Using the Sepsis Screening Tool

With the most recent Sepsis Screening Tool optimization, the Sepsis Screening Tool will now pull in data relevant to **SIRS** and **organ dysfunction** criteria from clinical documentation and lab results. The goal is to make it easier and more efficient for nurses to screen their adult patients for severe sepsis/septic shock.

It is important to note that the Sepsis Screening Tool must be used in real-time. The tool will look back at the last 12 hours, starting from the current time and current encounter. For example, if a nurse were to document their 0700 assessment at 1000, it will pull data for the last 12 hours beginning at 1000, not 0700.

When completing the screen, make sure that **vitals** are documented before the screening is initiated. If vitals are not documented, the tool will **not** be able to pull in data.

**Important note:** The organ dysfunction criteria rows may not capture all possible organ dysfunction. It is ultimately up to the nurse’s clinical judgement to decide if they think the patient meets organ dysfunction criteria. This will be discussed further in this tipsheet.

Using the Severe Sepsis/Septic Shock Screening Tool.

**A.** To access the tool:

1. Click on the **Flowsheets** activity button
2. Click on the **Assessment** flowsheet
3. Select “**Add Column**” to add a new time column for the current time in the Assessment Flowsheet.
B. Using the Sepsis Screening Tool

1. To use the screen, answer the first question: “Do you suspect this patient has a new or worsening infection?” Use the Row information to review the criteria for this question.

2. After selecting “Yes” or “No” the next 12 rows will auto-populate based on relevant physiological, lab and flowsheet documentation in the patient’s chart. The rows will display a ***YES*** if positive, a No if negative, and NO DATA<12HRS if there is no data captured in the chart within the last 12 hours. As shown below, the tool is organized by SIRS Criteria and Organ Dysfunction Criteria.
3. There are two rows, shown in the screenshot below, which do not automatically fill-in. The registered nurse will need to answer these questions manually.

| IN THE LAST 12 HOURS ALTERED MENTAL STATUS |   |
| PATIENT HAS SUSPECTED ORGAN DYSFUNCTION NOT RELATED TO |

- When answering the “Patient has suspected organ dysfunction not related to a chronic condition or medication” row, the nurse will use the Row information to help answer this question. An example of a positive answer from an RN would be “Yes” in the case of a patient who has a high bilirubin, which is not related to a chronic condition or medication, such as chronic liver failure, instead of an acute condition.

- Important note: The organ dysfunction criteria rows may not capture all possible organ dysfunction. It is ultimately up to the nurse’s clinical judgement to decide if they think the patient meets organ dysfunction criteria. The nurse should use the accompanying row information shown in the screenshot below as a guide in identifying organ dysfunction.

- The next question, “Is the patient positive for severe sepsis/septic shock screen”? Will be answered automatically, based upon the formula shown in the Row Information. If the patient has a suspected source of clinical infection, two or more SIRS criteria, and the nurse documents “Yes” the “Patient has suspected organ dysfunction not related to a chronic condition or medication”, the screening will be Positive. If one or more of those criteria are not met, the screen will be negative. Please review the Row Information for clarification.
4. If the patient is **Positive**, please remember to chart your nursing interventions. The nurse can select multiple interventions to document.