td></td></tr>
</table>

7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via **Lpt-dataprivacy@leicspart.secure.nhs.uk** **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**		
Data Privacy approval name:	**N/A**	
Date of approval		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust