



An Roinn Sláinte
Department of Health

Sepsis Management for Adults (including maternity)

National Clinical Guideline No. 26 **(Version 2)**

2025



This National Clinical Guideline (NCG), has been developed by the Sepsis Guideline Development Group (GDG), within the HSE National Sepsis Programme (NSP). The National Clinical Effectiveness Committee (NCEC) was requested by the Minister for Health to commission the 2014 guideline arising from a significant patient safety/policy matter.

The Guideline in Sepsis Management for Adults (including maternity) was revised in September 2021. Following discussion between the National Clinical Programme (NCP) for Sepsis and the National Clinical Effectiveness Committee (NCEC) a decision was taken in 2025 to proceed with a rapid update incorporating the Surviving Sepsis Campaign Guidelines (SSCG 2021).

Scope of the Rapid Update 2025

A rapid update to National Clinical Guideline (NCG, No.26), Sepsis Management for Adults (including Maternity) (DoH, 2021), was undertaken by a sepsis guideline review team in November 2024 to incorporate five key recommendations from the SSCG 2021. The National Sepsis Programme convened key stakeholders and recognised experts in sepsis management to undertake this work. A literature search was undertaken by the HSE Library Service to identify any additional research evidence published since the SSCG 2021 to support this rapid update. No new practice changing research evidence was identified from the peer reviewed evidence since the publication of SSCG 2021.

While this guideline rapid update incorporates the most relevant aspects of the SSCG 2021 guidelines that were not previously reflected in NCG No. 26, a comprehensive review and full revision of NCG No. 26 will be undertaken in due course. Therefore, we have not changed the numerical order of the existing recommendations. This rapid update (2025) affects recommendations 11 and 16 (changed), 16a, 38a and 48a (new), and updated guidance on the structure and governance of acute hospital sepsis committees (3.1.1).

Recommendations which are new or have been updated can be recognised by the addition of the text '**[updated 2025]**' or '**[new 2025]**' following each updated or new recommendation. Minor editorial changes have been made throughout.

Using this National Clinical Guideline

- This NCG applies to all adult patients, including pregnant women and women in the postnatal period up to 42 days, in the acute hospital sector.
- All maternity specific information is highlighted using purple text.
- This NCG does not apply to paediatric patients up to the age of 16 years (HSE, 2016).
- This NCG is relevant to all healthcare professionals working in the acute hospital sector.
- This NCG is an adoption of the Surviving Sepsis Campaign Guideline (SSCG) (Rhodes et al. 2016). The wording of the recommendations have not been changed from the SSCG publication, with the exception of units of measurement applicable to the Irish context.
- Recognising that much of the research that informed the SSCG occurred in the critical care setting, the GDG provides Implementation Points after the SSCG recommendations to aid the implementation of the guideline within the Irish healthcare system and are aimed, primarily, at the pre- and post-critical care setting.
- All SSCG references are numbered.
- Additional references, that are included with the implementation points, are in a separate reference list called National Clinical Guideline References and are listed alphabetically.

Disclaimer

NCEC National Clinical Guidelines do not replace professional judgment on particular cases, whereby the clinician or health professional decides that individual guideline recommendations are not appropriate in the circumstances presented by an individual patient, or whereby an individual patient declines a recommendation as a course of action in their care or treatment plan. In these circumstances the decision not to follow a recommendation should be appropriately recorded in the patient's healthcare record.

Users of NCEC National Clinical Guidelines must ensure they have the current version by checking the relevant section in the National Patient Safety Office on the Department of Health website: <https://www.gov.ie/en/collection/c9fa9a-national-clinical-guidelines/>

Whilst every care has been taken to ensure that all the information contained in this publication is correct, the Department of Health cannot accept responsibility for any errors or omissions which may have occurred.

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Version History	
Version 1	September 2021
Version 2 (Rapid Update)	August 2025

Membership of the 2025 Rapid Update Guideline Development Group (GDG)

The GDG for the 2025 Rapid Update was chaired by Dr. Michael O'Dwyer, with support from the HSE NCP for Sepsis. Members of the GDG are listed in Table 1a.

Table 1a. Membership of Sepsis Guideline Review Team: Rapid Update 2025

Name	Job title and affiliation
Dr Michael O' Dwyer	National Clinical Programme: Sepsis Clinical Lead
Bláthnaid Connolly	National Clinical Programme: Sepsis Programme Manager
Susan Keane	Group Sepsis ADON HSE Dublin and South East (DSE)
Karen Davis Holden	Group Sepsis ADON HSE Dublin and Midlands (DMLG)
Denise McCarthy	Group Sepsis ADON HSE South West (SW)
Yvonne Young	Group Sepsis ADON HSE Mid-West (MW)
Ronan O Cathasaigh	Group Sepsis ADON HSE West and North West (WNW)
Sue Markey	Group Sepsis ADON Dublin and North East (DNE)
Nuala Clarke	Group Sepsis ADON Children's Health Ireland / DMLG
Siobhan McCarthy	HSE Library Information Specialist (Research and Evidence)

Membership of the 2014 Guideline Development Group (GDG)

The GDG was chaired by Dr Vida Hamilton BE, MB, BAO, LRCP & SI, FCARCSI, EDIC, FJFICMI, National Clinical Lead for Sepsis (2014 – 2018). This NCG is supported by HSE Clinical Design and Innovation.

Membership nominations were sought from a variety of clinical and non-clinical backgrounds so as to be representative of all key stakeholders within the acute sector. GDG members included those involved in clinical practice, education, administration, research methodology and 2 persons representing patients and the public. The terms of reference for this group are outlined in Appendix 1.

Table 1. The National Clinical Guideline Development Group Membership

Name	Job title and affiliation
Dr Vida Hamilton (Chair)	National Clinical Advisor and Group Lead (Acute Hospitals) National Sepsis Clinical Lead (2013 – 2018)
Dr Martina Healy	National Sepsis Clinical Lead (2018 onwards)
Ciara Hughes	Programme Manager National Sepsis (2019 onwards)
Christina Doyle	Programme Manager National Sepsis (2013 – 2018)
Mary Bedding	Group Sepsis ADON RCSI Hospital Group
Dr Karn Cliffe	Group Sepsis ADON/M Dublin Midlands Hospital Group
Celine Conroy	Group Sepsis ADON Ireland East Hospital Group
Yvonne Young	Group Sepsis ADON University Limerick Hospital Group
Ronan O'Cathasaigh	Group Sepsis ADON Saolta Hospital Group (2016 – 2018)
Fidelma Gallagher	Group Sepsis ADON Saolta Hospital Group (2019 onwards)
Sinead Horgan	Group Sepsis ADON South / South West Hospital Group (2015 – 2018 and 2020 onwards)
Catherine (Kay) O'Mahony	Group Sepsis ADON South / South West Hospital Group (2019)
Dr Fidelma Fitzpatrick	Chair of Steering Group / Consultant Microbiologist
Dr Miriam Bell	Project Lead for National Early Warning System Guideline 2020 update
Dr Dorothy Breen	Consultant Anaesthetist, Cork University Hospital
Avilene Casey	Lead for the Deteriorating Patient Improvement Programme (Response and Recognition)
Dr Garry Courtney	Clinical Lead for the National Acute Medicine Programme
Jacqui Curley	Healthcare Pricing Office, HSE
Barbara Egan	Patient Representative
Dr Lynda Fenelon	Consultant Microbiologist
Jamie Logan	Nurse Lead for the National Clinical Programme for Surgery
Dr Anna Moore	Consultant in Emergency Medicine, Tullamore Hospital
Dr Gerry McCarthy	Clinical Lead for the Emergency Medicine Programme
Fiona McDaid	Nurse Lead for the Emergency Medicine Programme
Julianne Mealy	Patient Representative

Dr Deborah McNamara	Clinical Lead for the National Clinical Programme for Surgery	
Michelle O'Neill	HRB-CICER /HIQA (Health Economics Expertise)	
Dr Michael Power	Clinical Lead for the Critical Care Programme	
Dr Karen Power	Irish Maternity Early Warning System representative	
Dr Yvonne Smith	Clinical Lead for the National Acute Medicine Programme	
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Gethin White	Clinical Librarian – Research, Information and Economic expert	
Experts co-opted on to GDG	Susan Ahern (HIQA) (Health Economics Expertise)	
	Subgroup of ICU Dietitians Group of INDI (Irish Nutrition and Dietetic Institute)	
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	Aine Kelly	Senior Dietitian
	Carmel O'Hanlon	Clinical Specialist Dietitian
	Marcella Richardson	Senior Dietitian
	Geraldine Sexton	Senior Dietitian
	Lisa Shanahan	Clinical Specialist Dietitian
	Marie Sheahan	Senior Dietitian
	Clare Twomey	Senior Dietitian

Credits

The role of the NCEC is to prioritise, quality assure and recommend clinical guidelines to the Chief Medical Officer for endorsement by the Minister for Health. It is intended through Ministerial endorsement that full implementation of the guideline will occur through the relevant service plans.

The NCEC and the Department of Health acknowledge and recognise the Chair and members of the Guideline Development Group (GDG) for development of the guideline. The NCEC and Department of Health wish to express thanks and sincere gratitude to all persons contributing to this National Clinical Guideline; especially those that give of their time on a voluntary basis.

Acknowledgments

Sepsis is a common and time dependent medical emergency. It can affect any person of any age, from any social background and can strike irrespective of underlying good health or concurrent medical condition. This National Clinical guideline is intended to be relevant to all healthcare staff involved in the care of patients with sepsis and the suspicion of sepsis in the Republic of Ireland.

The **Surviving Sepsis Campaign (SSC)** is a global initiative which brings together professional organizations with the aim of reducing mortality from sepsis. The purpose of the SSC is to create an international collaborative effort to improve the treatment of sepsis and reduce the high mortality rate associated with the condition. The SSC published guidelines for Managing Sepsis and Septic Shock in 2012, and then in 2015, a consensus committee of 55 international experts representing 25 international organisations was

convened. The SSCG panel provided 93 statements on early management and resuscitation of patients with sepsis or septic shock.

The NSP is very grateful to the SSC for their kind permission to adopt the SSCG as the Irish National Clinical Guideline on Sepsis Management.

We also wish to acknowledge all the members of the National Sepsis Steering Committee (Appendix 2) and the Guideline Development Group (Table 1) who gave freely of their time and expertise. A special word of thanks to the external experts, Professor Kevin Rooney, National Clinical Lead on Sepsis, Healthcare Improvement Scotland and Professor of Care Improvement, University of the West of Scotland and the Dr. John Bates from the Joint Faculty of Intensive Care Medicine in Ireland.

A special word of thanks also to the National Sepsis Programme team for their hard work and dedication to seeing this project through to completion. To the group sepsis ADONS, Celine Conroy, Karn Cliffe, Mary Bedding, Yvonne Young, Fidelma Gallagher, Sinead Horgan, and the programme manager, Ciara Hughes. Thanks also to the former team members, Kay O'Mahony, Ronán O'Cathasaigh and Christina Doyle for their part in the initial phase of this project.

Many thanks go to Grainne Cosgrove, Quality Improvement Division for providing extensive support regarding HIPE data analysis, to Jacqui Curley from the Health Pricing Office and Gethin White, HSE Clinical Librarian for their contributions. We wish to acknowledge Olivia O'Connor, Practice Development Coordinator for PHN Services Community Healthcare West, Mayo/Roscommon/ Galway, County Clinic, Castlebar who assisted with the development of the Sepsis Predisposition and Recognition in the Community tool.

We gratefully acknowledge the support and advice provided to the GDG from HRB-CICER and HIQA on the methodology and the budget impact analysis.

Finally, our appreciation goes to Dr Rob Cunney (HPSC) and AMRIC for their input to the antimicrobial stewardship section.

Dr Fidelma Fitzpatrick, Chair, National Sepsis Steering Committee.

Dr Vida Hamilton, National Clinical Advisor and Group Lead (Acute Hospitals), Chair, Guideline Development Group.

Dr Martina Healy, Clinical Lead for the National Sepsis Programme.

Signed by the Chair(s):



Fidelma Fitzpatrick

Date: 30th January 2020

National Clinical Guidelines

Providing standardised clinical care to patients in healthcare is challenging. This is due to a number of factors, among them variations in environments of care and complex patient presentations. It is self-evident that safe, effective care and treatment are important in ensuring that patients get the best outcomes from their care.

The Department of Health is of the view that supporting evidence-based practice, through the clinical effectiveness framework, is a critical element of the health service to deliver safe and high-quality care. The National Clinical Effectiveness Committee (NCEC) is a Ministerial committee set up in 2010 as a key recommendation of the report of the Commission on Patient Safety and Quality Assurance (2008). The establishment of the Commission was prompted by an increasing awareness of patient safety issues in general and high-profile health service system failures at home and abroad.

The NCEC on behalf of the Department of Health has embarked on a quality assured National Clinical Guideline development process linked to service delivery priorities. Furthermore, implementing National Clinical Guidelines sets a standard nationally, to enable healthcare professionals to deliver safe and effective care and treatment while monitoring their individual, team and organisation's performance.

The aim of NCEC National Clinical Guidelines is to reduce unnecessary variations in practice and provide an evidence base for the most appropriate healthcare, in particular circumstances. As a consequence of Ministerial mandate, it is expected that NCEC National Clinical Guidelines are implemented across all relevant services in the Irish healthcare setting.

The NCEC is a partnership between key stakeholders in patient safety. NCEC's mission is to provide a framework for national endorsement of clinical guidelines and clinical audit to optimise patient and service user care. The NCEC has a remit to establish and implement processes for the prioritisation and quality assurance of clinical guidelines and clinical audit so as to recommend them to the Minister for Health to become part of a suite of National Clinical Guidelines and National Clinical Audit. The aim of the suite of National Clinical Guidelines is to provide guidance and standards for improving the quality, safety and cost-effectiveness of healthcare in Ireland. The implementation of these National Clinical Guidelines will support the provision of evidence-based and consistent care across Irish healthcare services.

NCEC Terms of Reference

1. Provide strategic leadership for the national clinical effectiveness agenda.
2. Contribute to national patient safety and quality improvement agendas.
3. Publish standards for clinical practice guidance.
4. Publish guidance for National Clinical Guidelines and National Clinical Audit.
5. Prioritise and quality assure National Clinical Guidelines and National Clinical Audit.
6. Commission National Clinical Guidelines and National Clinical Audit.
7. Align National Clinical Guidelines and National Clinical Audit with implementation levers.
8. Report periodically on the implementation and impact of National Clinical Guidelines and the performance of National Clinical Audit.
9. Establish sub-committees for NCEC workstreams.
10. Publish an annual report.

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1**National Clinical Guideline recommendations****1.1 Summary of recommendations**

The glossary of terms and abbreviations used throughout this document are explained in Appendix 3.

SSC Guideline https://journals.lww.com/ccmjournal/Fulltext/2017/03000/Surviving_Sepsis_Campaign_International.15.aspx provides explanation on grading of recommendations and levels of evidence (Rhodes et al., 2017).

Table 2. The Surviving Sepsis Campaign (SSC) recommendations are adopted in total for this guideline.

Section	Recommendation	Quality of Evidence	Strength of Recommendation
Screening for sepsis and performance improvement	1. We recommend that hospitals and hospital systems have a performance improvement program for sepsis, including sepsis screening for acutely ill, high-risk patients. (SSCG Section B, Recommendation 1)	Low	Best Practice Statement (BPS).
Initial resuscitation	2. Sepsis and septic shock are medical emergencies, and we recommend that treatment and resuscitation begin immediately. (SSCG Section A, Recommendation 1)	Low	BPS
	3. We recommend that, in the resuscitation from sepsis-induced hypoperfusion, at least 30 mL/kg of IV crystalloid fluid be given within the first 3 hours. (SSCG Section A, Recommendation 2) SSCG 2018 Update: The 3-h and 6-h bundles have been combined into a single “hour-1 bundle” with the explicit intention of beginning resuscitation and management immediately for patients with sepsis and septic shock. More than 1 hour may be required for resuscitation to be completed, but initiation of resuscitation and treatment, such as obtaining blood for measuring lactate and blood cultures, administration of fluids and antibiotics, and in the case of life-threatening hypotension, initiation of vasopressor therapy, are all begun immediately.	Low	Strong

	4. We recommend that, following initial fluid resuscitation, additional fluids be guided by frequent reassessment of hemodynamic status. (SSCG Section A, Recommendation 3)	Low	BPS
	5. We suggest guiding resuscitation to normalize lactate in patients with elevated lactate levels as a marker of tissue hypoperfusion. (SSCG Section A, Recommendation 7)	Low	Weak
	6. We recommend further hemodynamic assessment (such as assessing cardiac function) to determine the type of shock if the clinical examination does not lead to a clear diagnosis. (SSCG Section A, Recommendation 4)	Low	BPS
	7. We suggest that dynamic over static variables be used to predict fluid responsiveness, where available. (SSCG Section A, Recommendation 5)	Low	Weak
	8. We recommend an initial target mean arterial pressure (MAP) of 65 mmHg in patients with septic shock requiring vasopressors. (SSCG Section A, Recommendation 6)	Moderate	Strong
	9. We recommend that a fluid challenge technique be applied where fluid administration is continued as long as hemodynamic factors continue to improve. (SSCG Section F, Recommendation 1)	Low	BPS
	10. We recommend crystalloids as the fluid of choice for initial resuscitation and subsequent intravascular volume replacement in patients with sepsis and septic shock. (SSCG Section F, Recommendation 2)	Moderate	Strong
	11. We suggest using balanced crystalloids instead of normal saline for resuscitation of patients with sepsis or septic shock (SSCG 2021, Rec 33) [updated 2025]	Low	Weak

Notes:

- i. See Appendix 7 for grading system used by NICE (7a) for Recommendations 1 and 2, and the GRADE approach (7b) used for Recommendation 3.
- ii. Fidelity in 3.5 is the degree to which the malnutrition screening tool is delivered exactly as set out and intended by those who developed it.

	12. We suggest using albumin in addition to crystalloids for initial resuscitation and subsequent intravascular volume replacement in patients with sepsis and septic shock when patients require substantial amounts of crystalloids. (SSCG Section F, Recommendation 4)	Low	Weak
	13. We recommend against using hydroxyethylstarches (HESs) for intravascular volume replacement in patients with sepsis or septic shock. (SSCG Section F, Recommendation 5)	High	Strong
	14. We suggest using crystalloids over gelatins when resuscitating patients with sepsis or septic shock. (SSCG Section F, Recommendation 6)	Low	Weak
Antimicrobial therapy	15. We recommend that appropriate routine microbiologic cultures (including blood) be obtained before starting antimicrobial therapy in patients with suspected sepsis or septic shock if doing so results in no substantial delay in the start of antimicrobials. (SSCG Section C, Recommendation 1)	Low	BPS
Start Smart	16. We recommend administering antimicrobials immediately, ideally within 1 hour of recognition for patients with possible septic shock or a high likelihood of sepsis (SSCG 2021, Rec 12) [updated 2025]	Low	Strong
	16a. We suggest a time-limited course of rapid investigation and if concern for infection persists, the administration of antimicrobials within 3 hours from the time when sepsis was first recognised for patients with possible sepsis without shock (SSCG 2021, Rec 14) [new 2025] See Appendix 16 Recommendations on Timing of Antibiotic Administration [new 2025]	Very Low	Strong

	<p>17. We recommend empiric broad-spectrum therapy with one or more antimicrobials for patients presenting with sepsis or septic shock to cover all likely pathogens (including bacterial and potentially fungal or viral coverage).</p> <p>(SSCG Section D, Recommendation 2)</p>	Moderate	Strong
	<p>18. We recommend that dosing strategies of antimicrobials be optimized based on accepted pharmacokinetic/pharmacodynamic principles and specific drug properties in patients with sepsis or septic shock.</p> <p>(SSCG Section D, Recommendation 5)</p>	Low	BPS
	<p>19. We suggest empiric combination therapy (using at least two antibiotics of different antimicrobial classes) aimed at the most likely bacterial pathogen(s) for the initial management of septic shock.</p> <p>(SSCG Section D, Recommendation 6)</p>	Low	Weak
	<p>20. We suggest that combination therapy not be routinely used for ongoing treatment of most other serious infections, including bacteraemia and sepsis without shock.</p> <p>(SSCG Section D, Recommendation 7)</p>	Low	Weak
	<p>21. We recommend against combination therapy for the routine treatment of neutropenic sepsis/bacteraemia.</p> <p>(SSCG Section D, Recommendation 8)</p>	Moderate	Strong
Then Focus	<p>22. We recommend that empiric antimicrobial therapy be narrowed once pathogen identification and sensitivities are established and/or adequate clinical improvement is noted.</p> <p>(SSCG Section D, Recommendation 3)</p>	Low	BPS
	<p>23. If combination therapy is initially used for septic shock, we recommend de-escalation with discontinuation of combination therapy within the first few days in response to clinical improvement and/or evidence of infection resolution. This applies to both targeted (for culture-positive infections) and empiric (for culture-negative infections) combination therapy.</p> <p>(SSCG Section D, Recommendation 9)</p>	Low	BPS

	24. We recommend daily assessment for de-escalation of antimicrobial therapy in patients with sepsis and septic shock. (SSCG Section D, Recommendation 13)	Low	BPS
	25. We recommend against sustained systemic antimicrobial prophylaxis in patients with severe inflammatory states of non-infectious origin (e.g., severe pancreatitis, burn injury). (SSCG Section D, Recommendation 4)	Low	BPS
	26. We suggest that measurement of procalcitonin levels can be used to support shortening the duration of antimicrobial therapy in sepsis patients. (SSCG Section D, Recommendation 14)	Low	Weak
	27. We suggest that procalcitonin levels can be used to support the discontinuation of empiric antibiotics in patients who initially appeared to have sepsis, but subsequently have limited clinical evidence of infection. (SSCG Section D, Recommendation 15)	Low	Weak
	28. We suggest that an antimicrobial treatment duration of 7 to 10 days is adequate for most serious infections associated with sepsis and septic shock. (SSCG Section D, Recommendation 10)	Low	Weak
	29. We suggest that longer courses are appropriate in patients who have a slow clinical response, undrainable foci of infection, bacteraemia with <i>S. aureus</i> , some fungal and viral infections, or immunologic deficiencies, including neutropenia. (SSCG Section D, Recommendation 11)	Low	Weak
	30. We suggest that shorter courses are appropriate in some patients, particularly those with rapid clinical resolution following effective source control of intra-abdominal or urinary sepsis and those with anatomically uncomplicated pyelonephritis. (SSCG Section D, Recommendation 12)	Low	Weak

Source Control	31. We recommend that a specific anatomic diagnosis of infection requiring emergent source control be identified or excluded as rapidly as possible in patients with sepsis or septic shock, and that any required source control intervention be implemented as soon as medically and logistically practical after the diagnosis is made. (SSCG Section E, Recommendation 1)	Low	BPS
	32. We recommend prompt removal of intravascular access devices that are a possible source of sepsis or septic shock after other vascular access has been established. (SSCG Section E, Recommendation 2)	Low	BPS
Vasoactive medications	33. We recommend norepinephrine as the first-choice vasopressor. (SSCG Section G, Recommendation 1)	Moderate	Strong
	34. We suggest adding either vasopressin (up to 0.03 U/min) (weak recommendation, moderate quality of evidence) or epinephrine (weak recommendation, low quality of evidence) to norepinephrine with the intent of raising MAP to target, or adding vasopressin (up to 0.03 U/min) to decrease norepinephrine dosage. (SSCG Section G, Recommendation 2)	Moderate	Weak
	35. We suggest using dopamine as an alternative vasopressor agent to norepinephrine only in highly selected patients (e.g., patients with low risk of tachyarrhythmias and absolute or relative bradycardia). (SSCG Section G, Recommendation 3)	Low	Weak
	36. We recommend against using low-dose dopamine for renal protection. (SSCG Section G, Recommendation 4)	High	Strong
	37. We suggest using dobutamine in patients who show evidence of persistent hypoperfusion despite adequate fluid loading and the use of vasopressor agents. (SSCG Section G, Recommendation 5)	Low	Weak
	38. We suggest that all patients requiring vasopressors have an arterial catheter placed as soon as practical if resources are available. (SSCG Section G, Recommendation 6)	Very Low	Weak

	38a. We suggest starting vasopressors peripherally to restore mean arterial pressure rather than delaying initiation until central venous access is secured for patients with septic shock (SSCG 2021, Rec 44) [new 2025] See Appendix 17 (in this document) and refer to local guidelines [new 2025]	Low	Weak
Corticosteroids	39. We suggest against using IV hydrocortisone to treat septic shock patients if adequate fluid resuscitation and vasopressor therapy are able to restore hemodynamic stability. If this is not achievable, we suggest IV hydrocortisone at a dose of 200 mg per day. (SSCG Section H, Recommendation 1)	Low	Weak
Blood products	40. We recommend that RBC transfusion occur only when haemoglobin concentration decreases to < 7.0 g/dL in adults in the absence of extenuating circumstances, such as myocardial ischemia, severe hypoxemia, or acute haemorrhage. (SSCG Section I, Recommendation 1)	High	Strong
	41. We recommend against the use of erythropoietin for treatment of anaemia associated with sepsis. (SSCG Section I, Recommendation 2)	Moderate	Strong
	42. We suggest against the use of fresh frozen plasma to correct clotting abnormalities in the absence of bleeding or planned invasive procedures. (SSCG Section I, Recommendation 3)	Very Low	Weak
	43. We suggest prophylactic platelet transfusion when counts are < 10 × 10 ⁹ /L (10,000/mm ³) in the absence of apparent bleeding and when counts are < 20 × 10 ⁹ /L (20,000/mm ³) if the patient has a significant risk of bleeding. Higher platelet counts ≥ 50 × 10 ⁹ /L (50,000/mm ³) are advised for active bleeding, surgery, or invasive procedures. (SSCG Section I, Recommendation 4)	Very Low	Weak
Immunoglobulins	44. We suggest against the use of IV immunoglobulins in patients with sepsis or septic shock. (SSCG Section J, Recommendation 1)	Low	Weak

Blood purification	45. We make no recommendation regarding the use of blood purification techniques. (SSCG Section K, Recommendation 1)	N/A	N/A
Anticoagulants	46. We recommend against the use of antithrombin for the treatment of sepsis and septic shock. (SSCG Section L, Recommendation 1)	Moderate	Strong
	47. We make no recommendation regarding the use of thrombomodulin or heparin for the treatment of sepsis or septic shock. (SSCG Section L, Recommendation 2)	N/A	N/A
Mechanical Ventilation	48. We recommend using a target tidal volume of 6 mL/kg predicted body weight (PBW compared with 12 mL/kg in adult patients with sepsis induced acute respiratory distress syndrome (ARDS). (SSCG Section M, Recommendation 1)	High	Strong
	48a. We suggest the use of high flow nasal oxygen over non-invasive ventilation for patients with sepsis-induced hypoxic respiratory failure (SSCG 2021, Rec 47) [new 2025]	Low	Weak
	49. We recommend using an upper limit goal for plateau pressures of 22mmHg (30cm H ₂ O) over higher plateau pressures in adult patients with sepsis induced severe ARDS. (SSCG Section M, Recommendation 2)	Moderate	Strong
	50. We suggest using higher PEEP over lower PEEP in adult patients with sepsis induced moderate to severe ARDS. (SSCG Section M, Recommendation 3)	Moderate	Weak
	51. We suggest using recruitment manoeuvres in adult patients with sepsis induced, severe ARDS. (SSCG Section M, Recommendation 4)	Moderate	Weak
	52. We recommend using prone over supine position in adult patients with sepsis induced ARDS and a PaO ₂ /Fio ₂ ratio < 20 KPA (150 mmHg). (SSCG Section M, Recommendation 5)	Moderate	Strong
	53. We recommend against using high-frequency oscillatory ventilation (HFOV) in adult patients with sepsis-induced ARDS. (SSCG Section M, Recommendation 6)	Moderate	Strong
	54. We make no recommendation regarding the use of non-invasive ventilation (NIV) for patients with sepsis induced ARDS. (SSCG Section M, Recommendation 7)	N/A	N/A

	55. We suggest using neuromuscular blocking agents (NMBAs) for ≤ 48 hours in adult patients with sepsis- induced ARDS and a PaO ₂ /FiO ₂ ratio < 20 KPA (150 mmHg). (SSCG Section M, Recommendation 8)	Moderate	Weak
	56. We recommend a conservative fluid strategy for patients with established sepsis induced ARDS who do not have evidence of tissue hypoperfusion. (SSCG Section M, Recommendation 9)	Moderate	Strong
	57. We recommend against the use of β-2 agonists for the treatment of patients with sepsis induced ARDS without bronchospasm. (SSCG Section M, Recommendation 10)	Moderate	Strong
	58. We recommend against the routine use of the PA catheter for patients with sepsis induced ARDS. (SSCG Section M, Recommendation 11)	High	Strong
	59. We suggest using lower tidal volumes over higher tidal volumes in adult patients with sepsis induced respiratory failure without ARDS. (SSCG Section M, Recommendation 12)	Low	Weak
	60. We recommend that mechanically ventilated sepsis patients be maintained with the head of the bed elevated between 30 and 45 degrees to limit aspiration risk and to prevent the development of VAP. (SSCG Section M, Recommendation 13)	Low	Strong
	61. We recommend using spontaneous breathing trials in mechanically ventilated patients with sepsis who are ready for weaning. (SSCG Section M, Recommendation 14)	High	Strong
	62. We recommend using a weaning protocol in mechanically ventilated patients with sepsis induced respiratory failure who can tolerate weaning. (SSCG Section M, Recommendation 15)	Moderate	Strong
Sedation and analgesia	63. We recommend that continuous or intermittent sedation be minimized in mechanically ventilated sepsis patients, targeting specific titration end points. (SSCG Section N, Recommendation 1)	Low	BPS

Glucose control	64. We recommend a protocolized approach to blood glucose management in ICU patients with sepsis, commencing insulin dosing when two consecutive blood glucose levels are $>10\text{mmol/L}$ (180mg/dL). This approach should target an upper blood glucose level $\leq 10\text{mmol/L}$ (180mg/dL) rather than an upper target blood glucose level $\leq 6.1\text{mmol/L}$ (110mg/dL). (SSCG Section O, Recommendation 1)	High	Strong
	65. We recommend that blood glucose values be monitored every 1 to 2 hours until glucose values and insulin infusion rates are stable, then every 4 hours thereafter in patients receiving insulin infusions. (SSCG Section O, Recommendation 2)	Low	BPS
	66. We recommend that glucose levels obtained with point-of-care testing of capillary blood be interpreted with caution because such measurements may not accurately estimate arterial blood or plasma glucose values. (SSCG Section O, Recommendation 3)	Low	BPS
	67. We suggest the use of arterial blood rather than capillary blood for point-of-care testing using glucose meters if patients have arterial catheters. (SSCG Section O, Recommendation 4)	Low	Weak
Renal Replacement Therapy	68. We suggest that either continuous RRT (CRRT) or intermittent RRT be used in patients with sepsis and acute kidney injury. (SSCG Section P, Recommendation 1)	Moderate	Weak
	69. We suggest using CRRT to facilitate management of fluid balance in hemodynamically unstable septic patients. (SSCG Section P, Recommendation 2)	Very Low	Weak
	70. We suggest against the use of RRT in patients with sepsis and acute kidney injury for increase in creatinine or oliguria without other definitive indications for dialysis. (SSCG Section P, Recommendation 3)	Low	Weak

Bicarbonate therapy	71. We suggest against the use of sodium bicarbonate therapy to improve haemodynamics or to reduce vasopressor requirements in patients with hypoperfusion-induced lactic acidemia with pH ≥ 7.15. (SSCG Section Q, Recommendation 1)	Moderate	Weak
Venous Thromboembolism prophylaxis	72. We recommend pharmacologic prophylaxis (unfractionated heparin [UFH] or low-molecular-weight heparin [LMWH]) against venous thromboembolism (VTE) in the absence of contraindications to the use of these agents. (SSCG Section R, Recommendation 1)	Moderate	Strong
	73. We recommend LMWH rather than UFH for VTE prophylaxis in the absence of contraindications to the use of LMWH. (SSCG Section R, Recommendation 2)	Moderate	Strong
	74. We suggest combination pharmacologic VTE prophylaxis and mechanical prophylaxis, whenever possible. (SSCG Section R, Recommendation 3)	Low	Weak
	75. We suggest mechanical VTE prophylaxis when pharmacologic VTE is contraindicated. (SSCG Section R, Recommendation 4)	Low	Weak
Stress Ulcer Prophylaxis	76. We recommend that stress ulcer prophylaxis be given to patients with sepsis or septic shock who have risk factors for gastrointestinal (GI) bleeding. (SSCG Section S, Recommendation 1)	Low	Strong
	77. We suggest using either proton pump inhibitors (PPIs) or histamine-2 receptor antagonists (H2RAs) when stress ulcer prophylaxis is indicated. (SSCG Section S, Recommendation 2)	Low	Weak
	78. We recommend against stress ulcer prophylaxis in patients without risk factors for GI bleeding. (SSCG Section S, Recommendation 3)	Low	BPS

Nutrition	79. We recommend against the administration of early parenteral nutrition alone or parenteral nutrition in combination with enteral feedings (but rather initiate early enteral nutrition) in critically ill patients with sepsis or septic shock who can be fed enterally. (SSCG Section T, Recommendation 1)	Moderate	Strong
	80. We recommend against the administration of parenteral nutrition alone or in combination with enteral feeds (but rather to initiate IV glucose and advance enteral feeds as tolerated) over the first 7 days in critically ill patients with sepsis or septic shock for whom early enteral feeding is not feasible. (SSCG Section T, Recommendation 2)	Moderate	Strong
	81. We suggest the early initiation of enteral feeding rather than a complete fast or only IV glucose in critically ill patients with sepsis or septic shock who can be fed enterally. (SSCG Section T, Recommendation 3)	Low	Weak
	82. We suggest either early trophic/hypocaloric or early full enteral feeding in critically ill patients with sepsis or septic shock; if trophic/hypocaloric feeding is the initial strategy, then feeds should be advanced according to patient tolerance. (SSCG Section T, Recommendation 4)	Moderate	Weak
	83. We recommend against the use of omega-3 fatty acids as an immune supplement in critically ill patients with sepsis or septic shock. (SSCG Section T, Recommendation 5)	Low	Strong
	84. We suggest against routinely monitoring gastric residual volumes (GRVs) in critically ill patients with sepsis or septic shock (weak recommendation, low quality of evidence). However, we suggest measurement of gastric residuals in patients with feeding intolerance or who are considered to be at high risk of aspiration. (SSCG Section T, Recommendation 6)	Very Low	Weak

	85. We suggest the use of prokinetic agents in critically ill patients with sepsis or septic shock and feeding intolerance. (SSCG Section T, Recommendation 7)	Low	Weak
	86. We suggest placement of post-pyloric feeding tubes in critically ill patients with sepsis or septic shock with feeding intolerance or who are considered to be at high risk of aspiration. (SSCG Section T, Recommendation 8)	Low	Weak
	87. We recommend against the use of IV selenium to treat sepsis and septic shock. (SSCG Section T, Recommendation 9)	Moderate	Strong
	88. We suggest against the use of arginine to treat sepsis and septic shock. (SSCG Section T, Recommendation 10)	Low	Weak
	89. We recommend against the use of glutamine to treat sepsis and septic shock. (SSCG Section T, Recommendation 11)	Moderate	Strong
	90. We make no recommendation about the use of carnitine for sepsis and septic shock. (SSCG Section T, Recommendation 12)	N/A	N/A
Setting goals of care	91. We recommend that goals of care and prognosis be discussed with patients and families. (SSCG Section U, Recommendation 1)	Low	BPS
	92. We recommend that goals of care be incorporated into treatment and end-of-life care planning, utilizing palliative care principles where appropriate. (SSCG Section U, Recommendation 2)	Moderate	Strong
	93. We suggest that goals of care be addressed as early as feasible, but no later than within 72 hours of ICU admission. (SSCG Section U, Recommendation 3)	Low	Weak

2**Development of the National Clinical Guideline****2.1 Background**

Sepsis is life-threatening organ dysfunction due to a dysregulated host response to infection (Singer et al., 2016). International estimates of incidence vary and despite declining age-standardised incidence and mortality, sepsis remains a major cause of health loss worldwide (Rudd et al., 2020). This study found that there were 48.9 million cases of sepsis in 2017 resulting in 11 million deaths worldwide, confirming that the actual rates are double than previously estimated, and that 20 per cent of global deaths are due to this under-reported but deadly medical condition. Information on the National Sepsis Programme and statistics on sepsis in Ireland are available at <https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/>

2.1.1 Definitions

It is recognised that in recent years, confusion has arisen with the changing definitions of sepsis and septic shock and the use of SIRS criteria. The understanding of sepsis has evolved over the years and as such so have the definitions (Table 3).

Table 3. History of Sepsis Definitions

Year	SRIS	Sepsis	Severe Sepsis	Septic Shock
Sepsis 1* (1992)	Systemic inflammatory response syndrome (SIRS) = the systemic inflammatory response to a variety of severe clinical insults in this instance infection: 1. Temperature >38°C or < 36°C 2. Heart rate >90 beats per minute 3. Respiratory rate >20 breaths per minute or PaCO ₂ < 32mmHg 4. White blood cell count >12,000 cells/µl <4,000/µl	Sepsis = the systemic response to infection, manifested by two or more of the SIRS criteria as a result of infection.	Severe sepsis = sepsis associated with organ dysfunction, hypoperfusion, or hypotension. Hypoperfusion and perfusion abnormalities may include, but are not limited to lactic acidosis, oliguria, or an acute alteration in mental status.	Septic Shock = sepsis-induced hypotension despite adequate fluid resuscitation along with the presence of perfusion abnormalities that may include, but are not limited to, lactic acidosis, oliguria, or an acute alteration in mental status.

Sepsis 2** (2001, 2008 & 2012)	<p>Systemic inflammatory response syndrome (SIRS) = the systemic inflammatory response to a variety of severe clinical insults in this instance infection:</p> <ul style="list-style-type: none"> i. Temperature $>38^{\circ}\text{C}$ or $<36^{\circ}\text{C}$ ii. Heart rate >90 beats per minute iii. Respiratory rate >20 breaths per minute or $\text{PaCO}_2 < 32\text{mmHg}$ iv. White blood cell count $>12,000$ cells/μl $<4,000/\mu\text{l}$ <p>(*Plus, general additional parameters under Sepsis)</p>	<p>Sepsis</p> <p>Infection documented or suspected and some of the following:</p> <p>General parameters*</p> <p>Fever (core temperature $>38.3^{\circ}\text{C}$)</p> <p>Hypothermia (core temperature 90 bpm or >2 SD above the normal value for age</p> <p>Tachypnoea: >30 bpm</p> <p>Altered mental status</p> <p>Significant oedema or positive fluid balance ($>20 \text{ mL kg}^{-1}$ over 24 h)</p> <p>Hyperglycaemia (plasma glucose $>110 \text{ mg dL}^{-1}$ or 7.7 mM L^{-1} in the absence of diabetes)</p> <p>Also:</p> <p>Inflammatory parameters, Organ dysfunction parameters and Tissue perfusion parameters</p>	<p>Severe sepsis = sepsis associated with organ dysfunction, hypoperfusion, or hypotension.</p> <p>Hypoperfusion and perfusion abnormalities may include, but are not limited to lactic acidosis, oliguria, or an acute alteration in mental status (1992, 2001, 2008, 2012)</p>	<p>Septic shock = a state of acute circulatory failure characterized by persistent arterial hypotension unexplained by other causes (2001, 2012).</p> <p>Sepsis induced tissue hypoperfusion is defined as either septic shock, an elevated lactate or oliguria (2008, 2012).</p>
Sepsis 3*** (2016)	No longer utilised in sepsis definition	Sepsis is life-threatening organ dysfunction caused by a dysregulated host response to infection	No longer used as a definition	Septic shock is a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality

* **Sepsis 1** refers to the 1st consensus definition (Bone et al., 1992)

****Sepsis 2** refers to the 2nd consensus definition (Levy et al., 2003) (Dellinger et al., 2008) (Martin, 2012)

*****Sepsis 3** refers to the 3rd consensus definition (Rhodes et al., 2017)

The NCG has adopted the Sepsis 3 definition and the rationale are outlined below.

Sepsis 6 is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis (Take 3 and Give 3). Sepsis 6 was developed by The UK Sepsis Trust (Daniels et al., 2011) as a practical tool to help healthcare professionals deliver the SSCG 1 hour bundle.

Sepsis 6 + 1 is the same as Sepsis 6 but + 1 refers to Fetal wellbeing. Resuscitating the mother will resuscitate the baby, however, it is important to assess fetal wellbeing and formulate a plan for delivery if required. Maternal sepsis with or without haemodynamic instability may present with fetal distress as the uteroplacental circulation is not auto-regulated (Chau, 2014). Thus any maternal circulatory insufficiency arising from sepsis may result in compromised fetal perfusion.

2.1.1.1 Systemic Inflammatory Response Syndrome (SIRS)

Much has been made of the removal of the systemic inflammatory response syndrome (SIRS) criteria from the definition of sepsis. However, this does not mean that SIRS have 'gone away'. It reflects the fact that self-limiting non-life-threatening infections may present with SIRS and that SIRS may be caused by infectious and non-infectious insults. The criteria for a systemic inflammatory response (SIRS) are fulfilled when 2 or more of the following are present (Bone et al., 1992).

Adult non-pregnant

- Heart rate > 90 beats/minute
- Respiratory rate > 20 breaths/minute
- Temperature > 38.3°C or < 36°C
- White cell count > 12 or < 4 x 10⁹ cells/L or normal with > 10% immature forms
- Bedside glucose > 7.7 mmol/L in the absence of diabetes mellitus.

Maternity: Modified SIRS for women, pregnant and up to 42 days in the postnatal period. Physiological changes must be sustained not transient.

- Heart rate ≥ 100 beats/minute (Carlin, 2008, Hayes, 2012, Soma-Pillay et al., 2016)
- Respiratory rate ≥ 20 breathes/minute
- Temperature > 38°C or < 36°C (NWIHP, 2019, NCEC, 2019)
- White cell count > 16.9 or < 4 x 10⁹ cells/L or > 10% immature bands
- Blood sugar level > 7.7 mmol/L (in the non-diabetic)
- Acutely altered mental status
- Fetal heart Rate > 160 bpm

The rationale behind the shift away from the SIRS-based definition of sepsis (Sepsis 2) is primarily three-fold.

- The over-sensitivity of the previous definition that included a cohort of patients who did not have a life-threatening illness and whose clinical course would not be impacted by escalated care (Churpek et al., 2015), (Comstedt et al., 2009).
- Its failure to recognise patients with a life-threatening acute organ dysfunction due to infection that would benefit from escalated care but who did not present with a SIRS response (Comstedt et al., 2009), (Kaukonen et al., 2015).
- The lack of specificity of the SIRS response that can be triggered by many non-infective insults (Thoeni, 2012).

Whilst the presence of a systemic inflammatory response (SIRS) is helpful in diagnosing infection, it is no longer a requirement for the diagnosis of sepsis, (Singer et al., 2016).

2.1.1.2 Sepsis definitions for this NCG

Sepsis is life-threatening organ dysfunction caused by a dysregulated host response to infection (Singer et al., 2016).

Maternal sepsis is a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion or postpartum period (WHO, 2017).

The clinical application of this latest definition requires that there be evidence to support infection as the cause of the patient being unwell based on history, examination and clinical or biochemical evidence of acute organ dysfunction consequent to that infection. The guideline recognises that there is no single test that confirms the presence of infection or sepsis but rather the diagnosis is based on the presence of a suite of symptoms and signs supported by tests and investigations. It also recognises that whilst the identification of a pathological organism is very valuable in guiding treatment, that blood cultures are only positive in 40-55% of cases (Martin et al., 2003), (Brun-Buisson et al., 1995), and in some cases even lower (Coburn et al., 2012) (Jones and Lowes, 1996), and that a negative culture does not preclude the diagnosis of infection or sepsis.

2.1.1.3 Septic Shock definition

All adults

Septic shock is a subset of sepsis with circulatory and cellular/metabolic dysfunction associated with a higher risk of mortality (Singer et al., 2016). The sepsis definition taskforce has defined this as the requirement for vasopressors/ inotropes to achieve a mean arterial pressure of $\geq 65\text{mmHg}$ AND a lactate $> 2\text{mmols/l}$ despite adequate fluid resuscitation (Singer et al., 2016). The rationale behind this definition is to identify the cohort of patients with a mortality risk of $> 40\%$ for the purposes of international comparison. Patients with a vasopressor requirement and normal lactate post resuscitation have a mortality risk of $> 30\%$ (Singer et al., 2016).

Patients who require vasopressors or inotropes to maintain adequate perfusion pressure post fluid resuscitation require critical care whether their lactate is raised or not. For this reason, this NCG uses the persistent requirement for vasopressors/inotropes post adequate fluid resuscitation as its definition of septic shock. This is a pragmatic decision for the purposes of facilitating clinical care, recognizing that lactate measurement is not always available and that the sepsis definition taskforce allowed for this:

'In settings in which lactate measurement is not available, the use of a working diagnosis of septic shock using hypotension and other criteria consistent with tissue hypoperfusion (e.g. delayed capillary refill) may be necessary' (Singer et al., 2016).

2.1.1.4. Criteria to support diagnosis of sepsis.

To assist healthcare professionals in diagnosing sepsis and septic shock, criteria outlined in Table 4 have been developed.

Table 4. Summary of diagnostic criteria used by the NCG

Infection	A clinical syndrome based on symptoms and signs caused by pathological organisms, which may or may not be identified.
Sepsis	One or more acute organ dysfunction consequent to infection. Of note this was formerly defined as "Severe sepsis". When used now, severe sepsis is a descriptive term rather than a definition much like severe pneumonia.
Septic shock	A vasopressor or inotrope requirement to maintain mean arterial pressure (MAP) $\geq 65\text{mmHg}$ despite adequate fluid resuscitation which has been triggered by infection.

What is the impact of sepsis in Ireland?

In 2018, sepsis or septic shock was documented in 14,639 non-pregnant adults and these patients had a mortality rate of 20.3% (HSE, 2019b). There were 12,005 patients, with a sepsis diagnosis, who were assigned to a medical diagnostic related group (DRG), and these patients had an average length of stay (AvLOS) of 17.1 days, which is 49.6% longer than those who had a diagnosis of infection. Medical patients with a hospital stay complicated by sepsis had a mortality rate of 19.4%. 2,634 patients were assigned to a surgical DRG and they had an AvLOS of 46.4 days, 127% longer than those with an infection diagnosis. Surgical patients whose hospital stay was complicated by sepsis had a mortality rate of 24.8%. 31.7% of all hospital inpatients were documented as having an infection or sepsis as part of their discharge diagnoses and they occupied 49.4% of the acute hospital beds.

Sepsis affected 3.33% of inpatients but contributed to 27% of all hospital deaths, a documentation rate of 303 cases per 100,000 population per annum. In 2017, chart review audits were performed by the Sepsis Group Assistant Directors of Nursing (ADONS) on 523 charts nationally. Charts were sampled from all acute hospitals and included patients with infection and acute kidney injury cared for by medical physicians, surgeons and emergency medicine physicians. This audit demonstrated that only 52% of cases that fulfilled the criteria for sepsis were actually documented as sepsis, applying this rate to national figures would lead to sepsis affecting up to 6.7% of hospital inpatients or approximately 583 per 100,000 population per annum. This is consistent with other jurisdictions that have published data based on administrative databases (Angus et al., 2001).

Three highly publicised maternal deaths have occurred in Ireland since 2007 identifying failings around assessment, monitoring and recognition of sepsis and septic shock. Mortality from maternal sepsis from direct causes is currently 0.5% (HSE, 2019b) and 0.44 per 100,000 maternities (Knight M, 2019). The Irish data is based on the number of women who developed sepsis in Ireland during 2018 (HSE, 2019b).

Table 5. Definitions of maternal deaths: (WHO 2010)

MATERNAL DEATH	
	Deaths of women while pregnant or within 42 days of the end of the pregnancy* from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
Direct	Deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.
Indirect	Deaths resulting from previous existing disease, or disease that developed during pregnancy, and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy
Late	Deaths occurring more than 42 days but less than 1 year after the end of pregnancy.
Coincidental [#]	Incidental/accidental deaths not due to pregnancy or aggravated by pregnancy

* Includes giving birth, ectopic pregnancy, miscarriage or termination of pregnancy.

Termed "Fortuitous" in the International Classification of Diseases (ICD)

Why is the pre-critical care setting important?

The Centres for Disease Control (CDC) in the U.S. have identified that 70-80% of sepsis cases arise in the community (CDC, 2016, NCEC, 2013). These patients present to the acute hospital sector via the emergency department (ED), the Acute Medical Unit (AMU), the Acute Surgical Assessment Unit (ASAU) and to a lesser extent the outpatient department (OPD). The remaining 20-30% of patients deteriorate with sepsis as an inpatient.

In order for patients to have the best opportunity to survive they need to present for medical review and have sepsis recognised and managed in an appropriate and timely manner. There is an important role for primary and community care in terms of risk recognition and for public awareness of the signs and symptoms of deterioration that may signal the development of sepsis, in order to ensure the right patient is in the right place at the right time to receive the right treatment; however, this is outside the remit of this guideline.

It is recognised that the presentation of sepsis is variable in symptoms, signs and time course. Thus, sepsis may not be present or not be diagnosed on first presentation and may not become apparent until the clinical condition evolves further. Deterioration whilst on treatment (including supportive) needs to be reviewed and diagnosis and treatment amended accordingly. The Irish National Early Warning System (2020) (INEWS) combined with clinical judgment should be deployed to recognise and respond to deterioration in the in-patient.

The Irish Maternity Early Warning System (IMEWS), (NCEC, 2019) combined with clinical judgement, should be deployed to detect deterioration in the pregnant woman.

Patient information leaflets and booklets are available at

<https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/>

2.2 Clinical and financial impact of condition/disease/topic

A literature search was undertaken by the HSE Library Service to identify any economic literature published since the previous Sepsis NCG was published in 2014. The methodology is provided in Appendix 4.

The programme uses the Hospital Inpatient Enquiry (HIPE) database to extract data on the burden of sepsis in the acute hospital sectors and to identify the common characteristics of patients with sepsis.

The methodology uses specific HIPE codes which are based on ICD-10-AM. Appendix 5 describes the coding process and a list of the codes used for the extraction can be found in the annual Sepsis report 2018.

There are a number of limitations to using this dataset:

- Causality cannot be inferred from administrative data.
- Sepsis may be a direct or indirect contributor to morbidity and mortality.
- In patients admitted to critical care, the sepsis event may be unrelated to the cause of critical care admission and indeed may not have occurred during the critical care stay.

The reasons contributing to the above include:

- Sepsis is not routinely coded as the main diagnosis.
- There is no order of precedence in the subsequent diagnostic and procedural codes dx 2-30.

For example, a patient admitted for treatment of lymphoma might develop neutropenic sepsis and end up in an intensive care unit (ICU). Their main diagnosis, dx1, is likely to be coded as lymphoma and sepsis could appear anywhere in dx2-30, as will the ICU stay.

Another patient might be admitted electively for a surgical procedure with routine post-operative ICU admission, subsequently, on the ward, they develop sepsis but do not require or no critical care bed is available, and they have a prolonged hospital stay. Their dx1 will be the reason for the surgical procedure with sepsis anywhere between dx2-30, as will the ICU stay.

In the first example sepsis is clearly the cause of deterioration and ICU admission, in the second the sepsis episode is unrelated to the ICU admission but has clearly contributed to morbidity. In both cases the sepsis episode has had a profound effect on the patient and the healthcare costs.

Despite its limitations the use of administrative data has been validated for quality improvement programmes (Aylin et al., 2007).

In 2018, there were 14,639 patients who had sepsis included in their discharge coding. 4,002 of these patients required admission to a critical care bed at some point during their hospitalisation (HSE, 2019b).

The economic impact of sepsis can be looked at by assessing:

- Direct costs
- Economic and social burden
- ‘Loss of wages technique’

Direct:

The average cost per in-patient stay per night in 2017 (latest data available) was €878, (HPO, 2018). This cost is not specific to sepsis patients. It is the average cost of an inpatient stay per night when all diagnoses are included. Sepsis is acknowledged as one of the more expensive inpatient diagnosis (Pfuntner A., 2013), so this analysis is at risk of underestimating the costs of sepsis care in the Irish acute hospital sector.

Table 6 describes the healthcare usage of patients with sepsis, both medical and surgical, and the difference, in terms of numbers of patients, number of bed days, average length of stay (AvLOS) and cost between this cohort and the patient with any uncomplicated infection.

The estimated direct costs of patients with sepsis causing or complicating their hospital admission is €288 million per annum (i.e. €19,667 x 14,639) with an AvLOS of 22.4 days. The difference between the average hospital stay complicated by infection rather than sepsis is 9.79 days or €8,603 per patient.

Table 6. Healthcare usage in sepsis vs. infection 2018 (HSE, 2019)

Diagnosis	No. of Inpatients	No. of Bed Days Used (BDU)	Average Length of Stay (Days) (No. of BDU ÷ No. of inpatients)	Cost per patient per day €	Total Cost per patient per stay (AvLOS X Cost per day)
Surgical Sepsis	2,634	122,255	46.4	878	€40,739
Medical Sepsis	12,005	205,638	17.1	878	€15,013
Total Sepsis	14,639	327,893	22.4	878	€19,667
Surgical Infection	12,802	261,636	20.4	878	€17,911
Medical Infection	102,301	1,050,662	10.3	878	€9,043
Total Uncomplicated Infection	115,103	1,312,298	11.4	878	€10,009
Difference between Sepsis and Infection	100,464	984,405	9.79	878	€8,603

The average length of stay for a patient in a surgical diagnostic-related group (DRG) with a sepsis diagnosis is 46.4days with a cost of €40,739. Surgical DRG patients with an infection diagnosis have an AvLOS of 20.4 days, a difference in cost of €22,828 per patient between sepsis and infection complicating their hospitalisation. This is a total cost differential of approximately €60 million between surgical patients with sepsis and surgical patients with any uncomplicated infection (Table 7).

Table 7. Calculation of the annual cost differential for surgical patients sepsis and all other infections 2018** (HSE, 2019)

No. of in-patients	Cost per day €	Average Length of Stay (AvLOS) Days	Total Cost (No x Cost x AvLOS)
2634 - Sepsis	878	46.4	€107 Million
2634 – Other infection	878	20.4	€47M
Differential			€60 Million

The average length of stay for a patient in a medical diagnostic-related group (DRG) with a sepsis diagnosis is 17.1 days with a cost of €15,013. Medical DRG patients with an infection diagnosis have an AvLOS of 10.3 days, a difference in cost of €5,970 per patient between sepsis and infection complicating their hospitalisation. This is a total cost differential of approximately €72 million between medical patients with sepsis and medical patients with any uncomplicated infection (Table 8).

Table 8. Annual cost differential for medical patients sepsis and all other infections, 2018** (HSE, 2019)

No. of in-patients	Cost per day €	Average Length of Stay (AvLOS) Days	Total Cost (No x Cost x AvLOS)
12005 - Sepsis	878	17.1	€180 Million
12005 – Other infection	878	10.3	€108 Million
Differential			€72 Million

Economic and Social Burden:

Silva and Araujo (2009) performed a review to standardise the concepts related to health economic analysis and provide guidelines for reporting economic analyses that were largely based on the US Public Health Service Panel on Cost Effectiveness in Health and Medicine (PCEHM) for the conduct and reporting of economic analyses. This guidance and the methodology deployed by Schmidt were in sufficient detail and used data points available for the Irish Health Care System to allow them to do a short analysis on the costs incurred by current sepsis management and potentially saved with performance and quality improvement. The analysis is for descriptive purposes only.

The costs of sepsis to the economy can be divided into direct costs (28%), loss of productivity due to mortality (56%), loss of productivity due to morbidity (12%) and loss of productivity due to temporary morbidity (4%) (Silva and Araujo, 2009).

Direct	€19,667 (28%)
Loss of productivity due to mortality	€39,334 (56%)
Loss of productivity due to morbidity	€8,429 (12%)
Temporary loss of productivity	€2,810 (4%)
Total costs = €70,240 per patient or €1.03 billion loss to the Irish Economy per annum.	

'Loss of wages' method (Mitchell and Bates, 2011)

An alternative method to estimate the loss of productivity due to mortality, is to use the 'Loss of wages' method (Mitchell and Bates, 2011). This is the most frequently used measure of productivity loss; using a retirement age of 65 years, there were a total of 12,600 years lost amongst 1,892 patients who died below the age of 65. It does not include direct costs or productivity loss due to morbidity.

The average annual earnings in 2016 were €36,919, making a total loss of earnings of €465.2million, with an estimated income tax loss to the exchequer of €93million. This is lower than the estimated €583.6million using the previous method above and would result in a total cost of €924 million to the Irish economy per annum.

Comparisons:

Direct costs in ICU versus Non-ICU:

In the U.S., Angus et al (2009), using the claims databases, estimated the ICU septic patient cost \$29,900, (€25,652)* with an AvLOS 23.3 days versus the non-ICU septic patient \$13,900 (€11,928)*, with an AvLOS of 15.6 days (Shen et al., 2016). In the same population, the calculated cost differential between survivors and non-survivors was \$38,304 (€32,870)* versus \$49,182 (€42,202)* (Chalfin et al., 1995).

In France, costs were reported from €26,256 to €35,185 depending on the severity of illness (Brun-Buisson et al., 2003). Other European studies have given lower cost estimates, ranging from €23,000 to €29,000 (Burchardi and Schneider, 2004). In Ireland, a prospective micro-costing of ICU treatment was performed (not limited to sepsis), with mean total ICU costs of €20,487, (McLaughlin et al., 2009).

In Brazil, a micro-costing analysis of ICU sepsis care showed a median total cost of \$9,773 (€8,386)* (\$4,643-\$19,221) (€3985-€16,499)* (Sogayar et al., 2008). In China, an analysis showed a mean hospital cost \$11,390 - \$11,455 (€ 9,777 -9831)* per sepsis case (Cheng et al., 2007).

Thus, it can be seen that the hospital costs calculated for Ireland are not out of sync with other high-income countries, although direct comparisons cannot be made due to the difference in methodology.

**(Currency conversion as of 25th September 2020 by XE Currency Converter)*

Economic and social burden:

In Germany in 2002, using the administrative and other databases, Schmidt et al. did an assessment of the economic and social burden of sepsis (Schmidt et al., 2002). He identified the ratios used in the analysis for Ireland.

His results include:

- Productivity loss due to temporary morbidity €3,431 to 7,409 depending on severity (calculated at €2,810 in Ireland).
- Productivity loss due to mortality €46,000 per case (calculated at €39,334 in Ireland).
- Total burden of illness €82,886 to €178,954 (calculated at €70,240 per patient in Ireland).

Economic impact of the National Sepsis Programme

An economic impact of the sepsis protocol in an academic, tertiary care hospital in the United States found median total hospital costs were reduced from \$21,985 to \$16,103, (€18,866 - €13,818)** mainly due to a shorter length of stay (Shorr et al., 2007).

***(Currency conversion as of 25th September 2020 by XE currency converter)*

This has also been seen in Ireland where the AvLOS for patients with sepsis causing or complicating their hospital admission in 2011-2015 was 25.9 with estimated direct costs of €21,437, as this AvLOS fell in 2016/17 to 20.9 this has resulted in a reduction of €3,583 per patient with an estimated direct cost of €17,890 per hospital stay.

Table 9. Cost per bed day according to year (€)

Year	Cost per bed day*
2017	€878
2016	€856
2015	€839
2014	€839
2013	€815
2012	€825
2011	€820

*Average costs, across all nights, all hospitals, and all types of in-patient cases. This figure is a fully absorbed cost which means it includes treatment and care costs (such as diagnostics, theatres etc.) as well as hotel costs but excludes capital and depreciation. It excludes day case, outpatient and emergency department costs. (Healthcare Pricing Office, 2017)

In the overall sepsis population, two changes occurred as a consequence of the implementation programme, improved recognition and improved treatment. In the non-critical care population changes over time will reflect improved recognition as well as changes due to improved treatment and as such, analysis of trends in this population are problematic. However, in the critical care population lower acuity would have no impact on critical care admission due to the limited number of such beds; indeed, there was a decrease in capacity over the study period suggesting a potential increase in acuity amongst the critical care population.

- Mean sepsis-associated mortality 2011-2015 in patients admitted to a critical care area: 34%,
- Mean sepsis-associated mortality 2016-2018 in patients admitted to a critical care area: 31.4%

An absolute decrease of 2.6% and a relative decrease of 8%.

In 2018, 4,002 patients admitted to ICU had a sepsis code on their hospital discharge.

The mortality decrease suggests an additional 302 lives saved over the 3 years post implementation from this subpopulation.

The hospital AvLOS for this subgroup decreased from 36.72 days in 2011-15 to 33.7 days in 2016-18, a gain of 12,086 bed days and a reduction in direct costs from €30,808 to €29,589 per patient. This represents a saving of €10.6million.

2.3 Rationale for this National Clinical Guideline

Sepsis is a common time-dependent medical emergency. Whilst it can affect a person of any age, from any social background and can strike irrespective of underlying good health, 90% of adults and 70% of children who develop sepsis have underlying risk factors (CDC, 2016). International sepsis campaigns that have introduced and promoted an approach to sepsis care based on early recognition of sepsis with resuscitation and timely referral to critical care are associated with an increased compliance with sepsis bundles and a decrease in mortality (Odds Ratio 0.6) (Damiani et al., 2015)

In 2016, the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) were developed by a taskforce at the request of the Society of Critical Care Medicine (SCCM) and the European Society of Intensive Care Medicine (ESICM), (Singer et al., 2016).

Sepsis-3 provides a welcome rationalization of the sepsis syndrome with sepsis only being diagnosed when infection has led to acute organ dysfunction and the presence of a systemic inflammatory response no longer being a requirement. A systemic inflammatory response may be caused by infective and non-infective conditions and represents an adaptive response to an insult. It is present in about 85% of sepsis cases and many more cases that are not sepsis. Thus, although its presence can alert a clinician that a patient may have a problem it is not sufficiently discriminatory to identify the cause of the problem.

These changes go a good way to reduce concerns about over diagnosis leading to overuse of antibiotics in a climate of increasing concern about multi-drug resistant organisms by identifying a subset of patients with infection who have a high mortality risk.

2.4 Aim and objectives

Aims

1. To ensure that all acute hospitals give patients with sepsis the best opportunity to survive.
2. To maximize the health-related quality of life in survivors of sepsis.
3. To minimize the burden of sepsis to the healthcare system by reducing the acuity and the chronic sequelae of sepsis.

The National Clinical Guideline for Sepsis Management was published in November 2014 (NCEC, 2014) and the implementation process started in 2015 with an education and awareness campaign. Hospital-based education was delivered by the National Sepsis Programme in all acute hospitals and clinical decision support tools and other educational aids and materials were rolled-out.

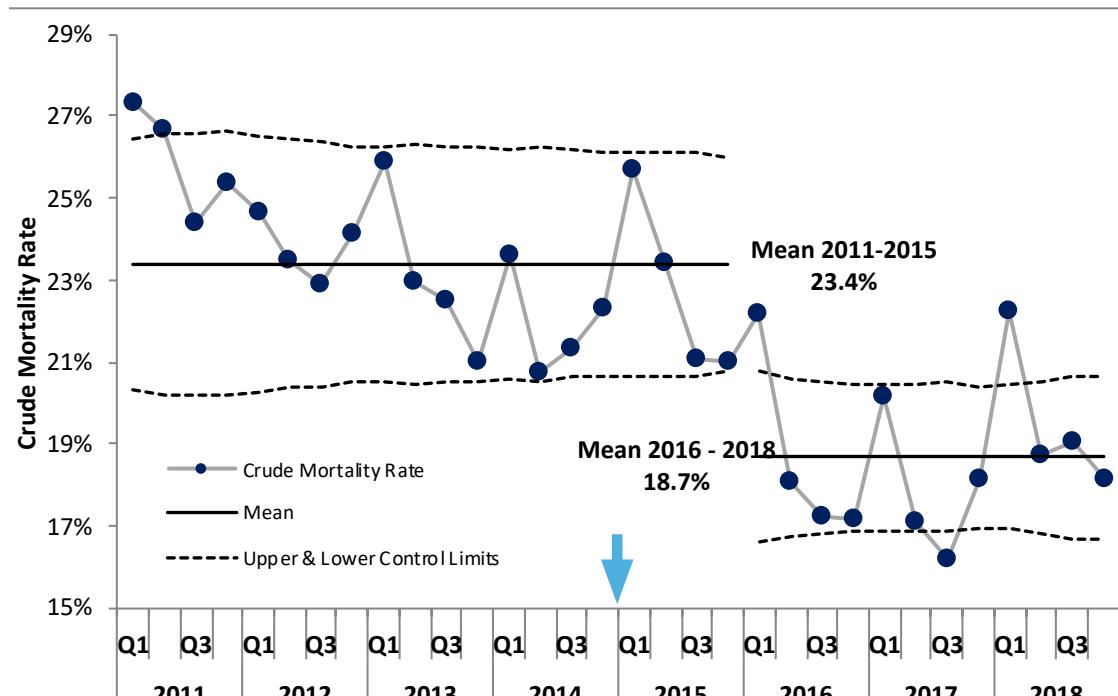


Figure 1. Impact of the National Clinical Guideline Implementation in Ireland; sepsis-associated hospital mortality in all inpatients with a discharge code of Sepsis & SIRS of Infectious origin. (HSE, 2019b)

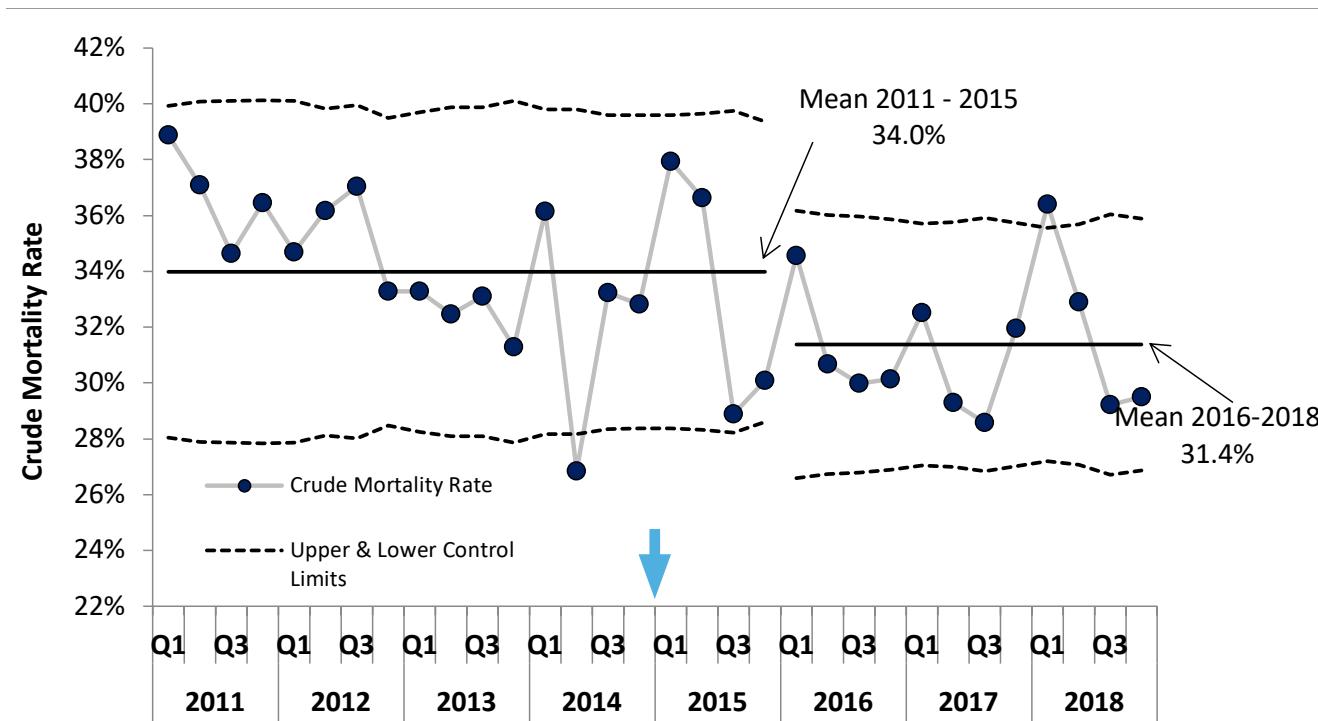
Quarterly data, 2011 – 2018 (Statistical Process Control Chart)

Quarterly rates of in-hospital mortality for inpatients with a diagnosis of sepsis from 2011 to 2018 were analysed using Statistical Process Control (SPC) methods (Figure 1). The use of SPC methods allows us to see whether the changes made resulted in improvements and allow us to distinguish between variation that may have happened by chance alone and variation that indicates a real improvement in mortality rates. There is an important caveat and that is that the education and awareness campaign will have led to the improved documentation of lower acuity sepsis cases that bring with them a lower mortality rate and this will have impact.

This figure demonstrates that the National Sepsis Programme had a statistically significant impact on the recognition and management of sepsis in Ireland. Between 2011 and 2015, the average in-hospital mortality for inpatients with a diagnosis of sepsis was 23.4%. Using control limits based on SPC methods it was expected during this period that the quarterly mortality rate would vary from around 20 to 26% by chance alone. Since 2016 the quarterly mortality rate has averaged 18.7% which is below this lower control limit of 20% indicating a significant improvement in mortality rates that is not explained by chance alone.

The control limits in the statistical process control chart have been re-calculated to reflect this reduction. We now anticipate that this improvement will be sustained, and mortality will remain below 20% (with some variation due to seasonal effects) (HSE, 2019b).

It is not possible to distinguish what portion of improvement is due to improved recognition and what is due to improved management, however, a 7.95% decrease in mortality is also observed in the critical care patient cohort (Figure 2), where capacity not recognition limits access and where there was a decrease in per capita bed stock. These effects are consistent with those found in other jurisdictions where sepsis quality improvement programmes were implemented (Rhodes et al., 2017).



*this includes ICU, HDU, CCU

↓ = Roll out of the NCG

Figure 2. Impact of the Sepsis Guideline Implementation in Ireland; sepsis-associated hospital mortality in inpatients admitted to a critical care area* with a discharge code of Sepsis & SIRS of Infectious origin.

SPC analysis does not identify which changes resulted in the demonstrated improvement. It is acknowledged that improved recognition and documentation of lower acuity sepsis cases, as well as improved management will have contributed to this effect. However, the average mortality rates can be benchmarked against other jurisdictions that have published (Seymour et al., 2017, Martin et al., 2003, Angus et al., 2001) and this indicates that Ireland is performing as well as other high-income countries in terms of sepsis-associated mortality rates.

Objectives

1. That all healthcare professionals have an understanding of the diagnostic criteria for sepsis and its basic pathophysiology.
2. That all medical, nursing and midwifery staff working in the acute sector, recognise patients at high risk of mortality from sepsis.
3. That all medical, nursing and midwifery staff working in the acute sector are:
 - i. Familiar with the initial management of patients with a high risk of mortality from sepsis
 - ii. Able to use the sepsis form which is a clinical decision support tool and forms part of the patient's clinical notes.
 - iii. Able to take a team approach to implementing the Sepsis 6 bundle (Daniels et al., 2011) and the sepsis management algorithms.

How should the aims and objectives be supported in the community?

70-80% of sepsis cases arise in the community thus a quality improvement campaign needs to have a 2-fold approach (CDC, 2016).

1. Address sepsis recognition and management by healthcare professionals who work in the community and
2. Improve Sepsis awareness in the public domain.

There is limited evidence-based data to guide recognition, management and escalation in the community and any such programme needs to have robust antimicrobial stewardship to support healthcare professionals in avoiding inappropriate usage (www.antibioticprescribing.ie) (HSE) and to prevent 'protocol-driven' inappropriate emergency department, medical or surgical assessment unit referrals. It needs to be developed with the end users and tested within its context to ensure that it fulfils its purpose without unintended consequences.

Awareness of sepsis and its symptoms and signs is an important part of public health education. Such a programme should be embedded in a strategy to promote prevention of infection, antimicrobial stewardship and the recognition of signs and symptoms of deterioration that should prompt urgent medical review.

Public information is available from <https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/>

Infection and sepsis in the older population

Infections in the elderly are different from infections in a younger population due to age-related alterations in immunology and concomitant medical diseases – multimorbidity is the norm.

They are more likely to:

- have decreased gag and cough reflex – predisposing them to respiratory tract infections (RTIs).
- be colonised by multi-resistant organisms.
- have poor response to neoantigens and vaccines due to immunosenescence.
- be less mobile than their younger counterparts and more prone to skin breakdown and decubiti.
- have poor urinary bladder emptying, prostate enlargement and neurogenic bladder - predisposing them to urinary tract infections (UTIs).
- have a high risk of falls and injuries predisposing them to skin and wound infections.
- Sepsis is more common and has a higher mortality when it occurs in patients with co-morbidities and as we get older, we accumulate co-morbidities.

This population often presents with:

- cognitive impairment – but there is a danger in normalising the abnormal.
- diminished cardiopulmonary reflexes and physiological reserve,
- malnutrition, endocrine deficiency, chronic inflammatory and prothrombotic effects of aging that weaken the immune system.

A lower threshold and higher index of suspicion is required to recognise sepsis in this population.

2.5 Guideline Scope

2.5.1 Target Population

This NCG applies to adult patients with confirmed or suspected sepsis, including pregnant women in all clinical settings in the acute sector.

The majority of recommendations and implementation points apply to both Adult non-pregnant patients and women pregnant and in the postnatal period up to 42 days. Recognition in the maternity patient is slightly different; therefore, maternity specific implementation points are signposted as such. All maternity specific information is highlighted using purple text. Treatment and escalation are generally the same for both groups. See maternity section for more details on the pregnant woman/post parturient.

2.5.2 Purpose

The purpose of this guideline is to implement the Surviving Sepsis Campaign Guideline (SSCG) in the management of the adult patient in the acute hospital sector in Ireland. It takes these international evidence-based recommendations and implements them in a format that applies to the structures and functions of the Irish Acute Health Care Sector. The National Sepsis Programme would like to thank the Surviving Sepsis Campaign for permission to do this.

The recommendations in the guideline are structured as follows:

- i. **SSCG - Key Questions**
- ii. **SSCG - Surviving Sepsis Campaign Guideline Rationale**
- iii. **SSCG - Recommendations**
- iv. **NCG - Implementation Points (where relevant)**

All **SSCG references are numbered** are extracted directly from the SSCG document. Additional references that have been incorporated into the implementation aspects are in a separate list called **National Clinical Guideline References** and are listed **alphabetically**.

The recommendations of the SSCG are included so that it can be read as a standalone document. However, it is recommended that clinicians familiarise themselves with the SSCG, and is endorsed by the Critical Care Programme, the Joint Faculty of Intensive Care Medicine in Ireland and the Intensive Care Society of Ireland. An important guideline for those dealing with maternity is the 'Critically ill women in obstetrics' (HSE, 2014).

Implementation has been divided into three phases,

1. Recognition
2. Treatment
3. Escalation

Implementation points included after SSCG recommendations are aimed, primarily, at the pre and post-critical care setting, recognizing that much of the research that informed the SSCG occurred in the critical care setting and thus the SSCG can be more directly applied in that setting.

The NCG is designed to guide clinical judgement but not replace it. In individual cases a healthcare professional may, after careful consideration, decide not to follow guideline recommendations if it is deemed to be in the best interests of the patient and is in line with best practice. Clinical decisions and therapeutic options should be discussed with a senior clinician on a case-by-case basis as necessary and documented in the clinical notes.

The Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children were published in February 2020. The HSE is adopting these guidelines directly as a HSE protocol. The National Sepsis Programme will provide an implementation plan to enable the application of the recommendations in the Irish health care setting.

The recommendations align with the aims of the National Sepsis Programme. Key recommendations are linked with other recommendations, practical guidance, roles, responsibilities and processes. The recommendations are linked to the best available evidence and/or expert opinion using the GRADE system for grading recommendations.

2.5.3 Target Users

This guideline is relevant to all healthcare professionals involved in the care of adult and maternity patients with sepsis and suspicion of sepsis, working in the acute hospital sector in the Republic of Ireland.

The guideline is also relevant to:

- Department of Health (DoH) to support the development, implementation and audit of this National Clinical Guideline.
- The HSE to provide appropriate structured support and adequate resources for the governance, operationalization, and audit of sepsis management.
- The Hospital Group Leadership Team, Hospital Management and Clinical Directors to support sepsis quality improvement and to foster and facilitate the implementation process and audit. They are also responsible for effecting and monitoring change arising from outlier intervention.

- Pre-Hospital Emergency Care to inform their clinical practice guidelines.
- The public as an information resource.

A summary version of the National Clinical Guideline outlining the key recommendations and National Implementation Plan is available at: <https://www.gov.ie/en/collection/c9fa9a-national-clinical-guidelines/>

2.6 Conflict of interest statement

The guideline development process followed the conflict of interest policy set out by the NCEC. All members of the Sepsis Management GDG were required to complete a conflict of interest declaration which was managed by the National Sepsis Programme Manager. There were no conflicts of interest stated.

2.7 Sources of funding

There was no external funding, commercial input or resource provided for this guideline by any service or organisation, and as such no potential for influence on editorial independence. The GDG sought and were granted permission to adopt the Surviving Sepsis Campaign Guideline for which no cost was incurred.

2.8 Guideline methodology

In order to update the 2014 Sepsis National Clinical Guideline (NCG) the National Sepsis Programme convened a Guideline Development Group (GDG) consisting of key stakeholders, recognised experts in sepsis management and patient advocates.

A literature search was undertaken by the HSE Library Service to identify any national and international sepsis clinical guidelines published since the previous Sepsis NCG was published in 2014 which could be adopted or adapted for use in the Irish Healthcare setting.

The search strategy included a search of Medline and PubMed using search terms related to the management of sepsis and septic shock (Appendix 6). The websites of key organisations were also searched. The search identified 11 documents, the majority of which were excluded immediately as they related to pre-hospital care, non-acute care settings, paediatrics or were related to a specific type of sepsis, e.g. acute meningitis and meningococcal sepsis.

When the exclusion criteria were applied only three guidelines were eligible for consideration:

- NICE Sepsis: recognition, assessment and early management (NICE, 2017)
- Surviving Sepsis Campaign (SSC): International Guidelines for Management of Sepsis and Septic Shock (Rhodes et al., 2017)
- The Japanese Clinical Practice Guidelines for the Management of Sepsis and Septic Shock (Nishida et al., 2018)

The Prisma flow diagram illustrates the process undertaken in narrowing down the guidelines for appraisal. (Figure 17. Appendix 6)

In order to assess which guideline was relevant for the Irish Healthcare system and to appraise the quality of the guidelines, including the rigour and transparency in which the guidelines were developed a quality assessment was undertaken by two of the GDG Members using the Appraisal of Guidelines for Research and Evaluation II (AGREE II) tool, (Brouwers et al., 2010). The SSC Guideline was the only guideline that scored >70% in all domains and was ranked highest in all domains by both appraisers with overall domain percentages ranging 71-100%. In addition, the appraisers noted that although the Japanese Guideline was an adaption of the SSC Guideline, it was tailored for the Japanese healthcare system with some recommendations that were not widely available within the Irish Healthcare system and the NICE Guideline although well researched and written, was tailored to the UK health service and focused on many elements beyond the scope of the Irish NCG e.g. pre-hospital care and paediatrics. Both appraisers agreed that based on the AGREE II process and the points noted previously that the SSC Guideline should be adopted for use in the Irish Healthcare system.

The SSC Guideline which focuses on early management of sepsis and septic shock, underwent a robust process to identify the evidence relating to five areas of practice (haemodynamics, infection, adjunctive therapies, metabolic, and ventilation). An extensive search was performed for each PICO and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system principles were used to guide the assessment of the quality of evidence and to determine the strength of the recommendations. Both of these are fully described in the SSC Guideline (Rhodes et al., 2017) and are summarised in Tables 10 and 11. Table 12 identifies the grading terminology used in the 2016 guideline. All of these terms are referred to within the recommendations section of this document.

Table 10. Determination of the quality of evidence

Underlying Methodology
1. High: RCTs
2. Moderate: Downgraded RCTs or upgraded observational studies.
3. Low: Well-done observational studies with RCTs.
4. Very Low: Downgraded controlled studies or expert opinion or other evidence.
Factors that may decrease the strength of evidence
1. Methodologic features of available RCTs suggesting high likelihood of bias.
2. Inconsistency of results, including problems with subgroup analyses.
3. Indirectness of evidence (differing population, intervention, control, outcomes, comparison)
4. Imprecision of results.
5. High likelihood of reporting bias.
Main factors that may increase the strength of evidence
1. Large magnitude of effect (direct evidence, relative risk >2 with no plausible confounders)
2. Very large magnitude of effect with relative risk >5 and no threats to validity (by two level).
3. Dose-response gradient.

RCT = Randomised controlled trials

Table 11. Factors determining strong versus weak recommendations

What should be considered	Recommendation Process
High or moderate evidence (Is there high, or moderate, quality evidence?)	The higher the quality of evidence, the more likely a strong recommendation.
Certainty about the balance of benefits versus harms and burdens (Is there certainty?)	The larger the difference between the desirable and the undesirable consequences and the certainty around the difference, the more likely a strong recommendation. The smaller the net benefit and the lower the certainty for that benefit, the more likely a weak recommendation.
Certainty in, or similar, values (Is there certainty or similarity?)	The more certainty or similarity in values and preferences, the more likely a strong recommendation.
Resource implications (Are resources worth expected benefits?)	The lower the cost of an intervention compared to the alternative and other costs related to the decision (i.e. fewer resources consumed), the more likely a strong recommendation.

Table 12. Grading terminology

	2016 Descriptor
Strength	Strong Weak
Quality	High Moderate Low Very low
Ungraded strong recommendation	Best practice statement (BPS)

The guideline provides recommendations for good practice that are based on the best available clinical and cost effectiveness evidence.

It was agreed by the GDG to fully adopt the SSC Guideline with the addition of implementation points to aid the implementation of the guideline within the Irish Healthcare System in both pregnant and non-pregnant adults. It was also agreed by the GDG to limit the NCG to adults, non-pregnant and pregnant, and to exclude paediatrics from the scope of the guideline as the SSC Guideline refers to adults only. In addition, the Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children were published in February 2020. The HSE is adopting these guidelines directly as a HSE protocol. The National Sepsis Programme will provide an implementation plan to enable the application of the recommendations in the Irish health care setting.

2.9 Consultation summary

The GDG sought to ensure that all stakeholders had an opportunity to review and contribute to the update of the National Clinical Guideline for Sepsis. The guideline and feedback form were placed on the HSE public website under the clinical programmes and the link was circulated to those listed in Appendix 7 with an invitation to review and provide feedback. The GDG gratefully acknowledges the contribution made by all those who contributed from professional, academic and patient groups.

The stakeholders are listed in Appendix 7.

2.10 External review

Two international experts were invited to review and provide feedback on an early draft of the guideline. These experts were independent from the Guideline Development Group and selected based on their contribution to academic literature and clinical practice:

1. Professor Kevin Rooney is a Consultant Anesthetist and Professor of Care Improvement at University of the West of Scotland. He is the Clinical Lead for the Acute Adult Workstream of the Scottish Patient Safety Program for Healthcare Improvement Scotland and led their breakthrough series collaborative on sepsis, which resulted in a sustained relative risk reduction of 21% in sepsis mortality across Scotland.
2. Dr John Bates, Galway University Hospital, Department of Anaesthesia and Intensive Care, Dean of Joint faculty of Intensive Care Medicine.

The GDG are very grateful to these reviewers for their time, expertise and contribution to this guideline.

2.11 Implementation

These guidelines are divided into sections with each one pertaining to a different aspect of patient care. Recommendations from the Surviving Sepsis Campaign Guideline Update 2016 are labelled ‘SSCG Recommendation’ and ‘SSCG Rationale’.

Implementation points are included to guide implementation of the SSCG recommendations in Ireland, particularly in the non-critical care environment. The implementation points arise from piloting clinical decision support tools in the acute hospital sector, particularly in emergency departments (EDs) and maternity units to ensure that the implementation recommendations could be affected within the resources of our healthcare system and had the support of end-users. The feedback from these pilots was overviewed by multidisciplinary committees (the National Steering Committee and the Maternity Working Group) and the forms amended based on this feedback and re-piloted, if required. Thus, the implementation programme is informed by end-users and by multidisciplinary specialist input.

Appendix 8 identifies the enablers and barriers to implementing the recommendations along with the responsibilities and timelines.

Funding for guideline implementation is subject to service planning and the estimates process.

2.12 Monitoring and audit

The aim of this National Clinical Guideline is to reduce unnecessary variations in practice and provide an evidence base for the most appropriate healthcare to optimize patient survival from sepsis.

The National Sepsis Programme (NSP) will monitor this aim in two ways:

- (1) Audit of implementation of the NCG (Clinical audit/Process audit)
- (2) Audit of outcomes resulting from implementation of the NCG (National Sepsis Report).

Clinical audit/Process audit is the systematic review and evaluation of current practice against research-based standards with a view to improving clinical care for service users and is an important part of any quality improvement programme. It takes a snapshot of performance and benchmarks it against the guideline and thus identifies areas that may benefit from improvement. Since process audit does not contextualize the decisions made during a patient's care episode, it is not designed to assess the quality of an individual care episode. However, should an area of concern be identified it should be brought to the attention of the local hospital sepsis committee for their consideration.

Outcomes: The primary aim of optimizing patient survival should be audited by the publication of age and co-morbidity adjusted sepsis-associated (direct and in-direct) hospital mortality rates for each acute hospital and benchmarked against the national average. International benchmarking of the national sepsis-associated hospital mortality rate should be done against other high-income jurisdictions that publish such mortality rates.

The National Sepsis Report is published annually and describes the burden of sepsis, in terms of the number of cases and the associated age adjusted mortality, to our healthcare system. The report (HSE 2019) recommends the development of a sepsis mortality prediction model and scoring system to compare age and co-morbidity adjusted hospital sepsis-associated mortality rates nationally and internationally.

Secondary outcome aims include healthcare utilization assessment such as the total number of bed days, average length of stay, critical care admission rates and average length of stay, and hospital readmission rates within three months (Chang et al., 2015) and should be reported where possible. The assessment of healthcare utilization is important as a monitor of the effectiveness of the sepsis quality improvement programme and also provides data for resource planning. As sepsis incidence increases with age with an ageing population it can be expected that healthcare provision for sepsis care will increase. An effective programme can modulate this increase.

Maternity

Sepsis outcome audits are carried out by The Confidential Enquiry into Maternal Deaths (CEMD) in the UK and Ireland. Since June 2012, these audits have been carried out by the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) collaboration and Maternal Death Enquiry (MDE) in the National Perinatal Epidemiology Centre-Ireland. They are published on the National Perinatal Epidemiology Unit (NPEU) website: <https://www.npeu.ox.ac.uk/mbrrace-uk/reports>. Each topic-specific/sepsis confidential enquiry chapter now appears in an annual report once every three years on a cyclical basis, in contrast to the past when a single report was produced every three years.

Practical guidance A:

The GDG suggests that a tool be developed to risk adjust sepsis-associated hospital mortality (direct and in-direct) based on the Hospital In-patient Enquiry database and that each acute hospital, on this database, have annual risk-adjusted sepsis-associated mortality rates benchmarked against the national average. When operational, this tool will facilitate the development of Key Performance Indicators (KPI's) for sepsis.

Rationale:

Optimising survival from sepsis depends on the hospital system working efficiently and effectively as a whole. It requires effective communication, adequate resources and capacity both in infrastructure and staffing. Sepsis management and risk-adjusted sepsis-associated hospital mortality are robust markers of the quality of acute health care delivery.

Monitoring and acting on outcome audit ensures improvement occurs throughout the acute healthcare system and is not sporadic. It informs the population a hospital serves and its staff on the effectiveness of its sepsis management and supports improvement processes.

Outlier management:

Hospitals whose outcome measures are in excess of the control limits will, in the first instance have their data reviewed by the national sepsis programme working group (Appendix 2). There are 3 possible outcomes from this initial review:

1. No action warranted
2. Monitor pending further review
3. Outlier intervention warranted

Outlier interventions:

1. The National Sepsis Team, including the Hospital Group Sepsis ADON, will discuss the findings and the outcome of the National Audit Committee data review with the Hospital Management and Clinical Director/s.
2. An improvement plan will be formulated by Hospital Management, the Clinical Director/s and the Sepsis/ Deteriorating Patient Committee, with advice from National Sepsis Team.
3. Audit of the improvement plan, its implementation and effect by the Hospital with support from the Hospital Group Sepsis ADON and the Hospital Group Leadership Team to ensure any identified issues are addressed.
4. It is the responsibility of the Hospital Management, Clinical Director/s and Sepsis/ Deteriorating Patient Committee to effect and monitor the findings of the outcome and process audits.

Practical guidance B

The GDG suggest that intermittent process audit be performed to support improvements in sepsis recognition, management and escalation.

Rationale:

The purpose of these audits is to benchmark different areas of practice against these guidelines for the purpose of informing on-going education and performance improvement initiatives.

The National Sepsis Programme will agree the process audit schedule annually and inform Hospital Group leadership of same. The Group Sepsis ADONs will also notify local sepsis committees and plan accordingly.

The process audits will be carried by the Group ADONs in collaboration with appropriate staff in local hospitals.

Process audit does not review the context of decision-making in patient management and as such, cannot comment on the standard of care relating to an individual patient. However, if during the course of an audit, the possibility of a serious patient safety incident is considered this should be brought to the attention of the Sepsis/ Deteriorating Patient Committee. It is the responsibility of the Committee to decide if any further action is warranted.

It is the responsibility of the hospital sepsis committee to inform clinicians of the audit findings and to adjust the hospital's sepsis education programme to improve management and to effect, along with hospital management, any outlier interventions.

Practical guidance C

The GDG suggests that an annual sepsis outcome report be published which includes, but is not limited to:

- the risk-adjusted hospital mortality rates
- the incidence, patient characteristics and healthcare utilization of patients with sepsis during their hospitalization
- hospital group level amalgamated process audit results
- balancing measures.

Rationale:

A culture of openness promotes good practice and confidence in the healthcare system. It is important that the community is aware of the limitations of sepsis care, its high mortality risk and the efforts being made to reduce that risk. Sepsis guidelines are based on the best available information at the time of publication; however, they are just guidelines and cannot anticipate the complexity of an individual case. Data collection on patient characteristics and risk factors allows the identification of high-risk patients for prioritization. However, for every patient prioritized there are others who have been deemed less at risk. When capacity is challenging, getting this right is a vital and difficult component of time-dependent care especially when the clinical scenario is evolving. A hospital working within the control limits of the national average demonstrates that it is providing a service, in terms of sepsis care, that is as good as anywhere else within the state.

Balancing measures:

Audits should also include considerations of potential unintended consequences of the National Sepsis Programme including inappropriate antimicrobial use. Inappropriate antimicrobial use is a patient safety issue (e.g. adverse reactions, Clostridium difficile infection) and of public health concern (increased rates of multidrug resistant organisms, MDRO) (DOH, 2017a).

In relation to antimicrobial use, there are at least three potential unintended consequences of implementing the Sepsis 6 bundle:

1. Patients who have deteriorated but have no evidence of potential infective source/sepsis are commenced inappropriately on antimicrobial therapy.
2. Patients with sepsis are commenced on inappropriate antimicrobial therapy that is not in line with local guidelines.
3. Empiric antimicrobial therapy that has been commenced in a patient with suspected sepsis is not reviewed at 24-48 hours as recommended by the Start Smart, then Focus Antimicrobial Care bundle (RCPI, 2012).

All hospitals should have antimicrobial stewardship programmes in place as outlined in National Guidelines (DOH, 2017a) (HSE, 2019a) that monitor process and outcome measures to ensure that antimicrobials are not being prescribed unnecessarily due to inappropriate application of Sepsis 6/Sepsis 6 + 1. Ensuring antimicrobials are used appropriately for all infections, not just those associated with sepsis, will help to ensure effective antimicrobial therapy is available when cases of sepsis do occur.

Roles and responsibilities:

The National Sepsis Programme is responsible for publishing an annual sepsis outcome report. Working with the Health Pricing Office (HPO), the National Sepsis Programme will provide guidance on what outcomes, processes and patient characteristics to audit and will review audit methodology and results to ensure that they make clinical and statistical sense. It is the responsibility of the Programme to provide outlier support to hospitals when indicated.

It is the responsibility of sepsis committees, Hospital Management and Hospital Group Leadership to effect recommendations arising out of outlier intervention.

It is the responsibility of the Department of Health, the HSE, hospital group leadership and hospital management to support the audit process and to ensure that adequate resources are available to perform the audit and to effect change required based on audit results.

It is the responsibility of the Department of Health and the HSE to resource a risk-adjusted sepsis-associated hospital mortality rate audit tool as the key performance indicator for sepsis in Ireland.

2.13 Legislation and other related policies

On occasion in clinical practice, prescriptions are written for licensed drugs given for unlicensed indications, and/or via an unlicensed route (NCEC, 2015b). Often it is simply a matter of the route or dose being different from those in the manufacturer's SPC (summary of product characteristics). It is of note that the licensing process for drugs regulates the marketing activities of pharmaceutical companies, and not prescribing practice. Unlicensed use of drugs by prescribers is often appropriate and guided by clinical judgment. This practice is safeguarded in legislation in accordance with Medicinal Products (Control of Placing on the Market) Regulations 2007 (S.I 540/2007) as amended, (GOV, 2007). Furthermore, drugs prescribed outside license can be dispensed by pharmacists and administered by nurses or midwives (NCEC, 2015b).

2.14 Plan to update this National Clinical Guideline

This guideline will be scheduled for review 3 years after publication by the National Sepsis Programme. In the event that new relevant evidence comes to light, then a rapid update may be required within the three-year period.

3

National Clinical Guideline

COVID-19

Any infection, including viral infections like the flu and COVID-19 can cause sepsis. Similarly to sepsis, anybody can develop COVID-19 if they become infected with SARS-CoV-2, but some people are at higher risk such as those with a weak immune system (Global Sepsis Alliance, 2020). The effects of COVID-19 on the respiratory system can result in patients requiring hospital admission with varying degrees of pneumonia, however other organs can be affected with signs of multi organ failure typical of sepsis occurring in around 2-5% after approximate 8-10 days of infection and sadly many patients affected by COVID-19 will die from sepsis and its complications (Global Sepsis Alliance, 2020), (Yang et al., 2020).

Known risk factors for rapid deterioration, severe disease, and/or increased mortality are: older age (> 60 years) and comorbidities such as cardiovascular disease, diabetes mellitus, chronic lung disease, cancer and cerebrovascular disease (Huang et al., 2020) and also obesity (Centre for Disease Control, 2020). Patients with one or more of these risk factors should be monitored closely for deterioration.

Maternity

Most pregnant women who are infected with SARS-CoV-2 will experience only mild or moderate cold/flu-like symptoms, (RCOG, 2020). However, health care providers should consider all differential diagnoses for women who present with a fever in pregnancy and postnatal up to 42 days and follow national advice and guidance. Although the evidence is limited, pregnant women who are older, overweight and have pre-existing medical conditions such as hypertension or diabetes may have an increased risk of developing severe COVID-19 including being admitted to intensive care (WHO, 2020) (Allotey et al., 2020).

It also recommend that women from a Black, Asian or Minority Ethnic (BAME) group should also seek advice without delay if they are concerned about symptoms of COVID-19, (MMBRACE, 2020).

Pregnant women should be counselled about the risk for severe COVID-19 associated illness and measures to prevent infection with SARS-CoV-2 should be emphasised for pregnant women and their families (Zambrano, 2020),(WHO, 2020).

The treatment and management of COVID-19 is evolving rapidly. The HSE monitors the evidence provided both nationally and internationally and has provided a repository of interim guidance for healthcare professionals on the treatment and management of COVID-19. This repository is updated regularly when new evidence is published and the link can be found here:

<https://hse.drsteevenslibrary.ie/Covid19V2>

For all other cases of sepsis and septic shock not related to COVID-19, the following recommendations should be adhered to.

National Clinical Guideline Recommendations

Recommendations from the Surviving Sepsis Campaign (SSC) Guideline Update 2016 and 2018 are adopted in total for this guideline. Recommendations are labelled 1-93 and are divided into sections with each one pertaining to a different aspect of patient care. Additionally, National Implementation Points are provided and are for the purpose of implementing the SSCG, in the Irish context, particularly in the non-critical care environment.

The implementation points arise from piloting clinical decision support tools in the acute hospital sector, in particular emergency departments (EDs) and maternity units to ensure that the implementation recommendations could be affected within the resources of our healthcare system and had the support of end-users. The feedback from these pilots was overseen by multidisciplinary committees (the National Steering Committee and the Maternal Sepsis Form oversight committee) and the forms amended based on this feedback and re-piloted, if required. Thus, the implementation programme is informed by end-users and by multidisciplinary specialist input.

The following guidance is based on the best available evidence. The Surviving Sepsis Campaign Guideline Update 2016* and 2018 bundle update can be found at the links below giving details of the methods and the evidence used to develop the guidance:**

*https://journals.lww.com/ccmjournal/Fulltext/2017/03000/Surviving_Sepsis_Campaign__International.15.aspx

**https://journals.lww.com/ccmjournal/Fulltext/2018/06000/The_Surviving_Sepsis_Campaign_Bundle__2018_Update.21.aspx

3.1 Key questions, evidence statements and recommendations

3.1.1 Recognition, Screening for Sepsis and Performance Improvement

Key question

- Should hospitals use a formal resourced performance improvement program for sepsis including sepsis screening for acutely ill, high risk patients?

SSCG Rationale

Performance improvement efforts for sepsis are associated with improved patient outcomes (40). Sepsis performance improvement programs should optimally have multi-professional representation (physicians, nurses, affiliate providers, pharmacists, respiratory therapists, dieticians, administrators) with stakeholders from all key disciplines represented in their development and implementation. Successful programs should include protocol development and implementation, targeted metrics to be evaluated, data collection, and ongoing feedback to facilitate continuous performance improvement (41). In addition to traditional continuing education efforts to introduce guidelines into clinical practice, knowledge translation efforts can be valuable in promoting the use of high-quality evidence in changing behaviour (42).

Sepsis performance improvement programs can be aimed at earlier recognition of sepsis via a formal screening effort and improved management of patients once they are identified as being septic. Because lack of recognition prevents timely therapy, sepsis screening is associated with earlier treatment (43,44). Notably, sepsis screening has been associated with decreased mortality in several studies (20,45). The implementation of a core set of recommendations (“bundle”) has been a cornerstone of sepsis performance improvement programs aimed at improving management (46). Note that the SSC bundles have been developed separately from the guidelines in conjunction with an educational and improvement partnership with the Institute for Healthcare Improvement (46). The SSC bundles that are based on previous guidelines have been adopted by the U.S.-based National Quality Forum and have also been adapted by the U.S. healthcare system’s regulatory agencies for public reporting. To align with emerging evidence and U.S. national efforts, the SSC bundles were revised in 2015.

While specifics vary widely among different programs, a common theme is the drive toward improvement in compliance with sepsis bundles and practice guidelines such as SSC (8). A meta-analysis of 50 observational studies demonstrated that performance improvement programs were associated with a significant increase in

compliance with the SSC bundles and a reduction in mortality (OR 0.66; 95% CI, 0.61–0.72)(47). The largest study to date examined the relationship between compliance with the SSC bundles (based on the 2004 guidelines) and mortality. A total of 29,470 patients in 218 hospitals in the United States, Europe, and South America were examined over a 7.5-year period. Lower mortality was observed in hospitals with higher compliance. Overall hospital mortality decreased 0.7% for every 3 months a hospital participated in the SSC, associated with a 4% decreased LOS for every 10% improvement in compliance with bundles. This benefit has also been shown across a wide geographic spectrum. A study of 1,794 patients from 62 countries with severe sepsis (now termed “sepsis” after the Sepsis-3 definition (1) or septic shock demonstrated a 36%–40% reduction of the odds of dying in the hospital with compliance with either the 3- or 6-hour SSC bundles (48). This recommendation met the pre-specified criteria for a BPS. The specifics of performance improvement methods varied markedly between studies; thus, no single approach to performance improvement could be recommended (Supplemental Digital Content 5, <http://links.lww.com/CCM/C326>).

Recommendation 1. (SSCG Section B, Recommendation 1).

We recommend that hospitals and hospital systems have a performance improvement program for sepsis, including sepsis screening for acutely ill, high-risk patients.

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Implementation Point 1 (Recommendation 1)

The National Sepsis Programme will support and monitor sepsis performance improvement to promote the population receiving safe and high-quality sepsis care.

The National Sepsis Programme follows the governance structure outlined in Figure 3 to coordinate the implementation and audit of the guideline.

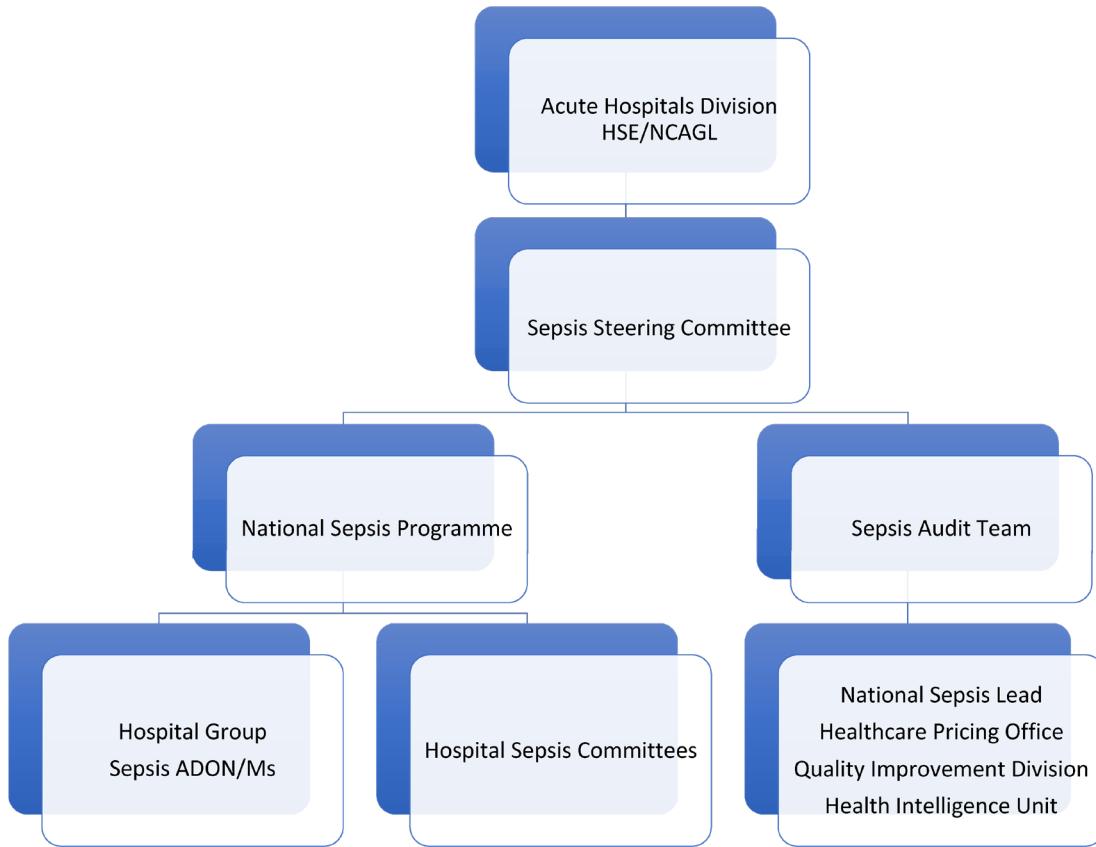


Figure 3. The National Sepsis Programme Governance Structure

The **National Sepsis Steering Committee** is a multi-disciplinary committee recognizing that sepsis affects all specialties and services. Its membership and terms of reference are listed in Appendix 1 & 2.

The National Sepsis Team reports to the steering committee and the office of the National Clinical Advisor and Group Lead for Acute Hospitals, Health Services Executive (HSE) and works with the National Clinical Effectiveness Committee for the scheduled updates of the National Clinical Guideline and advises the Department of Health on issues related to sepsis. Its membership and terms of reference are listed in Appendix 1 & 2.

Hospital Sepsis Committee: All acute hospitals are required to have a Sepsis Committee whose role is to guide the implementation of the National Clinical Guideline in their hospital by coordinating education, sepsis form rollout and reviewing audit feedback and using it to inform the education and roll-out processes. A stand-alone sepsis committee may be desirable and should be supported, it may also be appropriate for individual hospitals to incorporate this committee under an umbrella group, such as a deteriorating patient committee, provided some important caveats are adhered to:

1. The Terms of Reference (TOR) of the umbrella committee should state that sepsis is a standing item on the agenda and ample time should be set aside for discussion of relevant issues such as national updates, mandatory education status across all disciplines, sepsis audit recommendations and status of resulting action plans, and plans for World Sepsis Day awareness campaigns.
2. The TOR should state that the Sepsis ADON for the relevant Health Region should be a committee member
3. The arrangement should be reviewed every 12 months with the Sepsis ADON for each Health Region reporting back to the National Sepsis Team [new 2025]. This committee, along with Hospital Management and the Clinical Directors, has responsibility for effecting and auditing the improvements identified due to audit outlier intervention. This committee is multi-disciplinary with a named medical and nursing/midwifery lead with the inclusion of NCHDs, clinical microbiology, pharmacy (e.g. antimicrobial pharmacist), coding, practice facilitators and educators and may invite other specialties as required.

The committees liaise with their Group Sepsis Assistant Director of Nursing/Midwifery (ADON/M) and the National Team, this is a two-way relationship with the sepsis committees feeding back to the programme on the usefulness of aids and algorithms, suggestions to improve sepsis management and suggesting specific audits. Ideally, there should be a Hospital Group Sepsis ADON/M as a member of each hospital committee in their group.

In turn the National Team provides tools to assist education, implementation and audit feedback. Should outlier intervention be required, the National Team can advise the Hospital Sepsis Committee and Management and offer further education and audit support. The Hospital Group Sepsis ADON/M works with the hospital, the Hospital Group Leadership Team and the National Sepsis Team to support sepsis quality improvement.

Sepsis Education: This guideline recognises that the responsibility for sepsis education falls under a number of domains and recommends that education providers ensure that their education curricula are consistent with the National Clinical Guideline and its implementation programme.

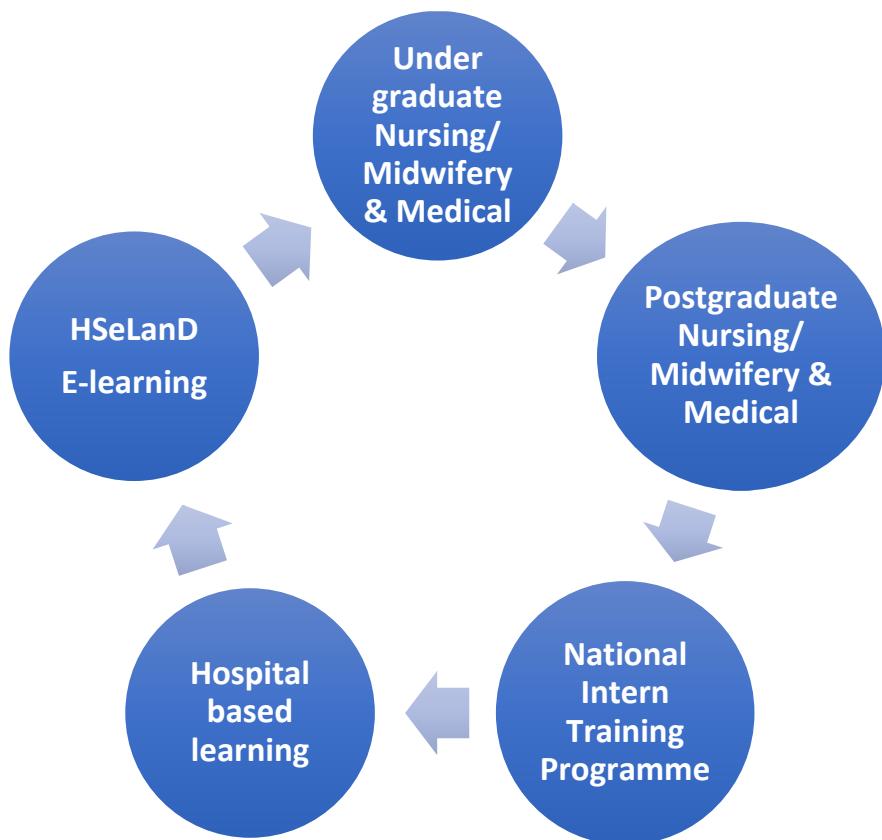


Figure 4. Sepsis Education Overview

Roles and Responsibilities

It is the responsibility of the Department of Health (DoH) to support the development, implementation and audit of this National Clinical Guideline.

It is the responsibility of the HSE to provide appropriate structured support and adequate resources for the governance, operationalization, and audit of sepsis management.

It is the responsibility of the Sepsis Steering Committee to provide clinical expertise and guidance for the National Sepsis Programme.

It is the responsibility of the National Sepsis Team to ensure that clinical guidance is in line with best international practice, to provide clinical advice and decision support tools to local hospital sepsis committees and to oversee process and outcome audit, provide feedback and to advise on outlier intervention when required.

It is the responsibility of the Hospital Group Leadership Team, Hospital Management and Clinical Directors to support sepsis quality improvement and to foster and facilitate the implementation process and audit. They are also responsible for effecting and monitoring change arising from outlier intervention.

It is the responsibility of hospital sepsis committees to co-ordinate sepsis guideline implementation in their hospital and to work with the Hospital Group Sepsis Assistant Directors of Nursing/Midwifery (ADON/Ms) and the National Sepsis Team with the aim of optimizing sepsis recognition and treatment. They are also responsible for ensuring that staff are aware of the sepsis eLearning module on HSeLaND and that sepsis is included in induction for all relevant healthcare professionals.

It is the responsibility of the Sepsis ADON/Ms to help support the local hospital sepsis committees' aims by performing audit and feedback on the sepsis care in their institution and by liaising with the National Sepsis Programme to ensure effective communication between the Programme, the Hospital Group Leadership and Local Hospitals. The Sepsis ADONs also have a role in fostering new sepsis initiatives and international benchmarking.

It is the responsibility of Nursing/Midwifery and Medical Colleges, Under and Post-Graduate to ensure that their sepsis curricula are consistent with the National Clinical Guideline and provide their graduates with the appropriate knowledge and skillset to be able to comply with the recommendations therein.

Healthcare professionals are responsible for undertaking relevant education as often as they deem necessary to develop their professional practice and maintain their professional competence.

Implementation Point 2 (Recommendation 1)

Adopt strategies for the prevention of infection and sepsis.

Hand hygiene:

Healthcare associated infections, which are infections acquired during health care delivery, are common and are a risk factor for developing sepsis. Effective hand hygiene plays a key role in preventing infection. The 5 moments of hand hygiene should be incorporated into practice and patients and visitors/carers should be instructed on how to perform hand hygiene to protect themselves too.

Food hygiene:

Pregnant women should avoid 'deli' meats; prepared dairy-based dressings, raw milk, soft cheeses, pâtés and smoked fish. All these are associated with listeriosis. Pregnant women should be advised to cook food thoroughly, especially meat, ensuring that it is cooked through to the middle. Salads, fruit and raw vegetables should be washed thoroughly before eating to prevent Listeriosis and Toxoplasmosis (Aylin et al., 2007).

More information is available at <https://www.safefood.eu/Food-safety.aspx> and also <https://www2.hse.ie/wellbeing/child-health/lifestyle-changes-and-things-to-avoid-during-pregnancy/food-and-drinks-to-avoid-in-pregnancy.html>

Vaccination or immunization:

Sepsis cannot always be prevented but promoting the uptake of vaccinations to reduce the risk of infection may also reduce the risk of developing sepsis. Compliance with primary childhood immunisations including measles, mumps and rubella is very important particularly for women planning to conceive. Pneumococcal vaccine and annual flu vaccine should be promoted where appropriate.

Maternity only

Vaccination

Modulation of the immune system occurs in pregnancy. Pregnant women are at increased risk for severe illness from influenza virus. The MBRRACE-UK confidential enquiry into maternal mortality during the H1N1 epidemic (2009-2012) demonstrated that one in eleven maternal mortalities were directly from the influenza virus (Knight M, 2014). Kay et al., found that vigorous cellular immune responses to influenza during pregnancy could drive pulmonary inflammation, explaining the increased morbidity and mortality (Kay et al., 2014).

Seasonal influenza and pertussis vaccination should be offered in any antenatal clinical setting. See <https://www.hse.ie/eng/health/immunisation/pubinfo/flu-vaccination/flu-vaccine-pregnancy/> for up to date recommendations. MMR childhood vaccination should be confirmed and if not recorded the advice outlined in <https://www.hse.ie/eng/health/immunisation/pubinfo/pregvaccs/> should be followed. Rubella (German measles) is particularly harmful to a fetus in early pregnancy as it can cause major birth defects.

Breastfeeding

Neonates have a developing immune system (Basha et al., 2014), and haven't been exposed to microorganisms in the environment. Breastfeeding protects against neonatal infections and sepsis (Xpress, 2019). Mother's milk includes large amounts of secretory IgA antibodies produced by lymphocytes which have migrated from the mother's gut to the mammary glands (Delves, 2000) (Delves PJ, 2000). The newborn is colonized with microbes from the mother's intestinal flora both during and after birth thus, breastfeeding controls the early exposure of the neonate's intestinal mucosa to microbes and limits bacterial translocation through the gut mucosa. Immunoglobulins which give protection for the first three months of life are transferred across the placenta before birth (Basha et al., 2014, Delves, 2000).

Animal Borne infections

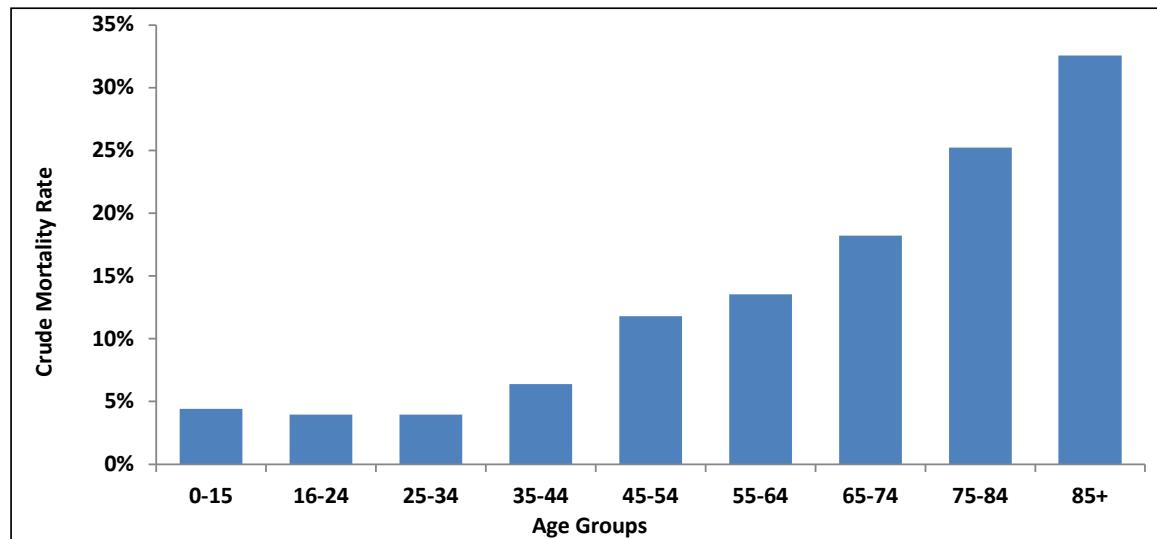
Toxoplasmosis is a disease caused by a parasite that infects warm-blooded animals, primarily cats. Women who are pregnant or planning pregnancy should avoid contact with all rodents and their droppings, including avoiding changing cat litter. If no one else can perform the task, disposable gloves should be worn, and hands washed with soap and warm water afterwards. Adopting or handling stray cats, especially kittens, should be avoided.

The HSE has further information on toxoplasmosis at www.hpsc.ie.

Implementation Point 3 (Recommendation 1)

Patients presenting or deteriorating as an inpatient, where infection is suspected to be the cause, are screened to identify those who are at high risk of mortality from sepsis.

Sepsis occurs most frequently at the extremes of age as illustrated in Figure 5. It is more common and has a higher mortality when it occurs in patients with co-morbidities (Figure 6), and as we get older, we accumulate co-morbidities. Certain medications act by suppressing the immune system and patients taking them are more susceptible to infection and sepsis. In Ireland there is no gender difference in mortality although sepsis is more common in males (Figure 7). This is also consistent with the published literature (HSE, 2019b, Navaneelan T, 2016, Martin et al., 2003, Angus et al., 2001, Brun-Buisson et al., 1995).



* 'Sepsis-associated' includes direct and indirect deaths. Causality cannot be inferred from administrative databases.

Figure 5. In-patient sepsis-associated hospital mortality* by age groups, 2018, (HSE, 2019b)

Profiling at-risk patient groups facilitates early recognition and treatment, which is the only proven method of reducing mortality from sepsis.

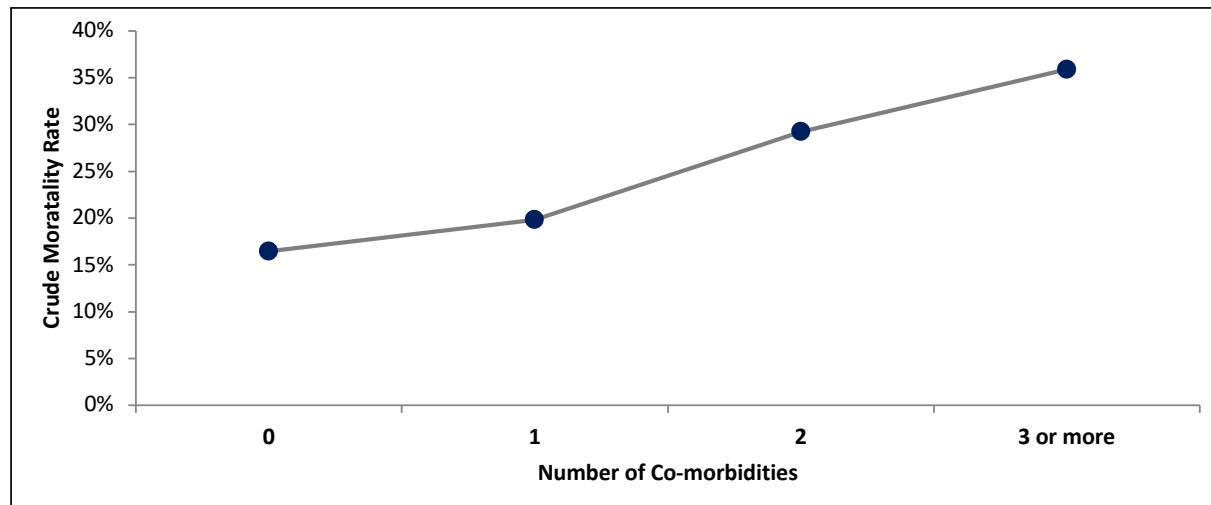


Figure 6. Inpatient sepsis-associated hospital mortality according to number of co-morbidities, 2018 (HSE, 2019b)

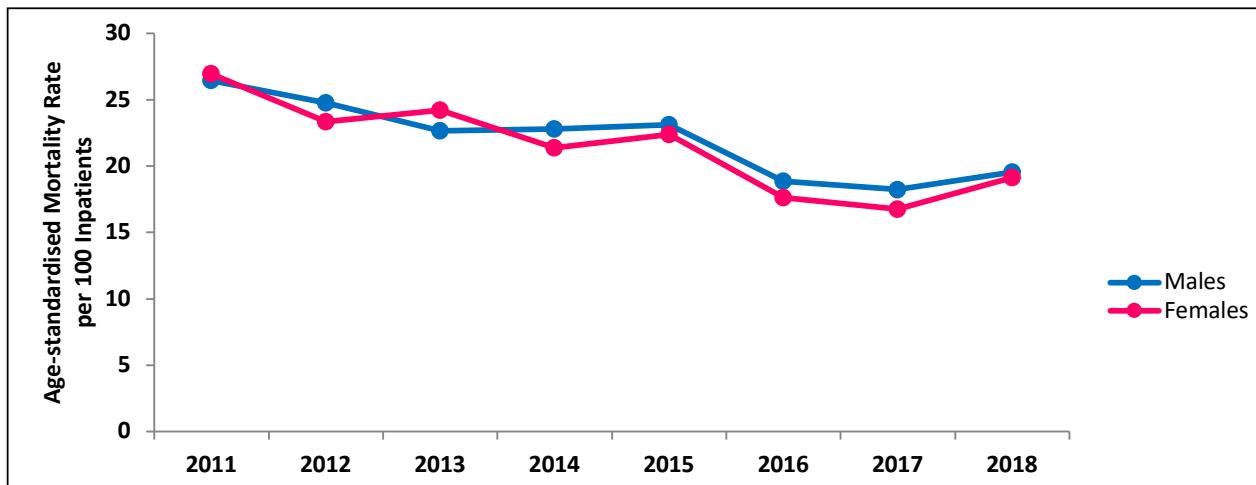


Figure 7. Inpatient sepsis-associated hospital mortality by gender, 2018 (HSE, 2019)

Maternity only

Sepsis, including deaths from all infectious causes, remains a leading contributor to maternal morbidity and mortality in both high- and low-income countries (MBRRACE, 2014). Sepsis was the leading cause of direct maternal mortalities in the Centre for Maternal & Child Enquiries (CMACE, 2011) and the second leading cause of maternal mortalities in the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiry (MBRRACE). The latest MBRRACE (2019) publication shows sepsis as the 4th leading direct cause with an increase in direct causes due to sepsis and an increase in indirect sepsis deaths from the previous report. Irish data demonstrates an increase in reported diagnoses of both sepsis and infection. In 2018, there were 61,016 live births in Ireland, and 9,471 maternity patients (period from conception up to 42 days post-birth or miscarriage) were either admitted to hospital with an infection or diagnosed with an infection as an in-patient. 442 were diagnosed with sepsis. However, it must be noted these cases were diagnosed using the Sepsis-2 definition of sepsis i.e. SIRS of infectious origin and thus include a wide range of acuity (HSE, 2019b).

Identifying pregnant women with sepsis can be particularly challenging as clinical and laboratory criteria may overlay with normal pregnant physiology (Parfitt, 2018) (Abir et al., 2017). The physiological changes of pregnancy, including an increase in heart rate (tachycardia), respiratory rate (tachypnoea) and cardiac output, combined with a rise in white cell count that peaks after delivery, can mask sepsis indicators normally seen in the non-pregnant population. If these observations are persistently abnormal it is important to rule out a pathological reason. Additionally, the altered physiology of pregnancy and the postnatal period can result in women presenting with vague signs and symptoms of sepsis. It may be difficult to distinguish between normal and pathological states. Importantly, pregnant and recently delivered women have a significant capacity to compensate physiologically to major stresses to the body (such as haemorrhage or sepsis), and therefore signs of tachycardia or hypotension (reduced blood pressure) may not appear until late, when sudden clinical deterioration becomes apparent. Sepsis, therefore, requires a high index of suspicion, as it may be difficult to diagnose resulting in delayed initiation of appropriate treatment and significant morbidity or mortality.

Screening

The purpose of screening is to identify patients with a high-risk presentation e.g. clinically apparent acute organ dysfunction such as acute confusion, respiratory failure or a purpuric rash AND patients who because of their medical history, e.g. on chemotherapy or having chronic co-morbidities or additional factors such as frailty, age ≥ 75 and recent trauma or surgery, have a high mortality risk if they have sepsis.

Sepsis diagnosis is not always obvious as the presentation can be variable. Having clinical decision support tools can help clinicians to identify high-risk patients, in making the diagnosis of sepsis and in the initiation of treatment.

Emergency Medicine Early Warning System (EMEWS) is recommended for use in EDs when patients are waiting longer for review by a Treating Clinician than is recommended based on their Manchester Triage System (MTS) Category. National Clinical Guideline No. 18: Emergency Medicine Early Warning System (EMEWS) strongly recommends adherence to the NCEC National Clinical Guideline No. 6 Sepsis Management in patients with a clinical suspicion of infection/sepsis (NCEC, 2018).

The Irish National Early Warning System (2020) (INEWS), is recommended as the system to be used to identify high risk and deteriorating admitted patients with infection and sepsis. An INEWS of ≥ 4 or 5 if on supplementary oxygen should prompt sepsis screening if infection is suspected.

The guideline is available to download from the National Clinical Effectiveness committee website at: <https://www.gov.ie/en/collection/c9fa9a-national-clinical-guidelines/?referrer=/national-patient-safety-office/ncec/national-clinical-guidelines>

The NEWS (NCEC, 2013) deployed in Ireland for the identification of deterioration of in-patients and in head to head testing has been shown to outperform qSOFA (Goulden et al., 2018) (Churpek et al., 2017).

Three patient groups have been identified as having a mortality risk of $> 20\%$ from sepsis (HSE, 2019b). All three patient presentations should be assigned Category 2 at Triage (unless Category 1 criteria apply) or have medical review within 30 minutes if an inpatient, if they present unwell or deteriorate and have signs and symptoms consistent with infection.

Patients at high risk of mortality from sepsis:

1. Patients at risk of neutropenia, due to bone marrow failure, autoimmune disorder or treatment including but not limited to, chemotherapy and radiotherapy, who present unwell, that is with specific or non-specific symptoms and signs of infection.
2. Patients presenting with clinical criteria for one or more acute organ dysfunction and a suspicion of infection as the cause.

i. Acutely altered mental state

- New onset confusion/agitation
- Altered functional state in an individual with underlying neurological disorder/ disability
- Decreased Glasgow Coma Scale Score

ii. Respiratory dysfunction

- Sustained respiratory rate > 30 breaths per minute
- Laboured breathing
- Hypoxia/ cyanosis
- Respiratory failure requiring invasive or non-invasive support

iii. Cardiovascular dysfunction

- Tachycardia > 130 beats per minute
- Systolic blood pressure < 100 mmHg or > 40 mmHg drop from usual pressure
- Pale cold peripheries with prolonged central capillary refill
- Inability to stand due to sustained dizziness with signs of hypoperfusion

iv. Renal dysfunction

- Oligo or anuria for > 12 hours with no urgency

v. Coagulation dysfunction

- Non-blanching, mottled or petechial rash

vi. Liver dysfunction

- Jaundice

3. Patients who present with a systemic inflammatory response (SIRS) to infection and who have 1 or more co-morbidity or additional factor associated with higher risk of mortality in sepsis.

Co-morbidities:

Chronic obstructive pulmonary disease
Diabetes mellitus
Cancer
Chronic kidney disease
Chronic liver disease
Immunosuppression

Additional factors:

Frailty
Age \geq 75 years
Recent major surgery or trauma

Clinical Decision Support Tools (CDST's) such as the 'Think Sepsis at Triage' algorithm (Figure 8) or the Screening Algorithm for In-Patients (Figure 9) will help nurses to:

- a) Correctly risk stratify 'at-risk' patients
- b) Escalate to medical review in a timely manner
- c) Start the appropriate sepsis form (Appendix 9). The completed sepsis form should be placed with the patient's documentation to assist in their management and diagnosis of sepsis. Clinicians should consider documenting when patients with infection screen negative for these high-risk categories. This guidance aims to support clinical decision-making and not to replace it, always exercising clinical judgment.

The outcome from screening is NOT the initiation of the Sepsis 6 bundle but rather to prompt an early thorough medical review. The result of the screen is communicated to the treating clinician so that sepsis is considered during the medical review. The ISBAR communication tool can be used to structure this communication. National clinical guidelines No 5 and 11 provide guidance on communication in both maternity and acute hospital service for adult and children, NCEC 2014, NCEC 2015). Links to these and other supporting tools, documents and websites can be found in Appendix 10)

If infection is included in the differential diagnosis, and the patient is in one of the at-risk groups then the Sepsis 6 bundle is administered. For this reason, 1 hour is allowed for screening and medical review and once completed this is considered TIME ZERO. All elements of the Sepsis 6 bundle are to be initiated within 1 hour of TIME ZERO.

TIME ZERO is the time at which a healthcare professional first recognises that a patient with suspected or confirmed infection has POSSIBLE SEPSIS, PROBABLE SEPSIS or SEPTIC SHOCK.

For patients with probable sepsis +/- shock,

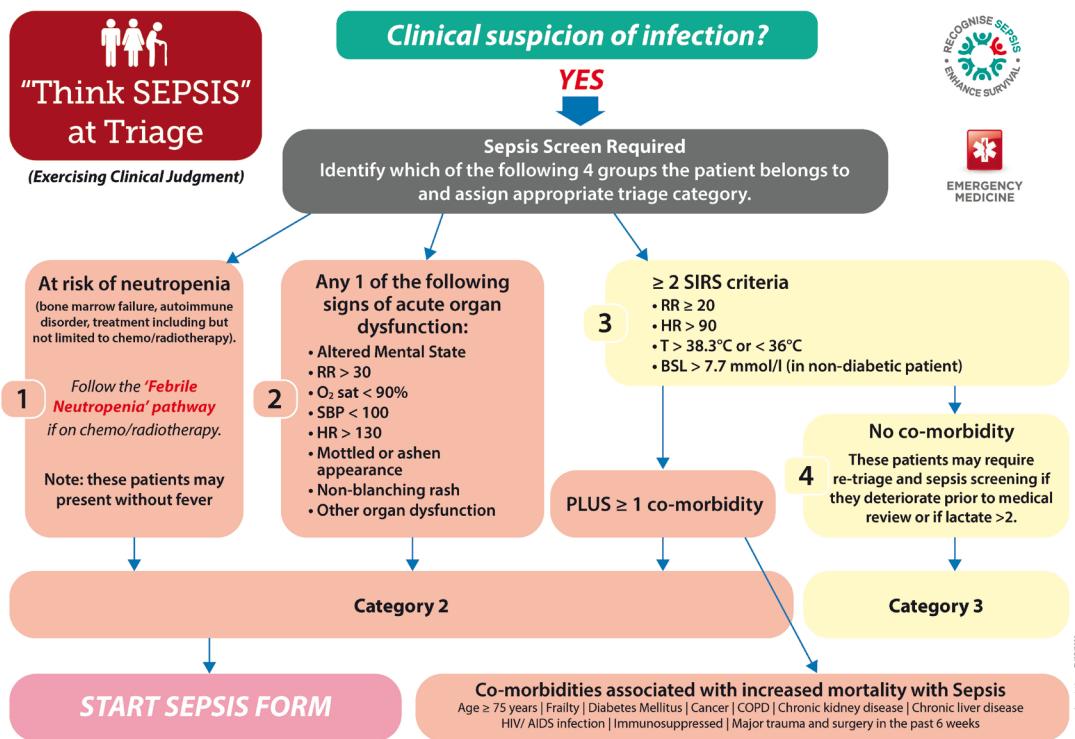
Sepsis 6 bundle should be initiated immediately and completed within 1 hour of Time Zero

For patients with possible sepsis without shock,

A time-limited course of rapid investigations should be undertaken and if concern for infection persists when clinical and laboratory data is reviewed, the administration of antimicrobials should be completed within 3 hours of Time Zero. **[new 2025]**

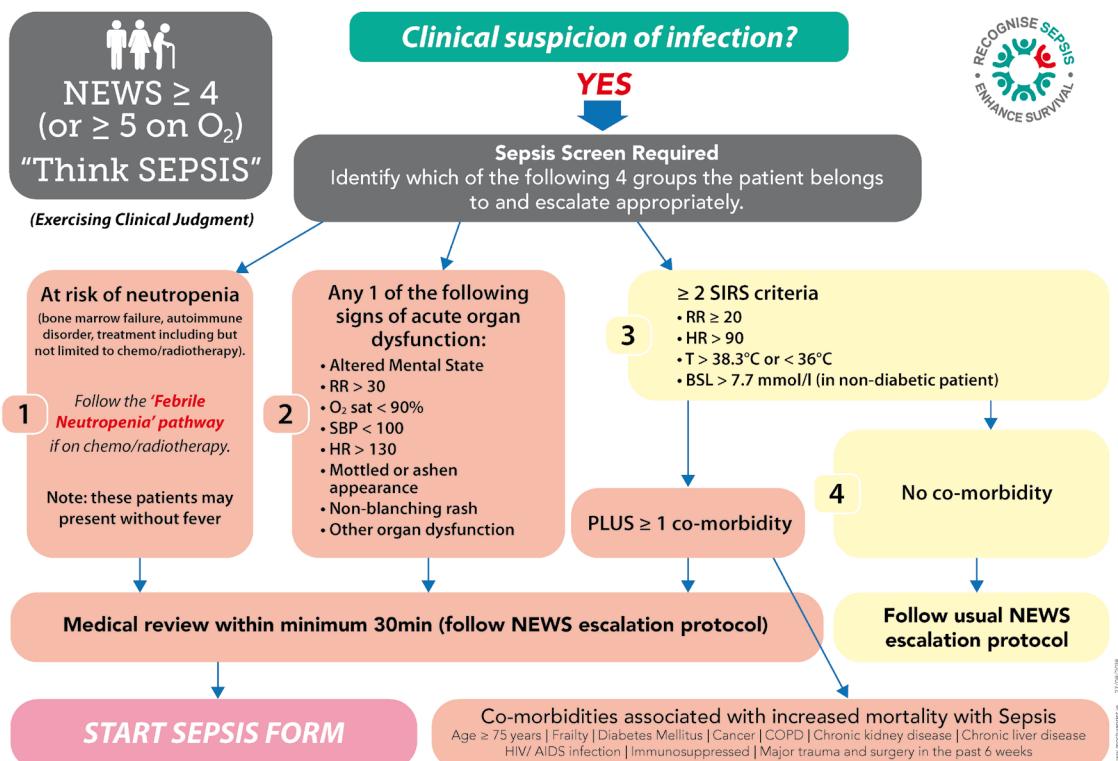
For patients who present with clinically apparent sepsis/septic shock, it is recommended that the Sepsis 6 bundle be administered within 1 hour of presentation (Levy et al., 2018).

In summary, patients who present to Emergency Department (ED) Triage with suspected infection or who deteriorate on the ward due to suspected infection should be screened to see if they fit into one of the high-risk groups. Deterioration on the ward is suggested by a INEWS score that has risen to ≥ 4 (≥ 5 if already on supplementary oxygen therapy) (NCEC, 2013) or by exercising clinical judgment. The patient should be escalated to medical review as per the 'Think Sepsis at Triage' algorithm or the INEWS escalation and response protocol and an appropriate sepsis form (Appendix 9) completed and placed with the patient's case notes.



Printable download available at <https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/>

Figure 8. Screening algorithm for Triage:



Printable download available at <https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/>

Figure 9. Screening algorithm for inpatients

Note: Sepsis may also need to be considered in patients whose INEWS score is < 4. However, it is recommended that patients with a INEWS ≥ 4 have a medical review within 30 minutes (NCEC, 2013) and if infection is suspected as the cause sepsis needs to be considered.

Patients who are attending other departments in the hospital such as outpatients and who become a cause of concern due to infection may be screened according to the Triage or INEWS criteria as best suits the clinical circumstance.

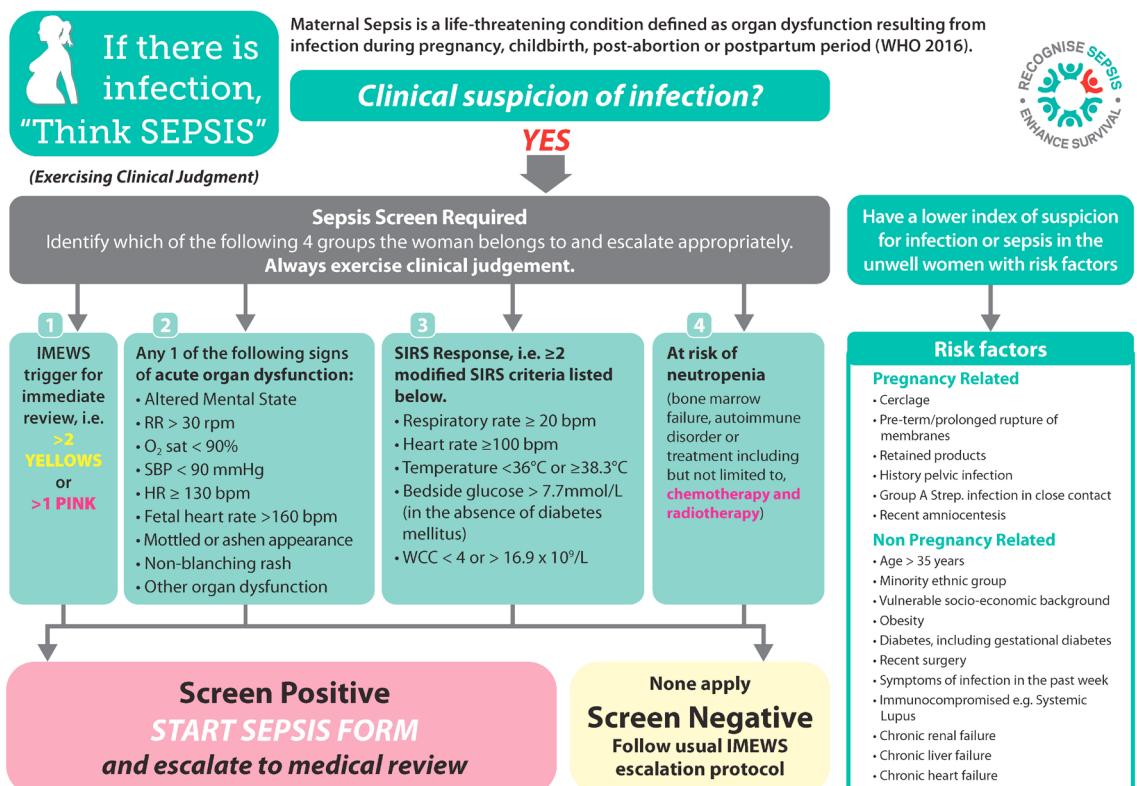
Screening

Maternity only

Sepsis is one of the leading causes of maternal mortality in obstetrics. Alongside thromboembolism (direct) and heart disease (indirect), sepsis is one of the leading causes of both direct and indirect morbidity (Knight M, 2019). Physiological changes of pregnancy may create a vulnerable environment, predisposing women to develop sepsis. These changes can mask, or mimic sepsis indicators seen in the non-obstetric population, making it difficult to recognise sepsis and possibly delaying treatment. The Irish Maternity Early Warning System (IMEWS) is recommended for the monitoring and detection of physiological deterioration in pregnant and postpartum women (NCEC, 2019).

The use of maternal-specific clinical decision support tools for sepsis identification and knowledge of appropriate interventions and their effects on the woman and fetus can help clinicians obtain the best outcomes in acute care settings (Parfitt, 2018).

The maternity sepsis form provides a time dependent pathway which aids the midwife in recognising women at risk of sepsis and supports effective communication to the medical professional. The form also supports the doctor in identifying women who should get the Sepsis 6+1 bundle and guides its completion. The form also lists the diagnostic criteria for sepsis and septic shock and the appropriate escalation for both. It can be found on the Maternal & Newborn Clinical Management System (MN-CMS) via the 'AD HOC' tab.



Printable download available at <https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/>

Figure 10. Screening algorithm for maternity

Up to 42 days Post birth

Many women are seen in the community by the Community Midwife, Community Midwifery Services from acute settings or a Public Health Nurse. A screening tool has been developed to aid early recognition of potential sepsis and advice on pathway of care (Appendix 11).

Pre-hospital

Pre-hospital emergency care is the clinical process of assessment, treatment and disposition of patients following an acute event in the community. As sepsis is a syndrome and not a specific disease, Pre-Hospital Emergency Care Council (PHECC) registered practitioners (EMT, paramedic and advanced paramedic) are advised to have a high index of suspicion in relation to sepsis for unwell patients. PHECC practitioners utilise Clinical Practice Guidelines (CPGs) to inform their scope of practice (Appendix 12).

Roles and responsibilities:

It is the responsibility of the HSE, Hospital Group and Hospital Management to facilitate appropriate training and provide adequate resources for the screening of patients with infection for high risk of mortality from sepsis.

It is the responsibility of clinicians to be familiar with the three high-risk presentations and to escalate care according to the Triage and Inpatient algorithms.

It is the responsibility of all clinicians working in the acute hospital sector to be familiar with the INEWS and any other relevant early warning systems.

3.1.2 Initial Treatment

Key questions

- In patients with sepsis or septic shock, should we use crystalloid with supplemental albumin for initial resuscitation versus crystalloids alone?
- In patients with sepsis or septic shock, should we be using HES versus crystalloids for acute resuscitation?
- In patients with severe sepsis or septic shock, should we be using gelatin versus crystalloid for acute resuscitation?
- In patients with sepsis or septic shock, should we use balanced crystalloid solutions versus normal saline?
- In patients with sepsis or septic shock, should we recommend using repeated fluid challenge based on hemodynamic variables?
- In patients with sepsis or septic shock, should we use early goal directed therapy protocol for resuscitation?
- In patients with sepsis or septic shock with elevated serum lactate, should we incorporate resuscitation goals aiming to normalize lactate levels?
- In patients with septic shock requiring vasopressors, should we target mean arterial pressure (MAP) of 65 mmHg vs. higher MAP?
- In patients with sepsis or septic shock, should we use dynamic parameters (versus static parameters) to predict fluid responsiveness?

SSCG Rationale

Early effective fluid resuscitation is crucial for stabilization of sepsis-induced tissue hypoperfusion or septic shock. Sepsis-induced hypoperfusion may be manifested by acute organ dysfunction and/or ± decreased blood pressure and increased serum lactate. Previous iterations of these guidelines have recommended a protocolized quantitative resuscitation, otherwise known as early goal-directed therapy (EGDT), which was based on the protocol published by Rivers (16). This recommendation described the use of a series of “goals” that included central venous pressure (CVP) and central venous oxygen saturation (ScvO_2). This approach has now been challenged following the failure to show a mortality reduction in three subsequent large multi-centre RCTs (17–19). No harm was associated with the interventional strategies; thus, the use of the previous targets is still safe and may be considered. Of note, the more recent trials included less severely ill patients (lower baseline lactate levels, ScvO_2 at or above the target value on admission, and lower mortality in the control group). Although this protocol cannot now be recommended from its evidence base, bedside clinicians still need guidance as to how to approach this group of patients who have significant mortality and morbidity. We recommend, therefore, that these patients be viewed as having a medical emergency that necessitates urgent assessment and treatment. As part of this, we recommend that initial fluid resuscitation begin with 30 mL/kg of crystalloid within the first 3 hours. This fixed volume of fluid enables clinicians to initiate resuscitation while obtaining more specific information about the patient and while awaiting more precise measurements of hemodynamic status. Although little literature includes controlled data to support this volume of fluid, recent interventional studies have described this as usual practice in the early stages of resuscitation, and observational evidence supports the practice (20, 21). The average volume of fluid pre-randomization given in the PROCESS and ARISE trials was approximately 30mL/kg, and approximately 2 litres in the PROMISE trial (17–19). Many patients will require more fluid than this, and for this group we advocate that further fluid be given in accordance with functional hemodynamic measurements.

One of the most important principles to understand in the management of these complex patients is the need for a detailed initial assessment and ongoing re-evaluation of the response to treatment. This evaluation should start with a thorough clinical examination and evaluation of available physiologic variables that can describe the patient’s clinical state (heart rate, blood pressure, arterial oxygen saturation, respiratory rate, temperature, urine output, and others as available). Echocardiography in recent years has become available to many bedside clinicians and enables a more detailed assessment of the causes of the hemodynamic issues (22).

The use of CVP alone to guide fluid resuscitation can no longer be justified (22) because the ability to predict a response to a fluid challenge when the CVP is within a relatively normal range (8–12 mm Hg) is limited (23). The same holds true for other static measurements of right or left heart pressures or volumes. Dynamic measures of assessing whether a patient requires additional fluid have been proposed in an effort to improve fluid management and have demonstrated better diagnostic accuracy at predicting those patients who are likely to respond to a fluid challenge by increasing stroke volume. These techniques encompass passive leg raises, fluid challenges against stroke volume measurements, or the variations in systolic pressure, pulse pressure, or stroke volume to changes in intrathoracic pressure induced by mechanical ventilation (24). Our review of five studies of the use of pulse pressure variation to predict fluid responsiveness in patients with sepsis or septic shock demonstrated a sensitivity of 0.72 (95% CI, 0.61–0.81) and a specificity of 0.91 (95% CI, 0.83–0.95); the quality of evidence was low due to imprecision and risk of bias (**Supplemental Digital Content 3**, <http://links.lww.com/CCM/C324>) (24). A recent multi-centre study demonstrated limited use of cardiac function monitors during fluid administration in the ICUs. Even though data on the use of these monitors in the emergency department are lacking, the availability of the devices and applicability of the parameters to all situations may influence the routine use of dynamic indices (22, 25).

MAP is the driving pressure of tissue perfusion. While perfusion of critical organs such as the brain or kidney may be protected from systemic hypotension by autoregulation of regional perfusion, below a threshold MAP, tissue perfusion becomes linearly dependent on arterial pressure. In a single-centre trial (26), dose titration of norepinephrine from 65 to 75 and 85 mm Hg raised cardiac index (from 4.7 ± 0.5 to 5.5 ± 0.6 L/min/m²) but did not change urinary flow, arterial lactate levels, oxygen delivery and consumption, gastric mucosal Pco₂, RBC velocity, or skin capillary flow. Another single-centre (27) trial compared, in norepinephrine-treated septic shock, dose titration to maintain MAP at 65 mmHg versus achieving 85 mmHg. In this trial, targeting high MAP increased cardiac index from 4.8 (3.8–6.0) to 5.8 (4.3–6.9) L/min/m² but did not change renal function, arterial lactate levels, or oxygen consumption. A third single-centre trial (28) found improved microcirculation, as assessed by sublingual vessel density and the ascending slope of thenar oxygen saturation after an occlusion test, by titrating norepinephrine to a MAP of 85 mm Hg compared to 65 mm Hg. Only one multi-centre trial that compared norepinephrine dose titration to achieve a MAP of 65 mm Hg versus 85 mm Hg had mortality as a primary outcome (29). There was no significant difference in mortality at 28 days (36.6% in the high-target group and 34.0% in the low-target group) or 90 days (43.8% in the high-target group and 42.3% in the low target group). Targeting a MAP of 85 mm Hg resulted in a significantly higher risk of arrhythmias, but the subgroup of patients with previously diagnosed chronic hypertension had a reduced need for renal replacement therapy (RRT) at this higher MAP. A recent pilot trial of 118 septic shock patients (30) suggested that, in the subgroup of patients older than 75 years, mortality was reduced when targeting a MAP of 60–65 mm Hg versus 75–80 mm Hg. The quality of evidence was moderate (**Supplemental Digital Content 4**, <http://links.lww.com/CCM/C325>) due to imprecise estimates (wide confidence intervals). As a result, the desirable consequences of targeting MAP of 65 mm Hg (lower risk of atrial fibrillation, lower doses of vasopressors, and similar mortality) led to a strong recommendation favouring an initial MAP target of 65 mm Hg over higher MAP targets. When a better understanding of any patient's condition is obtained, this target should be individualized to the pertaining circumstances.

Serum lactate is not a direct measure of tissue perfusion (31). Increases in the serum lactate level may represent tissue hypoxia, accelerated aerobic glycolysis driven by excess beta-adrenergic stimulation, or other causes (e.g., liver failure). Regardless of the source, increased lactate levels are associated with worse outcomes (32). Because lactate is a standard laboratory test with prescribed techniques for its measurement, it may serve as a more objective surrogate for tissue perfusion as compared with physical examination or urine output. Five randomized controlled trials (647 patients) have evaluated lactate-guided resuscitation of patients with septic shock (33–37). A significant reduction in mortality was seen in lactate-guided resuscitation compared to resuscitation without lactate monitoring (RR 0.67; 95% CI, 0.53–0.84; low quality). There was no evidence for difference in ICU length of stay (LOS) (mean difference –1.51 days; 95% CI, –3.65 to 0.62; low quality). Two other meta-analyses of the 647 patients who were enrolled in these trials demonstrate moderate evidence for reduction in mortality when an early lactate clearance strategy was used, compared with either usual care (non-specified) or with a Scvo₂ normalization strategy (38, 39).

The use of IV fluids in the resuscitation of patients is a cornerstone of modern therapy. Despite this, there is little available evidence from RCTs to support its practice; this is an area in which research is urgently needed. One trial of children (mostly with malaria) in Africa, in a setting where escalation to mechanical ventilation and other organ support was limited, questioned this practice (230). We believe that the extrapolation of these data to patients in better-resourced settings is not valid and thus recommend that clinicians restore euvoolemia with IV fluids, more urgently initially, and then more cautiously as the patient stabilizes. There is some evidence that a sustained positive fluid balance during ICU stay is harmful (231–235). We do not recommend, therefore, that fluid be given beyond initial resuscitation without some estimate of the likelihood that the patient will respond positively.

The absence of any clear benefit following the administration of colloid compared to crystalloid solutions in the combined subgroups of sepsis, in conjunction with the expense of albumin, supports a strong recommendation for the use of crystalloid solutions in the initial resuscitation of patients with sepsis and septic shock.

We were unable to recommend one crystalloid solution over another because no direct comparisons have been made between isotonic saline and balanced salt solutions in patients with sepsis. One before-after study in all ICU patients suggested increased rates of acute kidney injury and RRT in patients managed with a chloride-liberal strategy compared to a chloride-restrictive strategy (236). There is indirect low-quality evidence from a network meta-analysis suggesting improved outcome with balanced salt solutions as compared to saline in patients with sepsis (237)(Supplemental Digital Content 6, <http://links.lww.com/CCM/C327>). In addition, the neutral result of the SPLIT cluster RCT in ICU patients (mainly surgical patients) in four New Zealand ICUs lowered our confidence in recommending one solution over the other (238). No cost-effectiveness studies compare balanced and unbalanced crystalloid solutions. Therefore, we considered the desirable and undesirable consequences to be comparable for both solutions and issued a weak recommendation to use either solution. Hyperchloraemia should be avoided, however, and thus close scrutiny of serum chloride levels is advised, whichever fluid solutions are used.

The SAFE study indicated that albumin administration was safe and equally effective as 0.9% saline in ICU patients requiring fluid administration (239). A meta-analysis aggregated data from 17 randomized trials ($n = 1,977$) of albumin versus other fluid solutions in patients with sepsis or septic shock (240); 279 deaths occurred among 961 albumin-treated patients (29%) versus 343 deaths among 1,016 patients (34%) treated with other fluids, favouring albumin (OR, 0.82; 95% CI, 0.67–1.00). When albumin-treated patients were compared with those receiving crystalloids (seven trials, $n = 144$), the odds ratio of dying was significantly reduced for albumin-treated patients (OR, 0.78; 95% CI, 0.62–0.99).

Since the 2012 SSC guideline publication, six systematic reviews/meta-analyses (237,241–245) were published assessing the use of albumin solutions in the management of patients with sepsis or septic shock. Each meta-analysis included different populations (adult/child, septic/nonseptic, and acute resuscitation/maintenance), different comparators and different duration of exposure to the intervention (hours, days), which made combining data challenging (Supplemental Digital Content 7, <http://links.lww.com/CCM/C328>).

Xu et al. (242) evaluated albumin compared to crystalloid as a resuscitation fluid. Five studies, encompassing 3,658 sepsis and 2,180 septic shock patients, were included. Albumin use resulted in reduced septic shock 90-day mortality (OR, 0.81; 95% CI, 0.67–0.97) and trended toward reduced 90-day mortality in sepsis (OR, 0.88; 95% CI, 0.76–1.01; $p = 0.08$). Jiang et al. (245) evaluated albumin in a mixed population of sepsis severity including adults and children. Three septic shock studies, encompassing 1,931 patients, were included. Albumin use resulted in decreased mortality (OR, 0.89; 95% CI, 0.80–0.99) with low heterogeneity ($I^2 = 0\%$). A mortality reduction trend was reported for albumin administration compared to crystalloids when given less than 6 hours from identification (11 studies; $n = 5515$; OR, 0.94; 95% CI, 0.86–1.03).

Patel et al. (244) evaluated mixed populations, including resuscitation and maintenance. Additionally, a series of studies excluded from other meta-analyses due to accuracy concerns was included in this evaluation (246–248). When comparing crystalloid and albumin, the authors report a combined mortality benefit of albumin as compared to crystalloid (7 studies, $n = 3,878$; OR, 0.93; 95% CI, 0.86–1.00), but it was not consistent across individual severity subgroups. Use of albumin in septic shock trended toward mortality benefit (4 studies; $n = 1,949$; OR, 0.91; 95% CI, 0.82–1.01; $p = 0.06$), and the use of albumin in sepsis was not significant (4 studies; $n = 1,929$; OR, 0.96; 95% CI, 0.83–1.10). Evaluation of treatment within 24 hours also trended toward mortality benefit (4 studies; $n = 3,832$; RR, 0.93; 95% CI, 0.86–1.01). Rochwerg et al. (2014) (237) evaluated resuscitative fluid use in a network meta-analysis of 14 trials, encompassing 18,916 patients. When comparing albumin to crystalloid, there was no significant reduction in mortality with moderate quality of evidence in both the four-

and six-node analyses (four-node: OR, 0.83; credible interval [Crl] 0.65–1.04; six-node OR 0.82; Crl 0.65–1.04). The ALBIOS trial (249) showed no mortality benefit of albumin in combination with crystalloids compared to crystalloids alone in patients with sepsis or septic shock (RR, 0.94; 95% CI, 0.85–1.05); a subgroup analysis suggested that the albumin group was associated with lower 90-day mortality in patients with septic shock (RR, 0.87; 95% CI, 0.77–0.99). Fluid administration continued for 28 days or until discharge and was not targeted for acute resuscitation. In addition, the amount of 20% albumin was guided by serum albumin level with the ultimate goal of achieving levels > 30 g/L. These results are limited by significant indirectness and imprecision, resulting in low quality of evidence.

HESs are colloids for which there are safety concerns in patients with sepsis. A meta-analysis of nine trials (3,456 patients) comparing 6% HES 130/0.38–0.45 solutions to crystalloids or albumin in patients with sepsis showed no difference in all-cause mortality (RR, 1.04; 95% CI, 0.89–1.22) (250). However, when low risk of bias trials were analysed separately, HES use resulted in higher risk of death compared to other fluids (RR, 1.11; 95% CI, 1.01–1.22; high-quality evidence), which translates to 34 more deaths per 1,000 patients. Furthermore, HES use led to a higher risk of RRT (RR, 1.36; 95% CI, 1.08–1.72; high-quality evidence) (250). A subsequent network meta-analysis focused on acute resuscitation of patients with sepsis or septic shock and found that HES resulted in higher risk of death (10 RCTs; OR, 1.13; Crl, 0.99–1.30; high-quality evidence) and need for RRT (7 RCTs; OR, 1.39; Crl, 1.17–1.66; high-quality evidence) compared to crystalloids. When comparing albumin to HES, albumin resulted in lower risk of death (OR, 0.73; Crl, 0.56–0.93; moderate-quality evidence) and a trend toward less need for RRT (OR, 0.74; Crl, 0.53–1.04; low-quality evidence) (237). Overall, the undesirable consequences of using HES (increased risk of death and need for RRT) along with moderate to high quality of available evidence resulted in a strong recommendation against the use of HES in resuscitation of patients with sepsis or septic shock.

Gelatin is another synthetic colloid that can be used for fluid resuscitation; however, high-quality studies comparing gelatins to other fluids in patients with sepsis or septic shock are lacking. Trials conducted in critically ill patients were summarized in a recent meta-analysis (251). Gelatin use in critically ill adult patients did not increase mortality (RR, 1.10; 95% CI, 0.85–1.43; low-quality evidence) or acute kidney injury (RR, 1.35; 95% CI, 0.58–3.14; very low-quality evidence) compared to albumin or crystalloid. These results are limited by indirectness, since the studies did not focus on critically ill patients. The aforementioned network meta-analysis by Rochwerg et al did not identify any RCTs comparing gelatins to crystalloids or albumin; therefore, the generated estimates were imprecise and were based on indirect comparisons (237). Given the low quality of the available data and the cost associated with gelatin use, we issued a weak recommendation favoring the use of crystalloids over gelatins.

Recommendation 2. (SSCG Section A, Recommendation 1).

Sepsis and septic shock are medical emergencies, we recommend that treatment and resuscitation begin immediately.

Quality/level of evidence: Low + **Strength of recommendation:** BPS.

Recommendation 3. (SSCG Section A, Recommendation 2).

We recommend that, in the resuscitation from sepsis- induced hypoperfusion, at least 30 mL/kg of IV crystalloid fluid be given within the first 3 hours

Quality/level of evidence: Low + **Strength of recommendation:** Strong

SSCG 2018 Update: The 3-h and 6-h bundles have been combined into a single “hour-1 bundle” with the explicit intention of beginning resuscitation and management immediately for patients with sepsis and septic shock. More than 1 hour may be required for resuscitation to be completed, but initiation of resuscitation and treatment, such as obtaining blood for measuring lactate and blood cultures, administration of fluids and antibiotics, and in the case of life-threatening hypotension, initiation of vasopressor therapy, are all begun immediately.

Recommendation 4. (SSCG Section A, Recommendation 3).

We recommend that, following initial fluid resuscitation, additional fluids be guided by frequent reassessment of hemodynamic status

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Recommendation 5. (SSCG Section A, Recommendation 7).

We suggest guiding resuscitation to normalize lactate in patients with elevated lactate levels as a marker of tissue hypoperfusion.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 6. (SSCG Section A, Recommendation 4).

We recommend further hemodynamic assessment (such as assessing cardiac function) to determine the type of shock if the clinical examination does not lead to a clear diagnosis.

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Recommendation 7. (SSCG Section A, Recommendation 5).

We suggest that dynamic over static variables be used to predict fluid responsiveness, where available.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 8. (SSCG Section A, Recommendation 6).

We recommend an initial target mean arterial pressure (MAP) of 65 mm Hg in patients with septic shock requiring vasopressors.

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 9. (SSCG Section F, Recommendation 1).

We recommend that a fluid challenge technique be applied where fluid administration is continued as long as hemodynamic factors continue to improve.

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Recommendation 10. (SSCG Section F, Recommendation 2).

We recommend crystalloids as the fluid of choice for initial resuscitation and subsequent intravascular volume replacement in patients with sepsis and septic shock.

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 11. (SSCG Section F, Recommendation 3).

We suggest using balanced crystalloids instead of normal saline for resuscitation of patients with sepsis or septic shock (SSCG 2021, Rec 33).

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 12. (SSCG Section F, Recommendation 4).

We suggest using albumin in addition to crystalloids for initial resuscitation and subsequent intravascular volume replacement in patients with sepsis and septic shock when patients require substantial amounts of crystalloids.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 13. (SSCG Section F, Recommendation 5).

We recommend against using hydroxyethyl starches (HESs) for intravascular volume replacement in patients with sepsis or septic shock.

Quality/level of evidence: High

+ Strength of recommendation: Strong

Recommendation 14. (SSCG Section F, Recommendation 6).

We suggest using crystalloids over gelatins when resuscitating patients with sepsis or septic shock.

Quality/level of evidence: Low

+ Strength of recommendation: Weak

SSC Remarks: Reassessment should include a thorough clinical examination and evaluation of available physiologic variables (heart rate, blood pressure, arterial oxygen saturation, respiratory rate, temperature, urine output, and others, as available) as well as other non-invasive or invasive monitoring, as available.

Implementation Point 4 (Recommendations 2-9)**Sepsis 6 bundle**

Initial treatment: Following medical review, patients with a history and examination suggestive of systemic infection **and** who were identified as being in one of the three high-risk group for mortality from sepsis, should be given the Sepsis 6 bundle, and have their initial response reviewed with results of tests and investigations, within one hour of this differential diagnosis (i.e. TIME ZERO). Patients who present in extremis, for example, with profound hypotension, respiratory failure requiring ventilatory support and/or purpuric rash should receive the Sepsis 6 bundle immediately.

- Patients, with a clinical suspicion of infection who have screened as high risk of mortality from sepsis should have the Sepsis 6 bundle of care completed within one hour of a medical review.
- For patients who present with clinically apparent sepsis/septic shock, it is recommended that the Sepsis 6 bundle be administered within **1 hour of presentation (Levy et al., 2018)**
- A time-limited course of rapid investigations should be undertaken and if concern for infection persists when clinical and laboratory data is reviewed, the administration of antimicrobials should be completed within 3 hours of Time Zero. **[new 2025]**

A time-dependent bundled approach to sepsis resuscitation facilitates compliance with SSCG recommendations 1-3.

Roles and Responsibilities

All clinicians (medical, midwifery and nursing) should be familiar with the Sepsis 6 treatment bundle; they should work together to ensure that patients, who on history and examination have a suspicion of infection and are identified by screening as high risk of mortality from sepsis, receive the components of the Sepsis 6 bundle completed and reviewed correctly and within 1 hour of differential diagnosis.

Table 13. The sepsis 6 bundle:

Take 3	Give 3
<p>Blood cultures: Take at least 2 sets of blood cultures using aseptic (non-touch) technique prior to giving antimicrobials unless this leads to a delay > 45 minutes. If a central venous catheter is in situ, take blood cultures through that line. Take other specimens as indicated by history and examination e.g. influenza swabs, wound swabs, sputum, urine etc.</p> <p>[updated 2025]</p>	<p>Oxygen: Titrate supplementary oxygen to achieve oxygen saturations 94-96% (88-92% in patients with chronic lung disease).</p>
<p>Blood Tests: Point of care lactate (venous or arterial). Full blood count, Renal Profile, Liver Profile +/- Coagulation screen.</p> <p>Other tests and investigations as indicated.</p>	<p>Fluids: For patients with hypotension or hypoperfusion give a 250 - 500mls IV fluid bolus of balanced crystalloid. Administer a total volume of fluid resuscitation up to 30ml/kg within the first 3 hours unless fluid intolerant or the patients clinical condition requires earlier referral to critical care for consideration of inotropes/vasopressors. Reassess response to fluid resuscitation frequently.</p> <p>(Refer to Appendix 13 fluid resuscitation algorithm for adults with sepsis) [updated 2025]</p>
<p>Urine output: Assess urinary output as part of volume/ perfusion status assessment. Strict hourly monitoring and documentation of urine output assessment and measurement in millilitres on a fluid balance chart for both probable and possible sepsis and/or septic shock. [updated 2025]</p>	<p>Antimicrobials: Give antimicrobials as per local antimicrobial guideline based on the site of infection, community or healthcare acquired and the patient's allergy status. Assess requirement for source control within 12 hours. [updated 2025]</p> <p>Additional Guidance: Administer antimicrobials immediately, ideally within 1 hour of recognition for patients with possible septic shock or a high likelihood of sepsis.</p> <p>Complete time-limited course of rapid investigation and if concern for infection persists, administer antimicrobials within 3 hours from the time when sepsis was first recognised for patients with possible sepsis without shock. [new 2025]</p>

Take 3: Three diagnostic interventions

1. **Blood cultures:** Take using aseptic (non-touch) technique before the first dose of antimicrobials unless it will delay administering the antimicrobial therapy for more than 45 minutes. If a central venous catheter is in situ, blood cultures should also be taken through that line. Other specimens should be sent as clinically indicated e.g. influenza swabs, wound swabs, sputum, urine etc.

SSCG remarks that appropriate routine microbiologic cultures always include at least two sets of blood cultures (aerobic and anaerobic).

2. **Blood tests:** send blood for a full blood count, renal profile and liver profile tests and do a Point of care lactate (venous or arterial). These tests help support an infection diagnosis and identify any acute organ dysfunction as its consequence. Other tests and investigations to assess the patient and aid in diagnosis should be according to the clinical assessment and based on usual management.

3. **Urine output:** assessing and quantifying urinary output is part of diagnosing a fluid deficit and response to resuscitation. This does not require all patients to have a urinary catheter. A urinary catheter may be necessary, however, for patients who are sick enough to warrant fluid resuscitation and ongoing hourly urinary output monitoring.

Give 3: three therapeutic interventions:

4. **Oxygen:** supplementary oxygen is administered to ensure oxygen saturation levels are between 94 – 96% ($\text{PaO}_2 \geq 10\text{kPa}$) or 88 – 92% ($\text{PaO}_2 \geq 8\text{kPa}$) in patients with chronic lung disease. A recent meta-analysis on oxygen therapy indicates an increased mortality when aiming for SpO_2 of above 96%. (Chu et al., 2018).
5. **Fluids:** For patients with hypotension or hypoperfusion give a 250 - 500mls IV fluid bolus of balanced crystalloid. Administer a total volume of fluid resuscitation up to 30ml/kg within the first 3 hours unless fluid intolerant or the patients clinical condition requires earlier referral to critical care for consideration of inotropes/vasopressors. Reassess response to fluid resuscitation frequently. **[updated 2025]**
6. (Refer to Appendix 13 fluid resuscitation algorithm for adults with sepsis). Patients who present with hypotension should receive at least 30mls/kg intravenous isotonic crystalloid fluid with the aim of restoring tissue perfusion. Patients, with hypotension, who are fluid intolerant or fluid resistant should have a critical care review with respect to invasive monitoring and advanced cardiorespiratory support. **[updated 2025]**

Apply vasopressors if the patient is hypotensive during or after fluid resuscitation to maintain mean arterial pressure (MAP) $\geq 65\text{mmHg}$.

Fluid administration to high-risk patients with infection who present without hypotension should be based on clinical need. The patient's volume status should be assessed by reviewing their heart rate, blood pressure, urinary output and Point of Care lactate (venous or arterial). If a deficit is diagnosed, it should be corrected using a bolus and review method. This entails administering boluses of 500mls isotonic crystalloid given over 15 minutes followed by a prompt review to see if the patient needs further fluid or is showing signs of overload. A fluid balance chart should be commenced to monitor input and output in patients who require ongoing fluid resuscitation. A patient with no deficit or whose deficit has been corrected needs no further fluid. Exercise professional judgment in patients who due to chronic health issues are at high risk of fluid overload. Consider 250ml boluses and more frequent review in such cases. A fluid resuscitation algorithm for non-critical care specialists is available in Appendix 13. A fluid balance chart should be started to monitor hourly input and output in patients who require fluid resuscitation.

7. **Antimicrobials and Source Control:** Appropriate antimicrobials should be administered according to local antimicrobial guidelines. Refer to Section D: Antimicrobial therapy for further information. Antimicrobials can only work if there is a blood supply to the source, therefore review the need for source control. See Section E: Source Control for further information.

Maternity only

All clinicians (medical, midwifery and nursing) should be familiar with the adapted Sepsis 6+1 treatment bundle. They should work together to ensure that patients, who on history and examination have infection and who are identified by screening as at risk of sepsis, receive the components of the Sepsis 6+1 bundle, completed correctly and within 1 hour of diagnosis.

Table 14. Maternity sepsis 6 + 1 bundle

Take 3	Give 3
Blood cultures: Take at least 2 sets of blood cultures blood cultures using aseptic (non-touch) technique prior to giving antimicrobials unless this leads to a delay > 45 minutes. Take other specimens as indicated by history and examination e.g. influenza swabs, wound swabs, sputum, urine etc. [updated 2025]	Oxygen: Titrate supplementary oxygen to achieve oxygen saturations 94-96% (88-92% in patients with chronic lung disease).
Bloods: Check point of care lactate (venous or arterial). Full blood count, CRP, Renal Profile, Liver Profile +/- Coagulation screen. Other tests and investigations as indicated. [updated 2025]	Fluids: For patients with hypotension or hypoperfusion give a 250 - 500mls IV fluid bolus of balanced crystalloid. Administer a total volume of fluid resuscitation up to 30ml/kg within the first 3 hours unless fluid intolerant or the patients clinical condition requires earlier referral to critical care for consideration of inotropes/vasopressors. Reassess response to fluid resuscitation frequently. Caution in pre-eclampsia. (Refer to Appendix 13 fluid resuscitation algorithm for adults with sepsis) [updated 2025]
Urine output: Assess urinary output as part of volume/ perfusion status assessment. Strict hourly monitoring and documentation of urine output assessment and measurement in millilitres on a fluid balance chart for both probable and possible sepsis and/or septic shock. [updated 2025]	Antimicrobials: Give antimicrobials as per local antimicrobial guideline based on the site of infection, community or healthcare acquired and the patient's allergy status. Assess requirement for source control. Administer antimicrobials immediately, ideally within 1 hour of recognition for patients with possible septic shock or a high likelihood of sepsis. Complete time-limited course of rapid investigation and if concern for infection persists, administer antimicrobials within 3 hours from the time when sepsis was first recognised for patients with possible sepsis without shock. [updated 2025]

+1 If Pregnant, assess fetal wellbeing

Note: There is no auto-regulation of the feto-placental unit. One of the earlier signs of maternal hypoperfusion may be fetal tachycardia. Resuscitating the mother resuscitates the baby.

Antimicrobials specific to maternal shock

For acute maternal septic shock, as defined by the current HSE maternal sepsis form, empirical antibiotics should be administered within 1 hour. In patients with no penicillin allergy reported, in line with international and national guidance above, three antimicrobials should be given in setting of acute maternal septic shock (RCPI, 2017):

- a. Broad spectrum beta-lactam antimicrobial (Meropenem is recommended in to cover for extended spectrum beta-lactamases, (RCOG also give piperacillin/tazobactam as an option) (RCOG, 2012)).
- b. Gentamicin: This is for bactericidal action against Gram-negative organisms mainly.
- c. Clindamycin: This is to switch off exotoxin production with significantly decreased mortality (RCOG, 2012).
- d. A combination of either piperacillin/tazobactam or carbapenem PLUS clindamycin provides one of the broadest ranges of treatment for sepsis (RCOG, 2012).

If there is a strong suspicion clinically that the septic shock may be relating to group A Streptococcus, then IV immunoglobulin (HPSC, 2006), could be considered in line with the national Group A Streptococcal management guidelines which were produced by the Health Protection Surveillance Centre (HPSC).

If MRSA is present, always give vancomycin in addition to the other antimicrobials (RCPI, 2017).

+ 1: Fetal wellbeing

Resuscitating the mother will resuscitate the baby, however, it is important to assess fetal wellbeing and formulate a plan for delivery if required. Maternal sepsis with or without haemodynamic instability may present with fetal distress as the uteroplacental circulation is not auto-regulated (Chau, 2014). Thus, any maternal circulatory insufficiency arising from sepsis may result in compromised fetal perfusion.

Management plans need to take into consideration the altered immunological response of the woman and the altered physiological responses during pregnancy (Mor and Cardenas, 2010). Particular consideration needs to be taken of the physiological effects of anaesthesia, general and regional, on the pregnant septic women.

Implementation Point 5 (Recommendations 10-14)

For clarification, recommendations 10 and 11 refer to different time points in the patient's journey under the care of two different teams. Recommendation 10 is applicable to patients in the ED or ward i.e. where initial resuscitation takes place and Recommendation 11 is applicable to patients in the ICU.

Patients who present with shock should receive 30mls/kg of intravenous balanced crystalloid fluid and vasopressors started in those with fluid resistant shock within one hour of presentation (Levy et al., 2018).

The initial resuscitation of patients with tissue hypo-perfusion may be guided by physiological parameters such as normalisation of mental status, skin perfusion, blood pressure, urinary output and Point of care lactate (venous or arterial) measurement. A fluid resuscitation algorithm outlining the fluid bolus and review method to initial resuscitation is available (Appendix 13). Four potential scenarios need to be considered after each bolus.

1. Persistent hypoperfusion: continue fluid resuscitation.
2. Fluid intolerant:
 - a. Persistent hypoperfusion, as evidenced by hypotension and/or raised lactate with clinical signs of overload. These patients should have a critical care review and consideration for inotropes and invasive monitoring for fluid responsiveness. Forced diuresis is unlikely to be helpful and may be harmful in this group due to ongoing intra-vascular hypovolaemia.
 - b. Normotension with signs of overload, these patients may benefit from diuresis. Before giving the diuretic check the patient's perfusion.
3. Fluid resistant: these patients have no or transient improvement in physiological parameters with fluid resuscitation due to a high degree of vascular leak, vasoplegia +/- cardiac impairment and require vasopressors and/or inotropes and invasive monitoring of fluid responsiveness with critical care input.
4. Fluid replete – the fluid deficit has been corrected, stop fluid resuscitation.

In certain patient populations, such as those with chronic renal failure, congestive cardiac failure and frailty, lead clinicians may be reluctant to administer intravenous fluid to avoid causing harm. However, these patients if they have an infection-induced perfusion deficit require restoration of tissue perfusion to avert progressive organ dysfunction and reduce mortality. Taking a bolus approach allows good control of resuscitation and early detection of signs of overload. Exercise clinical judgment and, if clinically indicated use smaller boluses e.g. 250mls with more frequent review.

Maternity only

Pulmonary vascular resistance decreases during pregnancy. Pulmonary capillary wedge pressure and central venous pressure do not change during pregnancy, but serum colloid pressure is reduced by 10% to 15%, predisposing pregnant women to an increased risk of pulmonary oedema (Soma-Pillay et al., 2016).

Normal physiologic changes of pregnancy cause a reduction in colloid oncotic pressures (Price et al., 2008), allowing interstitial fluid shifts to occur and placing obstetric patients at risk of developing pulmonary oedema and acute respiratory distress syndrome

Roles and responsibilities:

All clinicians should be familiar with the fluid resuscitation algorithm and the use of the bolus and review approach to fluid resuscitation and that, unless otherwise indicated, isotonic crystalloid is the fluid of choice¹. They should be aware of the importance of exercising clinical judgement to use smaller boluses when clinically indicated.

Implementation Point 6

Sepsis Diagnosis

Sepsis is diagnosed when acute organ dysfunction consequent to infection occurs. This diagnosis can be made before or after the Sepsis 6 bundle depending on whether the organ dysfunction is diagnosed clinically or based on the laboratory results. This includes acute or chronic organ dysfunction.

As the SSC guidelines were being developed, new definitions for sepsis and septic shock (Sepsis-3) were published. Sepsis is now defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. Septic shock is a subset of sepsis with circulatory and cellular/metabolic dysfunction associated with a higher risk of mortality (Singer et al., 2016).

Infection, sepsis and septic shock are clinical diagnoses. There is no one test that will confirm the presence of infection, sepsis or septic shock to the exclusion of other diagnoses. Rather the suite of symptoms and signs along with tests and investigations need to be weighed against the differential diagnoses and a clinical decision made. The presence of positive cultures does much to support an infective aetiology but only occurs in 40-60% of sepsis cases, (Martin et al., 2003) (Brun-Buisson et al., 1995) (Phua et al., 2013), and has a time lag to positivity. Much has been made of the removal of the systemic inflammatory response syndrome (SIRS) criteria from the definition of sepsis, however, this does not mean that SIRS has 'gone away' it reflects the fact that self-limiting non-life threatening infections may present with SIRS and that SIRS may be caused by infectious and non-infectious insults.

SIRS in non-pregnant adults include:

- o Heart rate > 90 beats/minute
- o Respiratory rate > 20 breaths/minute
- o Temperature > 38.3°C or < 36°C
- o White cell count > 12 or < 4 x 10⁹ cells/L or normal with > 10% immature forms.
- o Bedside glucose > 7.7 mmol/L in the absence of diabetes mellitus.

The presence of a SIRS response is not required for the diagnosis of sepsis to be made but, in fact, it is present in 86.7% of critical care sepsis patients (Raith et al., 2017). The SIRS criteria continue to be helpful in identifying patients with infection.

Table 15. Non-specific signs and symptoms of infection include:

Temperature > 38.3°C or < 36°C	Myalgia / arthralgia
Rigors	Vomiting
Anorexia	Diarrhoea
Fatigue	Rash

Table 16. Localising signs & symptoms of infection may include
(Disclaimer: this list is by no means exhaustive):

Respiratory tract	Bones & Joints
Tachypnoea	Pain
Hypoxia/cyanosis	Swelling
Cough	Redness
Purulent sputum	Dysfunction
Pleuritic pain	
Sore throat	
Ear/ Mastoid pain	
Intra-abdominal	Brain & meninges
Pain	Altered consciousness
Peritonism	Headache
Distension	Neck stiffness
Vomiting	Photophobia
Diarrhoea	Pain with straight leg raise
Urinary tract	Device related
Dysuria	Redness
Flank pain	Swelling
Frequency	Discharge
Blood in the urine	May be a diagnosis of exclusion
Skin	Bloodstream infection
Pain	Severe non-specific signs of infection +/- source symptoms
Redness	
Swelling	
Rash	
Discharge	
Mottling/ blistering	

Note: Patients with immunocompromise may not manifest the usual signs and symptoms of infection due to their inability to mount the appropriate immune response. These patients often present unwell with evidence of new onset organ dysfunction. They may have no temperature and mount no white cell increase. A high index of suspicion must be deployed to diagnose these patients correctly and a presumption of infection and treatment with empiric antimicrobial therapy is recommended until the diagnosis is confirmed.

Maternity only

Obstetric patients with infections may present with nonspecific symptoms and early investigation is necessary to exclude severe infection (Mor and Cardenas, 2010).

- History of fevers or rigors
- Cough/sputum/breathlessness
- Flu-like symptoms
- Unexplained abdominal pain/distension
- Pelvic pain
- Vomiting and/or diarrhoea
- Line associated infection/redness/swelling/pain
- Possible intrauterine infection

- Myalgia/back pain/general malaise/headache
- New onset of confusion
- Cellulitis/wound infection/perineal infection
- Possible breast infection/mastitis
- Multiple presentations with non-specific malaise
- Others

Note: Women with severe immuno-compromise may not manifest the usual signs and symptoms of infection due to their inability to mount the appropriate immune response. These women often present unwell with evidence of new onset organ dysfunction. They may have no temperature and mount no white cell increase. A high index of suspicion must be deployed to diagnose these women correctly and a presumption of infection and treatment with empiric antimicrobial therapy is recommended until the diagnosis is confirmed.

Organ dysfunction criteria:

Organ dysfunction is identified if one or more of the following is diagnosed either on the blood tests sent as part of the Sepsis 6 bundle OR persisting clinically after the bundle has been administered. This is outlined in Table 17.

Table 17. Evidence of organ dysfunction

Central Nervous System	Respiratory
Acutely altered mental status	New need for oxygen to achieve saturation > 90% (note: this is a definition not the target)
Cardiovascular Systolic BP < 90 or Mean Arterial Pressure (MAP) < 65 or Systolic BP more than 40mmHg below the patient's normal Systolic BP Point of care lactate (venous or arterial) ≥ 4mmol/L	Renal Creatinine > 170 µmol/l (micromols/l) or Urine output < 500mls/24 hrs – despite adequate fluid resuscitation
Haematological Platelets < 100 x 10 ⁹ /L Petechial or purpuric rash	Liver Total Bilirubin > 32 µmol/l (micromols/l)

The Sepsis Definition Taskforce (Singer et al., 2016) recommends the use of the SOFA score to assess for the presence of acute organ dysfunction. Two sepsis forms were trialled by the National Sepsis Team; one using the organ dysfunction list (Fig. 11) (Section 7 Sepsis Form Appendix 9) and the other using the SOFA score (Fig 12) (Singer et al., 2016). Twelve Emergency Departments, nationally, participated in a PDSA cycle to inform the format. Whilst Consultants preferred the SOFA score, Non-Consultant Hospital Doctors (NCHDs) and nurses preferred the list of organ dysfunctions (NSP, 2016). As NCHDs are, by far, the more likely first treating clinicians we suggest continuing to use the list, which has been adapted to reflect the SOFA tool. The SOFA score may equally be used, if preferred.

Section 7

Look for signs of new organ dysfunction after the Sepsis 6 bundle has been given or from blood test results – any one is sufficient:

- Lactate ≥ 4 after 30mls/kg Intravenous therapy
- Cardiovascular - Systolic BP < 90 or Mean Arterial Pressure (MAP) < 65 or Systolic BP more than 40 below patient's normal
- Respiratory - New need for oxygen to achieve saturation > 90% (note: this is a definition not the target)
- Renal - Creatinine > 170 micromol/L **or** Urine output < 500mls/24 hrs – despite adequate fluid resuscitation
- Liver - Bilirubin > 32 micromol/L
- Haematological - Platelets < 100 x 10⁹/L
- Central Nervous System - Acutely altered mental status

One or more new organ dysfunction due to infection:

- This is SEPSIS:** Seek senior input as per local guideline.

No new organ dysfunction due to infection:

- This is NOT SEPSIS:** If infection is diagnosed proceed with usual treatment pathway for that infection.

Figure 11. The Organ Dysfunction List

Section 7: SOFA Score. The SOFA Score needs to be assessed in order to make a diagnosis of sepsis.

Sepsis is diagnosed when there is an increase ≥ 2 from baseline. As soon as the data is available, clinical or laboratory, circle the relevant result and add the score. Patient's baseline SOFA score: _____ If unknown it is assumed to be zero.

Organ	Indicator	None (0)	Minimal (1)	Mild (2)	Moderate (3)	Severe (4)
Respiratory with ABG Respiratory with SpO ₂ /FiO ₂	PaO ₂ /FiO ₂ ratio (kPa) PaO ₂ /FiO ₂ ratio (mmHg)	≥ 53.3 > 400	≤ 53.3 ≤ 400	< 40 ≤ 315	< 26.7 (+ respiratory support) ≤ 235	< 13.3 (+respiratory support) ≤ 150
Renal	Serum Creatinine (μmol/l) UOP (mls/day)	< 110	110 - 170	171 - 299	300 - 440 < 500	> 440 ≤ 200
Hepatic	Serum Bilirubin (μmol/l)	≤ 20	21 - 32	33 - 101	102 - 204	> 204
CVS	Inotropes	MAP ≥ 65	Dobutamine any dose	MAP ≤ 65	≤ 0.1 Noradrenaline μg.kg ⁻¹ .min ⁻¹	≥ 0.1 Noradrenaline μg.kg ⁻¹ .min ⁻¹
Haem	Platelets (x10 ³ mm ³)	≥ 150	< 150	< 100	< 50	≤ 20
CNS	GCS	15	13-14	10-12	7-9	≤ 6

Total score above baseline: _____ **If ≥ 2** **This is SEPSIS:** seek senior input as per local guideline. Doctor's Initials _____

Figure 12. The Sepsis Sofa Score

(Singer et al., 2016)

Previously the NEWS scoring system was not sensitive for new onset confusion or agitation as both these conditions may be scored as 'Alert'. INews 2020 addresses this deficit as it contains an additional parameter to assess new onset confusion (ACVPU/CNS response – Alert, New Confusion, Voice, Pain, Unresponsive). In conditions where infection is thought to contribute to the deterioration of a patients' clinical status professional judgment should be exercised and sepsis screening performed.

Singer et al. (2016) described a simplified method to facilitate easier identification of patients potentially at risk of dying from sepsis termed "quick SOFA". This score is a modified version of SOFA and consists of only three components (RR $\geq 22/\text{min}$, Altered Mental Status and SBP $\leq 100 \text{ mmHg}$) that are each allocated one point. A qSOFA score of ≥ 2 points was deemed to indicate organ dysfunction. However, Marik & Taeb (2017) state that use of qSOFA score risks missing early identification of sepsis when treatment is most effective (Marik and Taeb, 2017). In addition, the National Sepsis Programme does not support the use of the qSOFA score to identify patients with sepsis, as it was not developed as a diagnostic tool but rather as a prognostic indicator in patients with sepsis (Goulden et al., 2018) (Churpek et al., 2017)

Roles and responsibilities:

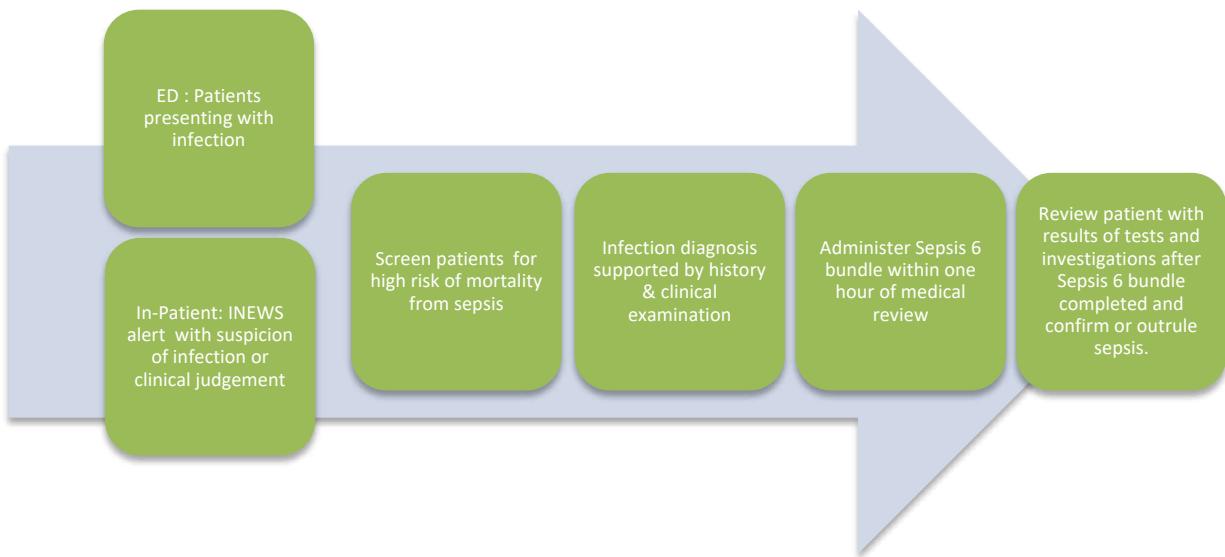
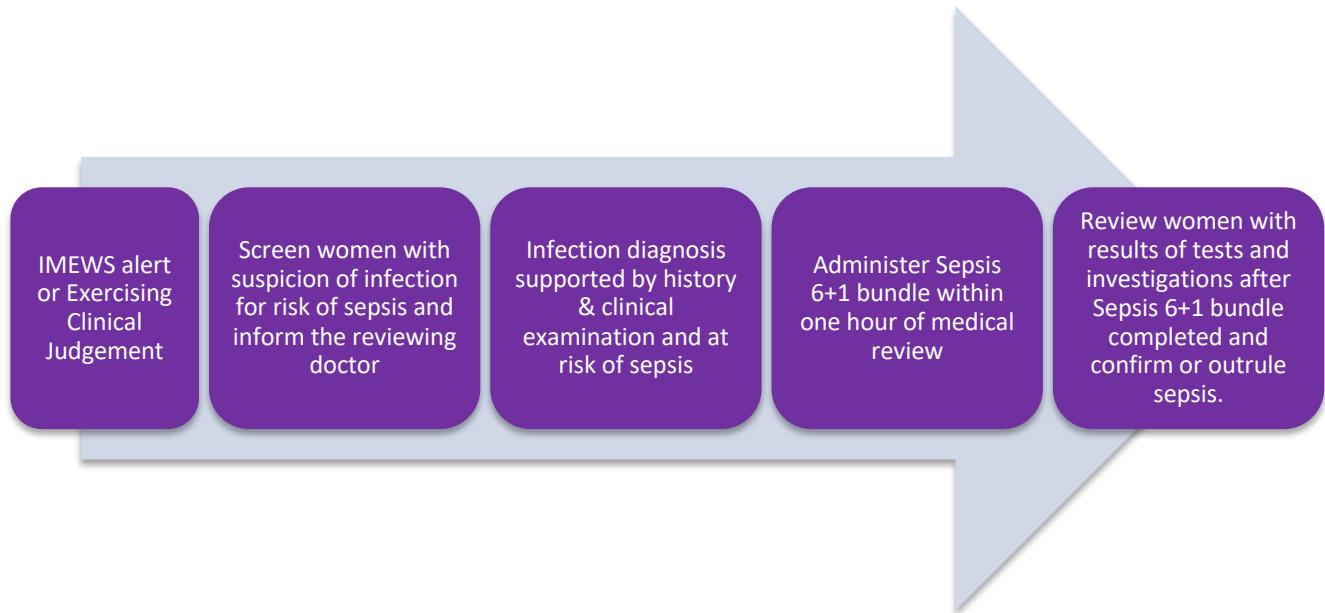
It is the responsibility of all clinicians in the acute hospital sector to be familiar with the diagnostic criteria for sepsis and septic shock.

Septic Shock Diagnosis

Septic shock is diagnosed if vasopressors or inotropes are required to maintain a mean arterial blood pressure (MAP) $> 65 \text{ mmHg}$ and the patient has evidence of tissue hypoperfusion after adequate fluid resuscitation.

Implementation Point 7 (Recommendation 7)

The sepsis-3 definition taskforce (Singer et al., 2016) have defined septic shock as requiring vasopressors to maintain a MAP $> 65 \text{ mmHg}$ AND a lactate $\geq 2 \text{ mmol/L}$ after adequate fluid resuscitation. This identifies a cohort of patients with a mortality risk $> 40\%$ versus $> 30\%$ in those with a pressor requirement and a normal lactate. Patients who require vasopressors or inotropes to support their blood pressure after appropriate fluid resuscitation require critical care review. Adequate fluid resuscitation, for the purpose of this guideline, is a minimum of 30mls/kg intravenous crystalloid or that the patient is fluid intolerant. Patients with a persistent lactate $> 4 \text{ mmol/L}$ despite adequate fluid resuscitation who are maintaining a MAP $> 65 \text{ mmHg}$ have a high mortality risk and as such may benefit from critical care review despite not fulfilling shock criteria.

**Figure 13.** Adult Sepsis Pathway**Figure 14.** Maternity Sepsis Pathway

Implementation Point 8

Having administered the Sepsis 6 bundle, the patient should be reviewed with the results of the tests and investigations sent as a consequence of their medical review.

This review should be performed within 1 hour of Time Zero but may be performed earlier and as frequently as clinically indicated. This provides the first opportunity to review the working diagnosis and treatment. If a non-infective aetiology for the patients' presentation has been identified, stop antimicrobials.

If the investigations have localised the site of infection, review antimicrobial prescription using the local antimicrobial guidelines to ensure it is the most appropriate choice. If not already reviewed when empiric antimicrobial therapy was prescribed, review patients past microbiology results, as a previous history of multi-drug resistant organisms may influence choice of antimicrobial. Complex cases may benefit from Clinical Microbiology/ Infectious diseases review.

Source control is a vital component of the treatment of infection. Organise for drainage/ debridement to be performed as soon as practicable.

Suggested components of the review:

Clinical assessment:

- **Assess clinical response to Sepsis 6 bundle**
 - Has your patient improved, stabilised or deteriorated?
 - Is there clinical evidence of acute organ dysfunction?
- **Review blood tests**
 - Do they support an infective aetiology?
 - Are there abnormalities in the biochemical profile with evidence of acute organ dysfunction?
- **Review other tests and investigations ordered and completed**
 - Do they support an infective aetiology?
 - Is source control required?
- **Perform repeat Point of Care lactate (venous or arterial)**
 - If clinically indicated or if the first was $> 2\text{mmol/l}$ in order to monitor restoration of tissue perfusion and/ or guide on-going fluid resuscitation. Note: a normal Lactate does not exclude sepsis

Actions

- Seek senior input if patient is not stabilized or improving.
- Document the diagnosis as infection, sepsis, or septic shock and amend treatment plan accordingly.
- Obtain critical care review for patients with septic shock and/or other organ dysfunctions requiring support.
- Review differential diagnoses.

Maternity only

In a very unwell or unstable patient it is not usual to have a definitive diagnosis in the first instance. If infection is on the differential give the Sepsis 6+1 and if a non-infective aetiology is subsequently found, stop the antibiotics.

Table 18. Differential diagnosis: common maternal clinical features
(Bowyer et al., 2017)

Acute pulmonary embolism	Hypotension, tachypnoea, tachycardia, low-grade fever
Amniotic fluid embolism	Hypotension, tachycardia, haemorrhage
Acute pancreatitis	Fever, nausea, vomiting, abdominal pain
Acute fatty liver of pregnancy	Fatigue, nausea, vomiting, abdominal pain, jaundice, impaired level of consciousness
Adverse drug reactions, drug fever	Hypotension, relative bradycardia, fever, rash, angio-oedema
Acute liver failure-drug related/viral	Jaundice, nausea, vomiting, abdominal pain impaired level of consciousness
Acute adrenal insufficiency	Weakness, fatigue, nausea, anorexia, weight loss, hypotension, fever
Acute pituitary insufficiency	Failure to lactate, hypotension, relative bradycardia, polyuria, polydipsia
Autoimmune conditions	Low-grade fever, rash (e.g. malar rash), arthritis, dry eyes or mouth, mouth ulcers, diagnostic serology
Concealed haemorrhage including ectopic pregnancy	Hypotension, tachycardia, low-grade fever
Disseminated malignancy	Low-grade fever, weight loss
Pelvic thrombosis	Pelvic pain, fever
Transfusion reactions	High fever, rigors, dysrhythmia, tachypnoea, hypotension, rash, bleeding, haematuria

Used with kind permission from SOMANZ (2017).

Roles and responsibilities:

It is the responsibility of the treating clinician to review the patients' clinical response to the Sepsis 6 bundle of care, the results of the tests ordered, to diagnose and document sepsis as appropriate and to escalate the patient for specialist intervention as indicated. In the circumstance where the treating clinician changes during the care episode; clear transfer of responsibility should be made and documented, outlining outstanding tasks and concerns and the name(s) of the clinicians taking over care (NCEC, 2015a). The relevant Sepsis Form (Appendix 9) or ISBAR Communication Tool (Appendix 14) can be used for this. The ISBAR communication tool can be used to structure this communication. National clinical guidelines No 5 and 11 provide guidance on communication in both maternity and acute hospital service for adult and children, (NCEC 2014, NCEC 2015).

This information should also be communicated to other clinicians involved in the patients' immediate care. It is the responsibility of the HSE, Hospital Group Leadership and Hospital Management to ensure adequate resources are available for tests and investigations to be performed in a timely manner and for capacity to be available for escalation to critical care when required.

Maternity only

It is the responsibility of the midwife to screen for the possibility of sepsis in a woman presenting with symptoms suggestive of infection and to initiate the sepsis form in women who screen positive, then to escalate to urgent medical review and to communicate current concerns and relevant clinical history in line with the Maternity Sepsis Form and ISBAR. It is also their responsibility to assist with the timely delivery of the Sepsis 6 + 1 bundle, subsequent monitoring, care and escalation in line with the maternity sepsis form and IMEWS.

It is the responsibility of the treating clinicians to review the woman's clinical response to the sepsis 6+1 bundle of care and the results of the tests ordered and to diagnose and document sepsis as appropriate and to escalate the woman for specialist intervention as indicated.

When should a patient be escalated for critical care review?

Initial assessment of a patient presenting unwell or deteriorating should include review of airway, breathing, circulation and neurological status.

- Patients who need immediate airway management and/or ventilatory support and/or have fluid resistant or profound shock and/ or have a purpuric rash should be escalated to critical care review.
- Patients who despite adequate fluid resuscitation* have not achieved a mean arterial pressure of $\geq 65\text{mmHg}$ should be referred to critical care.

**For the purposes of this guideline adequate fluid resuscitation in patients presenting with hypotension is a minimum of 30mls/kg of isotonic crystalloid fluid unless the patient is or becomes fluid intolerant as evidenced by worsening cardio-respiratory status and/or oedema.*

What are the goals of critical care?

The goals of critical care management are to support organ function during the diagnosis and treatment of reversible disease processes, in this instance sepsis, whilst minimizing nosocomial injury. It is recommended that this management be guided by evidence-based regimes as outlined by the Surviving Sepsis Campaign Guideline adopted in this document.

3.1.3 Antimicrobial therapy

Key questions

- In patients with sepsis, should we use broad empiric antimicrobial coverage?
- In patients with septic shock, should we administer empirically appropriate antimicrobials (within one hour of recognition)?
- In patients with sepsis, should we administer empirically appropriate antimicrobials (within one hour of recognition)?
- In critically ill septic patients, should we implement pharmacokinetic dosing optimization for each antimicrobial?
- In patients with sepsis and neutropenia, should we use empiric combination antimicrobial therapy versus mono-therapy?
- In patients with sepsis at high risk for multi-drug resistant pathogens, should we use empiric combination antibiotic therapy (versus mono-therapy) until sensitivities are determined?
- In patients with septic shock, should we use empiric double-coverage antibiotic agents until hemodynamic stabilization and pathogen identification?
- In patients with sepsis who are receiving antimicrobials, should we assess for de-escalation of therapy daily?
- In patients with uncomplicated infections causing sepsis or septic shock, should we recommend a duration of therapy of 7-10 days versus longer course?

- In patients with sepsis or septic shock who are receiving empiric combination of antimicrobials should we assess for de-escalation of therapy daily?
- In patients with sepsis, should we use procalcitonin levels to support de-escalation of antimicrobial therapy?
- In patients with severe inflammatory state of non-infectious origin should we use systemic prophylactic antimicrobials.

SSCG Rationale

The rapidity of administration is central to the beneficial effect of appropriate antimicrobials. In the presence of sepsis or septic shock, each hour delay in administration of appropriate antimicrobials is associated with a measurable increase in mortality (57,74). Further, several studies show an adverse effect on secondary end points (e.g., LOS (75), acute kidney injury (76), acute lung injury (77), and organ injury assessed by Sepsis-Related Organ Assessment score (78) with increasing delays. Despite a meta-analysis of mostly poor-quality studies that failed to demonstrate a benefit of rapid antimicrobial therapy, the largest and highest-quality studies support giving appropriate antimicrobials as soon as possible in patients with sepsis with or without septic shock (57,74,79-81). The majority of studies within the meta-analysis were of low quality due to a number of deficiencies, including small study size, using an initial index time of an arbitrary time point such as emergency department arrival, and indexing of outcome to delay in time to the first antimicrobial (regardless of activity against the putative pathogen)(82,83). Other negative studies not included in this meta-analysis are compromised by equating bacteraemia with sepsis (as currently defined to include organ failure) and septic shock (84-87). Many of these studies are also compromised by indexing delays to easily accessible but non-physiologic variables such as time of initial blood culture draw (an event likely to be highly variable in timing occurrence).

While available data suggest that the earliest possible administration of appropriate IV antimicrobials following recognition of sepsis or septic shock yields optimal outcomes, one hour is recommended as a reasonable minimal target. The feasibility of achieving this target consistently, however, has not been adequately assessed. Practical considerations, for example, challenges with clinicians' early identification of patients or operational complexities in the drug delivery chain, represent poorly studied variables that may affect achieving this goal. A number of patient and organizational factors appear to influence antimicrobial delays (88).

Accelerating appropriate antimicrobial delivery institutionally starts with an assessment of causes of delays (89). These can include an unacceptably high frequency of failure to recognize the potential existence of sepsis or septic shock and of inappropriate empiric antimicrobial initiation (e.g., as a consequence of lack of appreciation of the potential for microbial resistance or recent previous antimicrobial use in a given patient). In addition, unrecognized or underappreciated administrative or logistic factors (often easily remedied) may be found. Possible solutions to delays in antimicrobial initiation include use of "stat" orders or including a minimal time element in antimicrobial orders, addressing delays in obtaining blood and site cultures pending antimicrobial administration, and sequencing antimicrobial delivery optimally or using simultaneous delivery of key antimicrobials, as well as improving supply chain deficiencies. Improving communication among medical, pharmacy, and nursing staff can also be highly beneficial.

Most issues can be addressed by quality improvement initiatives, including defined order sets. If antimicrobial agents cannot be mixed and delivered promptly from the pharmacy, establishing a supply of premixed drugs for urgent situations is an appropriate strategy for ensuring prompt administration. Many antimicrobials will not remain stable if premixed in a solution. This issue must be taken into consideration in institutions that rely on premixed solutions for rapid antimicrobial availability. In choosing the antimicrobial regimen, clinicians should be aware that some antimicrobial agents (notably β -lactams) have the advantage of being able to be safely administered as a bolus or rapid infusion, while others require a lengthy infusion.

If vascular access is limited and many different agents must be infused, drugs that can be administered as a bolus or rapid infusion may offer an advantage for rapid achievement of therapeutic levels for the initial dose.

While establishing vascular access and initiating aggressive fluid resuscitation are very important when managing patients with sepsis or septic shock, prompt IV infusion of antimicrobial agents is also a priority. This may require additional vascular access ports. Intraosseous access, which can be quickly and reliably established (even in adults), can be used to rapidly administer the initial doses of any antimicrobial (90,91). In addition, intramuscular preparations are approved and available for several first-line β -lactams, including imipenem/cilastatin, cefepime, ceftriaxone, and ertapenem. Several additional first-line β -lactams can also be effectively administered intramuscularly in emergency situations if vascular and intraosseous access is unavailable, although regulatory approval for intramuscular administration for these drugs is lacking (92-94). Intramuscular absorption and distribution of some of these agents in severe illness has not been studied; intramuscular administration should be considered only if timely establishment of vascular access is not possible.

The initiation of appropriate antimicrobial therapy (i.e., with activity against the causative pathogen or pathogens) is one of the most important facets of effective management of life-threatening infections causing sepsis and septic shock. Failure to initiate appropriate empiric therapy in patients with sepsis and septic shock is associated with a substantial increase in morbidity and mortality (79, 95-97). In addition, the probability of progression from gram-negative bacteremic infection to septic shock is increased (98). Accordingly, the initial selection of antimicrobial therapy must be broad enough to cover all likely pathogens. The choice of empiric antimicrobial therapy depends on complex issues related to the patient's history, clinical status, and local epidemiologic factors. Key patient factors include the nature of the clinical syndrome/site of infection, concomitant underlying diseases, chronic organ failures, medications, indwelling devices, the presence of immunosuppression or other form of immunocompromise, recent known infection or colonization with specific pathogens, and the receipt of antimicrobials within the previous three months. In addition, the patient's location at the time of infection acquisition (i.e., community, chronic care institution, acute care hospital), local pathogen prevalence, and the susceptibility patterns of those common local pathogens in both the community and hospital must be factored into the choice of therapy. Potential drug intolerances and toxicity must also be considered.

The most common pathogens that cause septic shock are gram-negative bacteria, gram-positive, and mixed bacterial microorganisms. Invasive candidiasis, toxic shock syndromes, and an array of uncommon pathogens should be considered in selected patients. Certain specific conditions put patients at risk for atypical or resistant pathogens. For example, neutropenic patients are at risk for an especially wide range of potential pathogens, including resistant gram-negative *bacilli* and *Candida* species. Patients with nosocomial acquisition of infection are prone to sepsis with methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant *Enterococci*.

Historically, critically ill patients with overwhelming infection have not been considered a unique subgroup comparable to neutropenic patients for purposes of selection of antimicrobial therapy. Nonetheless, critically ill patients with severe and septic shock are, like neutropenic patients, characterized by distinct differences from the typical infected patient that impact on the optimal antimicrobial management strategy. Primary among these differences are a predisposition to infection with resistant organisms and a marked increase in frequency of death and other adverse outcomes if there is a failure of rapid initiation of effective antimicrobial therapy. Selection of an optimal empiric antimicrobial regimen in sepsis and septic shock is one of the central determinants of outcome. Survival may decrease as much as fivefold for septic shock treated with an empiric regimen that fails to cover the offending pathogen (95). Because of the high mortality associated with inappropriate initial therapy, empiric regimens should err on the side of over-inclusiveness. However, the choice of empiric antimicrobial regimens in patients with sepsis and septic shock is complex and cannot be reduced to a simple table. Several factors must be assessed and used in determining the appropriate antimicrobial regimen at each medical centre and for each patient.

These include:

- a) The anatomic site of infection with respect to the typical pathogen profile and to the properties of individual antimicrobials to penetrate that site.
- b) Prevalent pathogens within the community, hospital, and even hospital ward.
- c) The resistance patterns of those prevalent pathogens.
- d) The presence of specific immune defects such as neutropenia, splenectomy, poorly controlled HIV infection and acquired or congenital defects of immunoglobulin, complement or leukocyte function or production.
- e) Age and patient comorbidities including chronic illness (e.g., diabetes) and chronic organ dysfunction (e.g., liver or renal failure), the presence of invasive devices (e.g., central venous lines or urinary catheter) that compromise the defence to infection.

In addition, the clinician must assess risk factors for infection with multidrug-resistant pathogens including prolonged hospital/chronic facility stay, recent antimicrobial use, prior hospitalization, and prior colonization or infection with multidrug-resistant organisms. The occurrence of more severe illness (e.g., septic shock) may be intrinsically associated with a higher probability of resistant isolates due to selection in failure to respond to earlier antimicrobials.

Given the range of variables that must be assessed, the recommendation of any specific regimen for sepsis and septic shock is not possible. The reader is directed to guidelines that provide potential regimens based on anatomic site of infection or specific immune defects (67,99-109).

However, general suggestions can be provided. Since the vast majority of patients with severe sepsis and septic shock have one or more forms of immunocompromise, the initial empiric regimen should be broad enough to cover most pathogens isolated in healthcare-associated infections. Most often, a broad-spectrum carbapenem (e.g., meropenem, imipenem/cilastatin or doripenem) or extended-range penicillin/β-lactamase inhibitor combination (e.g., piperacillin/tazobactam or ticarcillin/clavulanate) is used. However, several third- or higher-generation cephalosporins can also be used, especially as part of a multidrug regimen. Of course, the specific regimen can and should be modified by the anatomic site of infection if it is apparent and by knowledge of local microbiologic flora.

Multidrug therapy is often required to ensure a sufficiently broad spectrum of empiric coverage initially. Clinicians should be cognizant of the risk of resistance to broad-spectrum β-lactams and carbapenems among gram-negative bacilli in some communities and healthcare settings. The addition of a supplemental gram-negative agent to the empiric regimen is recommended for critically ill septic patients at high risk of infection with such multidrug-resistant pathogens (e.g., *Pseudomonas*, *Acinetobacter*, etc.) to increase the probability of at least one active agent being administered (110). Similarly, in situations of a more-than-trivial risk for other resistant or atypical pathogens, the addition of a pathogen-specific agent to broaden coverage is warranted. Vancomycin, teicoplanin, or another anti-MRSA agent can be used when risk factors for MRSA exist. A significant risk of infection with *Legionella* species mandates the addition of a macrolide or fluoroquinolone.

Clinicians should also consider whether *Candida* species are likely pathogens when choosing initial therapy. Risk factors for invasive *Candida* infections include immunocompromised status (neutropenia, chemotherapy, transplant, diabetes mellitus, chronic liver failure, chronic renal failure), prolonged invasive vascular devices (haemodialysis catheters, central venous catheters), total parenteral nutrition, necrotizing pancreatitis, recent major surgery (particularly abdominal), prolonged administration of broad-spectrum antibiotics, prolonged hospital/ICU admission, recent fungal infection, and multisite colonization (111,112). If the risk of *Candida* sepsis is sufficient to justify empiric antifungal therapy, the selection of the specific agent should be tailored to the severity of illness, the local pattern of the most prevalent *Candida* species, and any recent exposure to antifungal drugs. Empiric use of an echinocandin (anidulafungin, micafungin, or caspofungin) is preferred in most patients with severe illness, especially in those patients with septic shock, who have recently been treated

with other antifungal agents, or if *Candida glabrata* or *Candida krusei* infection is suspected from earlier culture data (100,105). Triazoles are acceptable in hemodynamically stable, less ill patients who have not had previous triazole exposure and are not known to be colonized with azole-resistant species. Liposomal formulations of amphotericin B are a reasonable alternative to echinocandins in patients with echinocandin intolerance or toxicity (100,105). Knowledge of local resistance patterns to antifungal agents should guide drug selection until fungal susceptibility test results, if available, are received. Rapid diagnostic testing using β -D-glucan or rapid polymerase chain reaction assays to minimize inappropriate anti-*Candida* therapy may have an evolving supportive role. However, the negative predictive value of such tests is not high enough to justify dependence on these tests for primary decision-making.

Superior empiric coverage can be obtained using local and unit-specific antibiograms (113,114) or an infectious diseases consultation (115-117). Where uncertainty regarding appropriate patient-specific antimicrobial therapy exists, infectious diseases consultation is warranted. Early involvement of infectious diseases specialists can improve outcome in some circumstances (e.g. *S. aureus* bacteraemia) (113-115).

Although restriction of antimicrobials is an important strategy to reduce both the development of pathogen resistance and cost, it is not an appropriate strategy in the initial therapy for this patient population. Patients with sepsis or septic shock generally warrant empiric broad-spectrum therapy until the causative organism and its antimicrobial susceptibilities are defined. At that point, the spectrum of coverage should be narrowed by eliminating unneeded antimicrobials and replacing broad-spectrum agents with more specific agents (118). However, if relevant cultures are negative, empiric narrowing of coverage based on a good clinical response is appropriate. Collaboration with antimicrobial stewardship programs is encouraged to ensure appropriate choices and rapid availability of effective antimicrobials for treating septic patients.

In situations in which a pathogen is identified, de-escalation to the narrowest effective agent should be implemented for most serious infections. However, approximately one third of patients with sepsis do not have a causative pathogen identified (95-119). In some cases, this may be because guidelines do not recommend obtaining cultures (e.g., community-acquired abdominal sepsis with bowel perforation) (108). In others, cultures may have followed antimicrobial therapy. Further, almost half of patients with suspected sepsis in one study have been adjudicated in post hoc analysis to lack infection or represent only “possible” sepsis (120). Given the adverse societal and individual risks to continued unnecessary antimicrobial therapy, we recommend thoughtful de-escalation of antimicrobials based on adequate clinical improvement even if cultures are negative. When infection is found not to be present, antimicrobial therapy should be stopped promptly to minimize the likelihood that the patient will become infected with an antimicrobial-resistant pathogen or develop a drug-related adverse effect. Thus, the decisions to continue, narrow, or stop antimicrobial therapy must be made on the basis of clinician judgment and clinical information.

A systemic inflammatory response without infection does not mandate antimicrobial therapy. Examples of conditions that may exhibit acute inflammatory signs without infection include severe pancreatitis and extensive burn injury. Sustained systemic antimicrobial therapy in the absence of suspected infection should be avoided in these situations to minimize the likelihood that the patient will become infected with an antimicrobial-resistant pathogen or will develop a drug-related adverse effect.

Although the prophylactic use of systemic antimicrobials for severe necrotizing pancreatitis has been recommended in the past, recent guidelines have favoured avoidance of this approach (121). The current position is supported by meta-analyses that demonstrate no clinical advantage of prophylactic antibiotics that would outweigh their long-term adverse effects (122). Similarly, prolonged systemic antimicrobial prophylaxis has been used in the past for patients with severe burns. However, recent meta-analyses suggest questionable clinical benefit with this approach (123,124). Current guidelines for burn management do not support sustained antimicrobial prophylaxis (101). Summarizing the evidence is challenging due to the diversity of the population.

The quality of evidence was low for mortality in pancreatitis (122) and low for burns; therefore, we believe this recommendation is better addressed as a BPS, in which the alternative of administering antibiotics without indicators of infection is implausible (122-124). Despite our recommendation against sustained systemic antimicrobial prophylaxis generally, brief antibiotic prophylaxis for specific invasive procedures may be appropriate. In addition, if there is a strong suspicion of concurrent sepsis or septic shock in patients with a severe inflammatory state of non-infectious origin (despite overlapping clinical presentations), antimicrobial therapy is indicated.

Early optimization of antimicrobial pharmacokinetics can improve the outcome of patients with severe infection. Several considerations should be made when determining optimal dosing for critically ill patients with sepsis and septic shock. These patients have distinct differences from the typical infected patient that affect the optimal antimicrobial management strategy. These differences include an increased frequency of hepatic and renal dysfunction, a high prevalence of unrecognized immune dysfunction, and a predisposition to infection with resistant organisms. Perhaps most importantly with respect to initial empiric antimicrobial dosing is an increased volume of distribution for most antimicrobials, in part due to the rapid expansion of extracellular volume as a consequence of aggressive fluid resuscitation. This results in an unexpectedly high frequency of suboptimal drug levels with a variety of antimicrobials in patients with sepsis and septic shock (125-128). Early attention to appropriate antimicrobial dosing is central to improving outcome given the marked increase in mortality and other adverse outcomes if there is a failure of rapid initiation of effective therapy. Antimicrobial therapy in these patients should always be initiated with a full, high end-loading dose of each agent used.

Different antimicrobials have different required plasma targets for optimal outcomes. Failure to achieve peak plasma targets on initial dosing has been associated with clinical failure with aminoglycosides (129). Similarly, inadequate early vancomycin trough plasma concentrations (in relation to pathogen minimum inhibitory concentration [MIC]) have been associated with clinical failure for serious MRSA infections (130) (including nosocomial pneumonia (131) and septic shock (132)). The clinical success rate for treatment of serious infections correlates with higher peak blood levels (in relation to pathogen MIC) of fluoroquinolones (nosocomial pneumonia and other serious infections) (133-135) and aminoglycosides (gram-negative bacteraemia, nosocomial pneumonia, and other serious infections) (129,136). For β -lactams, superior clinical and microbiologic cures appear to be associated with a longer duration of plasma concentration above the pathogen MIC, particularly in critically ill patients (137-140).

The optimal dosing strategy for aminoglycosides and fluoroquinolones involves optimizing peak drug plasma concentrations. For aminoglycosides, this can most easily be attained with once daily dosing (5–7 mg/kg daily gentamicin equivalent). Once-daily dosing yields at least comparable clinical efficacy with possibly decreased renal toxicity compared to multiple daily dosing regimens (141,142). Once-daily dosing of aminoglycosides is used for patients with preserved renal function. Patients with chronically mildly impaired renal function should still receive a once-daily-equivalent dose but would normally have an extended period (up to 3 days) before the next dose. This dosing regimen should not be used in patients with severe renal function in whom the aminoglycoside is not expected to clear within several days. Therapeutic drug monitoring of aminoglycosides in this context is primarily meant to ensure that trough concentrations are sufficiently low to minimize the potential for renal toxicity. For fluoroquinolones, an approach that optimizes the dose within a nontoxic range (e.g., ciprofloxacin, 600 mg every 12 hours, or levofloxacin, 750 mg every 24 hours, assuming preserved renal function) should provide the highest probability of a favourable microbiologic and clinical response (127,143,144).

Vancomycin is another antibiotic whose efficacy is at least partially concentration dependent. Dosing to a trough target of 15–20 mg/L is recommended by several authorities to maximize the probability of achieving appropriate pharmacodynamic targets, improve tissue penetration, and optimize clinical outcomes (145-147). Pre-dose monitoring of trough concentrations is recommended. For sepsis and septic shock, an IV loading dose of 25–30 mg/kg (based on actual body weight) is suggested to rapidly achieve the target trough drug concentration. A loading dose of 1 gram of vancomycin will fail to achieve early therapeutic levels for a significant subset of patients. In fact, loading doses of antimicrobials with low volumes of distribution (teicoplanin, vancomycin, colistin) are warranted in critically ill patients to more rapidly achieve therapeutic drug levels due to their expanded extracellular volume related to volume expansion following fluid resuscitation (148-152). Loading doses are also recommended for β -lactams administered as continuous or extended infusions to accelerate accumulation of drug to therapeutic levels (153). Notably, the required loading dose of any antimicrobial is not affected by alterations of renal function, although this may affect frequency of administration and/or total daily dose.

For β -lactams, the key pharmacodynamics correlate to microbiologic and clinical response is the time that the plasma concentration of the drug is above the pathogen MIC relative to the dosing interval ($T > MIC$). A minimum $T > MIC$ of 60% is generally sufficient to allow a good clinical response in mild to moderate illness. However, optimal response in severe infections, including sepsis, may be achieved with a $T > MIC$ of 100% (139). The simplest way to increase $T > MIC$ is to use increased frequency of dosing (given an identical total daily dose). For example, piperacillin/tazobactam can be dosed at either 4.5 g every 8 hours or 3.375 g every 6 hours for serious infections; all things being equal, the latter would achieve a higher $T > MIC$. We suggested earlier that initial doses of β -lactams can be given as a bolus or rapid infusion to rapidly achieve therapeutic blood levels. However, following the initial dose, an extended infusion of drug over several hours (which increases $T > MIC$) rather than the standard 30 minutes has been recommended by some authorities (154,155). In addition, some meta-analyses suggest that extended/continuous infusion of β -lactams may be more effective than intermittent rapid infusion, particularly for relatively resistant organisms and in critically ill patients with sepsis (140, 156-158). A recent individual patient data meta-analysis of randomized controlled trials comparing continuous versus intermittent infusion of β -lactam antibiotics in critically ill patients with severe sepsis demonstrated an independent protective effect of continuous therapy after adjustment for other correlates of outcome (140).

While the weight of evidence supports pharmacokinetically optimized antimicrobial dosing strategies in critically ill patients with sepsis and septic shock, this is difficult to achieve on an individual level without a broader range of rapid therapeutic drug monitoring options than currently available (i.e., vancomycin, teicoplanin and aminoglycosides). The target group of critically ill, septic patients exhibit a variety of physiologic perturbations that dramatically alter antimicrobial pharmacokinetics. These include unstable hemodynamic, increased cardiac output, increased extracellular volume (markedly increasing volume of distribution), variable kidney and hepatic perfusion (affecting drug clearance) and altered drug binding due to reduced serum albumin (159). In addition, augmented renal clearance is a recently described phenomenon that may lead to decreased serum antimicrobial levels in the early phase of sepsis (160-162). These factors make individual assessment of optimal drug dosing difficult in critically ill patients. Based on studies with therapeutic drug monitoring, under-dosing (particularly in the early phase of treatment) is common in critically ill, septic patients, but drug toxicity such as central nervous system irritation with β -lactams and renal injury with colistin is also seen (163-166). These problems mandate efforts to expand access to therapeutic drug monitoring for multiple antimicrobials for critically ill patients with sepsis.

In light of the increasing frequency of pathogen resistance to antimicrobial agents in many parts of the world, the initial use of multidrug therapy is often required to ensure an appropriately broad-spectrum range of coverage for initial empiric treatment. The use of multidrug therapy for this purpose in severe infections is well understood.

The phrase “combination therapy” in the context of this guideline connotes the use of two different classes of antibiotics (usually a β -lactam with a fluoroquinolone, aminoglycoside, or macrolide) for a single putative pathogen expected to be sensitive to both, particularly for purposes of accelerating pathogen clearance. The term is not used where the purpose of a multidrug strategy is to strictly broaden the range of antimicrobial activity (e.g., vancomycin added to ceftazidime, metronidazole added to an aminoglycoside or an echinocandin added to a β -lactam).

A propensity-matched analysis and a meta-analysis/meta-regression analysis have demonstrated that combination therapy produces higher survival in severely ill septic patients with a high risk of death, particularly in those with septic shock (167,168). A meta-regression study (167) suggested benefit with combination therapy in patients with a mortality risk greater than 25%. Several observational studies have similarly shown a survival benefit in very ill patients (169-172). However, the aforementioned meta-regression analysis also suggested the possibility of increased mortality risk with combination therapy in low-risk (< 15% mortality risk) patients without septic shock (167). One controlled trial suggested that, when using a carbapenem as empiric therapy in a population at low risk for infection with resistant microorganisms, the addition of a fluoroquinolone does not improve patients’ outcomes (173). A close examination of the results, however, demonstrates findings consistent with the previously mentioned meta-regression (trend to benefit in septic shock with an absence of benefit in sepsis without shock). Despite the overall favourable evidence for combination therapy in septic shock, direct evidence from adequately powered RCTs is not available to validate this approach definitively. Nonetheless, in clinical scenarios of severe clinical illness (particularly septic shock), several days of combination therapy is biologically plausible and is likely to be clinically useful (152,167,168) even if evidence has not definitively demonstrated improved clinical outcome in bacteraemia and sepsis without shock (174,175). Thus, we issue a weak recommendation based on low quality of evidence.

A number of other recent observational studies and some small, prospective trials also support initial combination therapy for selected patients with specific pathogens (e.g., severe pneumococcal infection, multidrug-resistant gram-negative pathogens) (172,176-182). Unfortunately, in most cases and pending the development of rapid bedside pathogen detection techniques, the offending pathogen is not known at the time of presentation. Therefore, specifying combination therapy to specific identified pathogens is useful only if more prolonged, targeted combination therapy is contemplated. In addition, with respect to multidrug-resistant pathogens, both individual studies and meta-analyses yield variable results depending on the pathogen and the clinical scenario (179–184). Infectious diseases consultation may be advisable if multidrug-resistant pathogens are suspected. One area of broad consensus on the use of a specific form of combination therapy is for streptococcal toxic shock syndrome, for which animal models and uncontrolled, clinical experience demonstrate a survival advantage with penicillin and clindamycin, the latter as a transcriptional inhibitor to pyrogenic exotoxin superantigens (109,185,186).

Despite evidence suggesting benefit of combination therapy in septic shock, this approach has not been shown to be effective for ongoing treatment of most other serious infections, including bacteraemia and sepsis without shock (168,174,175). The term “ongoing treatment” includes extended empiric therapy for culture-negative infections and extended definitive/targeted therapy where a pathogen is identified. In the case of neutropenia in the absence of septic shock, studies using modern broad-spectrum antibiotics consistently suggest that, while multidrug therapy to broaden pathogen coverage (e.g., to include *Candida* species) may be useful, combination therapy using a β -lactam and an aminoglycoside for purposes of accelerating pathogen clearance is not beneficial for less severely ill “low-risk” patients (187). Combination therapy of this sort for even “high-risk” neutropenic patients (inclusive of hemodynamic instability and organ failure) with sepsis is inconsistently supported by several international expert groups (106,188). This position against combination therapy for a single pathogen in any form of neutropenic infection emphatically does not preclude the use of multidrug therapy for the purpose of broadening the spectrum of antimicrobial treatment.

High-quality data on clinically driven de-escalation of antimicrobial therapy for severe infections are limited (189). Early de-escalation of antimicrobial therapy in the context of combination therapy as described here has not been studied. However, observational studies have shown that early de-escalation of multidrug therapy is associated with equivalent or superior clinical outcomes in sepsis and septic shock (54,190-192); despite this, at least one study has indicated an increased frequency of superinfection and longer ICU stay (192). In addition to institutional benefit with respect to limiting a driver of antimicrobial resistance, early de-escalation can also benefit the individual patient (193-195). Although the data are not entirely consistent, on balance, an approach that emphasizes early de-escalation is favoured when using combination therapy.

While substantial consensus on the need for early de-escalation of combination therapy exists, agreement is lacking on precise criteria for triggering de-escalation. Among approaches used by panel members are de-escalation based on: a) clinical progress (shock resolution, decrease in vasopressor requirement, etc.), b) infection resolution as indicated by biomarkers (especially procalcitonin), and c) a relatively fixed duration of combination therapy. This lack of consensus on de-escalation criteria for combination therapy reflects the lack of solid data addressing this issue (notwithstanding procalcitonin data relating to general de-escalation).

Unnecessarily prolonged administration of antimicrobials is detrimental to society and to the individual patient. For society, excessive antimicrobial use drives antimicrobial resistance development and dissemination (196). For individual patients, prolonged antibiotic therapy is associated with specific illnesses such as Clostridium difficile colitis (195) and, more broadly, an increased mortality risk (54). The basis of the increased mortality with unnecessarily prolonged and broad antimicrobial therapy has not been convincingly demonstrated, although cumulative antimicrobial toxicity; the occurrence of antimicrobial-associated secondary infections (e.g., C difficile colitis); and selection of, and superinfection with, multidrug-resistant pathogens are all potential contributors.

Although patient factors will influence the length of antibiotic therapy, a treatment duration of 7 to 10 days (in the absence of source control issues) is generally adequate for most serious infections (103,197-199). Current guidelines recommend a 7-day course of therapy for nosocomial pneumonia (both hospital-acquired and ventilator-associated pneumonia [VAP]) (103). Recent data suggest that some serious infections may be treated with shorter courses especially if there is a need for and successful provision of source control (200,201). Subgroup analysis of the most critically ill subjects (Acute Physiologic and Chronic Health Evaluation [APACHE] II score greater than either 15 or 20) in the short course of antimicrobials in the intra-abdominal sepsis study of Sawyer et al (demonstrated no difference in outcome based on the duration of therapy (as with the overall group) (200,202). A treatment duration of 3 to 5 days or fewer was as effective as a duration of up to 10 days. Similarly, studies have shown that a treatment duration of < 7 days is as effective as longer durations in the management of acute pyelonephritis with or without bacteraemia (201), uncomplicated cellulitis (203), and spontaneous bacterial peritonitis (204). Some conditions are generally thought to require more prolonged antimicrobial therapy. These include situations in which there is a slow clinical response, undrainable foci of infection, bacteraemia with *S aureus* (particularly MRSA) (67,104), candidemia/invasive candidiasis (105) and other fungal infections, some viral infections (e.g., herpes, cytomegalovirus), and immunologic deficiencies, including neutropenia (188).

Assessment of the required duration of therapy in critically ill patients should include host factors, particularly immune status. For example, patients with neutropenic infection and sepsis usually require therapy for at least the duration of their neutropenia. The nature of the infecting pathogen also plays a role. In particular, uncomplicated *S aureus* bacteraemia requires at least 14 days of therapy, while complicated bacteraemia requires treatment as an endovascular infection with 6 weeks of therapy. Uncomplicated bacteraemia has been defined as: 1) exclusion of endocarditis, 2) no implanted prostheses, 3) negative results of follow-up blood cultures drawn 2 to 4 days after the initial set, 4) defervescence within 72 hours after the initiation of effective antibiotic therapy, and 5) no evidence of metastatic infection (104). Patients with candidemia (whether or not catheter-associated) and deep *Candida* infections, whether or not associated with sepsis, require more

prolonged therapy (105,205). Highly resistant gram-negative pathogens with marginal sensitivity to utilized antimicrobials may be slow to clear and represent another example. The nature and site of infection may also affect duration of therapy. Larger abscesses and osteomyelitis have limited drug penetration and require longer therapy. Although it is well known that endocarditis requires prolonged antimicrobial therapy, severe disease more typically presents as cardiac failure/cardiogenic shock and emboli rather than as sepsis or septic shock (206,207). A variety of other factors may play a role in determining the optimal duration of therapy, particularly in critically ill infected patients. If the clinician is uncertain, infectious diseases consultation should be sought. Few of the studies noted focused on patients with septic shock, sepsis with organ failure, or even critical illness. To an extent, standard recommendations on duration of therapy in this document depend on inferences from less ill cohorts. Therefore, decisions to narrow or stop antimicrobial therapy must ultimately be made on the basis of sound clinical judgment.

There are many reasons for unnecessarily prolonged antimicrobial therapy. For complicated, critically ill patients admitted with serious infections, non-infectious concurrent illness and medical interventions may produce signs and symptoms consistent with active infection (even following control of infection). For example, pulmonary infiltrates and shortness of breath may be caused by pulmonary oedema in addition to pneumonia; an elevated white cell count may occur as a consequence of corticosteroid administration or physiologic stress; fever may be associated with certain drugs, including β -lactams and phenytoin. In addition, there is a natural tendency to want to continue a therapy that is often seen as benign long enough to be confident of cure. However, as discussed, antimicrobials are not an entirely benign therapy. In low-risk patients, the adverse effects can outweigh any benefit.

Given the potential harm associated with unnecessarily prolonged antimicrobial therapy, daily assessment for de-escalation of antimicrobial therapy is recommended in patients with sepsis and septic shock. Studies have shown that daily prompting on the question of antimicrobial de-escalation is effective and may be associated with improved mortality rates (55,208).

During the past decade, the role of biomarkers to assist in the diagnosis and management of infections has been extensively explored. The use of galactomannan and β -D-glucan to assist in the assessment of invasive aspergillus (and a broad range of fungal pathogens) has become well accepted (209,210). Similarly, measurement of serum procalcitonin is commonly used in many parts of the world to assist in the diagnosis of acute infection and to help define the duration of antimicrobial therapy. Various procalcitonin-based algorithms have been used to direct de-escalation of antimicrobial therapy in severe infections and sepsis (211-216). However, it is not clear that any particular algorithm provides a clinical advantage over another. A large body of literature suggests that use of such algorithms can speed safe antimicrobial de-escalation compared to standard clinical approaches with reduced antimicrobial consumption without an adverse effect on mortality. Recently, a large randomized trial on procalcitonin use in critically ill patients with presumed bacterial infection demonstrated evidence of a reduction in duration of treatment and daily defined doses of antimicrobials (217). However, given the design of the study, the reduction could have been related to a prompting effect as seen in other studies (55,218). In addition, the procalcitonin group showed a significant reduction in mortality. This finding is congruent with studies demonstrating an association between early antimicrobial de-escalation and survival in observational studies of sepsis and septic shock (54,55). This benefit is uncertain, though, because another meta-analysis of randomized controlled studies of de-escalation failed to demonstrate a similar survival advantage (219). Meta-analyses also suggest that procalcitonin can also be used to assist in differentiating infectious and non-infectious conditions at presentation (211,214,216). The strongest evidence appears to relate to bacterial pneumonia versus non-infectious pulmonary pathology (216,220), where meta-analysis suggests that procalcitonin may assist in predicting the presence of bacteraemia, particularly in ICU patients (221).

No evidence to date demonstrates that the use of procalcitonin reduces the risk of antibiotic-related diarrhoea from *C difficile*. However, the occurrence of *C difficile* colitis is known to be associated with cumulative antibiotic exposure in individual patients (195), so such a benefit is likely. In addition, although prevalence of antimicrobial resistance has not been shown to be reduced by the use of procalcitonin, the emergence of antimicrobial resistance is known to be associated with total antimicrobial consumption in large regions (196).

It is important to note that procalcitonin and all other biomarkers can provide only supportive and supplemental data to clinical assessment. Decisions on initiating, altering, or discontinuing antimicrobial therapy should never be made solely on the basis of changes in any biomarker, including procalcitonin.

Sterilization of cultures can occur within minutes to hours after the first dose of an appropriate antimicrobial (49, 50). Obtaining cultures prior to the administration of antimicrobials significantly increases the yield of cultures, making identification of a pathogen more likely. Isolation of an infecting organism(s) allows for de-escalation of antimicrobial therapy first at the point of identification and then again when susceptibilities are obtained. De-escalation of antimicrobial therapy is a mainstay of antibiotic stewardship programs and is associated with less resistant microorganisms, fewer side effects, and lower costs (51). Several retrospective studies have suggested that obtaining cultures prior to antimicrobial therapy is associated with improved outcome (52, 53). Similarly, de-escalation has also been associated with improved survival in several observational studies (54, 55). The desire to obtain cultures prior to initiating antimicrobial therapy must be balanced against the mortality risk of delaying a key therapy in critically ill patients with suspected sepsis or septic shock who are at significant risk of death (56, 57).

We recommend that blood cultures be obtained prior to initiating antimicrobial therapy if cultures can be obtained in a timely manner. However, the risk/benefit ratio favours rapid administration of antimicrobials if it is not logistically possible to obtain cultures promptly. Therefore, in patients with suspected sepsis or septic shock, appropriate routine microbiologic cultures should be obtained before initiation of antimicrobial therapy from all sites considered to be potential sources of infection if it results in no substantial delay in the start of antimicrobials. This may include blood, cerebrospinal fluid, urine, wounds, respiratory secretions, and other body fluids, but does not normally include samples that require an invasive procedure such as bronchoscopy or open surgery. The decision regarding which sites to culture requires careful consideration from the treatment team. “Pan culture” of all sites that could potentially be cultured should be discouraged (unless the source of sepsis is not clinically apparent), because this practice can lead to inappropriate antimicrobial use (58). If history or clinical examination clearly indicates a specific anatomic site of infection, cultures of other sites (apart from blood) are generally unnecessary. We suggest 45 minutes as an example of what may be considered to be no substantial delay in the initiation of antimicrobial therapy while cultures are being obtained.

Two or more sets (aerobic and anaerobic) of blood cultures are recommended before initiation of any new antimicrobial in all patients with suspected sepsis (59). All necessary blood cultures may be drawn together on the same occasion. Blood culture yield has not been shown to be improved with sequential draws or timing to temperature spikes (60, 61). Details on appropriate methods to draw and transport blood culture samples are enumerated in other guidelines (61, 62).

In potentially septic patients with an intravascular catheter (in place > 48 hours) in whom a site of infection is not clinically apparent or a suspicion of intravascular catheter-associated infection exists, at least one blood culture set should be obtained from the catheter (along with simultaneous peripheral blood cultures). This is done to assist in the diagnosis of a potential catheter-related bloodstream infection. Data are inconsistent regarding the utility of differential time to blood culture positivity (i.e., equivalent volume blood culture from the vascular access device positive more than 2 hours before the peripheral blood culture) in suggesting that the vascular access device is the source of the infection (63–65). It is important to note that drawing blood cultures from an intravascular catheter in case of possible infection of the device does not eliminate the option of removing the catheter (particular non-tunneled catheters) immediately afterward.

In patients without a suspicion of catheter-associated infection and in whom another clinical infection site is suspected, at least one blood culture (of the two or more that are required) should be obtained peripherally.

However, no recommendation can be made as to where additional blood cultures should be drawn. Options include a) all cultures drawn peripherally via venepuncture, b) cultures drawn through each separate intravascular device but not through multiple lumens of the same intravascular catheter, or c) cultures drawn through multiple lumens in an intravascular device (66–70).

In the near future, molecular diagnostic methods may offer the potential to diagnose infections more quickly and more accurately than current techniques. However, varying technologies have been described, clinical experience remains limited, and additional validation is needed before recommending these methods as an adjunct to or replacement for standard blood culture techniques (71–73). In addition, susceptibility testing is likely to require isolation and direct testing of viable pathogens for the foreseeable future.

Recommendation 15: (SSCG Section C, Recommendation 1).

We recommend that appropriate routine microbiologic cultures (including blood) be obtained before starting antimicrobial therapy in patients with suspected sepsis or septic shock if doing so results in no substantial delay in the start of antimicrobials.

Quality/level of evidence: Low

+ Strength of recommendation: BPS

SSC remarks: Appropriate routine microbiologic cultures always include at least two sets of blood cultures (aerobic and anaerobic).

Start Smart

Recommendation 16. (SSCG Section D, Recommendation 1).

We recommend administering antimicrobials immediately, ideally within 1 hour of recognition for patients with possible septic shock or a high likelihood of sepsis (SSCG 2021, Rec 12) [updated 2025]

Quality/level of evidence: Low

+ Strength of recommendation: Strong

Recommendation 16a. (SSCG 2021, Rec 14).

We suggest a time-limited course of rapid investigation and if concern for infection persists, the administration of antimicrobials within 3 hours from the time when sepsis was first recognised for patients with possible sepsis without shock. [See Appendix 16 Recommendations on Timing of Antibiotic Administration \[new 2025\]](#)

Quality/level of evidence: Very Low

+ Strength of recommendation: Strong

Recommendation 17. (SSCG Section D, Recommendation 2).

We recommend empiric broad-spectrum therapy with one or more antimicrobials for patients presenting with sepsis or septic shock to cover all likely pathogens (including bacterial and potentially fungal or viral coverage).

Quality/level of evidence: Moderate

+ Strength of recommendation: Strong

Recommendation 18. (SSCG Section D, Recommendation 5).

We recommend that dosing strategies of antimicrobials be optimized based on accepted pharmacokinetic/pharmacodynamic principles and specific drug properties in patients with sepsis or septic shock.

Quality/level of evidence: Low

+ Strength of recommendation: BPS

Recommendation 19. (SSCG Section D, Recommendation 6).

We suggest empiric combination therapy (using at least two antibiotics of different antimicrobial classes) aimed at the most likely bacterial pathogen(s) for the initial management of septic shock.

Quality/level of evidence: Low

+ Strength of recommendation: Weak

SSC Remarks: Readers should review Table 2 for definitions of empiric, targeted/definitive, broad-spectrum, combination, and multidrug therapy.

Recommendation 20. (SSCG Section D, Recommendation 7).

We suggest that combination therapy not be routinely used for ongoing treatment of most other serious infections, including bacteraemia and sepsis without shock.

Quality/level of evidence: Weak

+ Strength of recommendation: Low

SSC Remarks: This does not preclude the use of multidrug therapy to broaden antimicrobial activity.

Recommendation 21. (SSCG Section D, Recommendation 8).

We recommend against combination therapy for the routine treatment of neutropenic sepsis/bacteraemia.

Quality/level of evidence: Moderate

+ Strength of recommendation: Strong

SSC Remarks: This does not preclude the use of multidrug therapy to broaden antimicrobial activity.

Then Focus**Recommendation 22.** (SSCG Section D, Recommendation 3).

We recommend that empiric antimicrobial therapy be narrowed once pathogen identification and sensitivities are established and/or adequate clinical improvement is noted.

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Recommendation 23. (SSCG Section D, Recommendation 9).

If combination therapy is initially used for septic shock, we recommend de-escalation with discontinuation of combination therapy within the first few days in response to clinical improvement and/or evidence of infection resolution. This applies to both targeted (for culture-positive infections) and empiric (for culture-negative infections) combination therapy.

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Recommendation 24. (SSCG Section D, Recommendation 13).

We recommend daily assessment for de-escalation of antimicrobial therapy in patients with sepsis and septic shock.

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Recommendation 25. (SSCG Section D, Recommendation 4).

We recommend against sustained systemic antimicrobial prophylaxis in patients with severe inflammatory states of non-infectious origin (e.g., severe pancreatitis, burn injury).

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Recommendation 26. (SSCG Section D, Recommendation 14).

We suggest that measurement of procalcitonin levels can be used to support shortening the duration of antimicrobial therapy in sepsis patients.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 27. (SSCG Section D, Recommendation 15).

We suggest that procalcitonin levels can be used to support the discontinuation of empiric antibiotics in patients who initially appeared to have sepsis, but subsequently have limited clinical evidence of infection.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 28. (SSCG Section D, Recommendation 10).

We suggest that an antimicrobial treatment duration of 7 to 10 days is adequate for most serious infections associated with sepsis and septic shock.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 29. (SSCG Section D, Recommendation 11).

We suggest that longer courses are appropriate in patients who have a slow clinical response, undrainable foci of infection, bacteremia with *S aureus*, some fungal and viral infections, or immunologic deficiencies, including neutropenia.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 30. (SSCG Section D, Recommendation 12).

We suggest that shorter courses are appropriate in some patients, particularly those with rapid clinical resolution following effective source control of intra-abdominal or urinary sepsis and those with anatomically uncomplicated pyelonephritis.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Table 19. Important terminology for antimicrobial recommendations
(Rhodes et al., 2017)

Empiric therapy	Initial therapy started in the absence of definitive microbiologic pathogen identification. Empiric therapy may be mono- combination, or broad-spectrum, and/or multidrug in nature.
Targeted/definitive therapy	Therapy targeted to a specific pathogen (usually after microbiologic identification). Targeted/definitive therapy may be mono- or combination but is not intended to be broad-spectrum.
Broad-spectrum therapy	The use of one or more antimicrobial agents with the specific intent of broadening the range of potential pathogens covered, usually during empiric therapy (e.g., piperacillin/tazobactam, vancomycin, and anidulafungin; each is used to cover a different group of pathogens). Broad-spectrum therapy is typically empiric since the usual purpose is to ensure antimicrobial coverage with at least one drug when there is uncertainty about the possible pathogen. On occasion, broad-spectrum therapy may be continued into the targeted/definitive therapy phase if multiple pathogens are isolated.
Multidrug therapy	Therapy with multiple antimicrobials to deliver broad-spectrum therapy (i.e., to broaden coverage) for empiric therapy (i.e., where pathogen is unknown) or to potentially accelerate pathogen clearance (combination therapy) with respect to a specific pathogen(s) where the pathogen(s) is known or suspected (i.e., for both targeted or empiric therapy). This term therefore includes combination therapy.
Combination therapy	The use of multiple antibiotics (usually of different mechanistic classes) with the specific intent of covering the known or suspected pathogen(s) with more than one antibiotic (e.g., piperacillin/tazobactam and an aminoglycoside or fluoroquinolone for gram-negative pathogens) to accelerate pathogen clearance rather than to broaden antimicrobial coverage. Other proposed applications of combination therapy include inhibition of bacterial toxin production (e.g., clindamycin with β -lactams for streptococcal toxic shock) or potential immune modulatory effects (macrolides with a β -lactam for pneumococcal pneumonia).

Antimicrobial Stewardship

Implementation Point 9 (Recommendations 16, 16A (new) & 17)

Managing sepsis in the era of increasing rates of multi-drug resistant organisms (MDRO) should be linked tightly with antimicrobial stewardship (DOH, 2017a) (HPSC, 2009). Coupled with rising rates of MDRO, few new antimicrobials are being developed, therefore, prescribing antimicrobials appropriately is essential for both patient safety (to minimise adverse effects) and for future generations (so effective antimicrobials are available to manage infection and sepsis). It is recommended that the ‘Start Smart and then Focus’ (Appendix 15), approach is employed for antimicrobial therapy (RCPI, 2012). Where more than one antimicrobial alternative exists, their relative costs should also be considered whilst adhering to local antimicrobial guidelines.

Further information on MDRO’s can be found on the Health Protection Surveillance centre website at the following link <https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/>

Start Smart

Intravenous antimicrobials are administered as part of the Sepsis 6 bundle within one hour of diagnosis of infection in patients screened to be at high risk of mortality from sepsis. (See Section A; Screening).

All acute hospitals have guidelines for the empiric use of antimicrobials in adults that are appropriate for the local MDRO epidemiology. It is recommended that these guidelines be used to choose empiric therapy for patients with infection, taking the following into consideration:

1. Source of the infection

- o Community acquired
- o Healthcare associated
- o Hospital acquired

2. Site of the infection

Based on the history and the examination of the patient e.g. respiratory, abdominal, genito-urinary, device or catheter-related, cellulitis, central nervous system, bone or joint or unknown.

3. Patient considerations

Patient factors that need to be taken into consideration and may influence the choice of empiric antimicrobial therapy include:

- o Group B Streptococcus
- o Group A Streptococcus (associated high mortality in maternity) (Steven and Bryant, 2019)
- o Previous infection or colonisation with MDRO such as meticillin resistant *Staphylococcus aureus* (MRSA), extended-spectrum B-lactamase (ESBL) producing/gram negative organism etc.
- o Recent antimicrobial therapy
- o Current outbreaks
- o Recent infections in close contacts
- o Recent travel or hospitalization and/or residence in another country
- o Allergy status.

Penicillin allergy is frequently reported and if inaccurate may compromise patient care. Getting a clear description of the reported reaction to penicillin distinguishes between allergy and side-effect and more accurately describes an allergic response. The majority (90%-99%) of patients with a reported penicillin allergy do not have immediate hypersensitivity and approximately 1% of patients with an allergy to penicillin will also react to cephalosporins (45). Thus a patient, who develops a rash in response to penicillin, may be considered low risk for treatment with a cephalosporin, but someone with angio-oedema or cardiovascular collapse at higher high risk.

Implementation Point 10 (Recommendation 18)

Empiric antimicrobial therapy should be prescribed at the optimal dose, frequency and duration, based on individual patient characteristics (e.g. age, weight, renal function), likely causative organism, site of infection, and pharmacokinetic and pharmacodynamic characteristics of the antimicrobial agent(s). For certain antimicrobials (e.g., aminoglycosides), it is essential that serum for therapeutic drug monitoring is measured appropriately, and the results acted upon in a timely manner. Local antimicrobial guidelines include recommendations on dosing, weight calculation and intravenous (IV) to oral (PO) switch and they should be consulted to ensure dose optimisation.

Implementation Point 11 (Recommendation 19)

The two-drug combination for septic shock is based on the likely source of the infection, rising MDRO rates and the fact that in some instances the source of infection may not be apparent. In guidelines that use the terminology of sepsis, severe sepsis and septic shock, use the guidance for severe sepsis for patients with acute organ dysfunction due to infection irrespective of the terminology used and the guidance for septic shock for patients on vasopressors/ inotropes due to acute infection.

Implementation Point 12 (Recommendations 20 & 21)

NB. Local guidelines should be taken into account when considering combination antimicrobial therapy for sepsis. The choice of single or combination agents may vary depending on local MDRO epidemiology.

Start smart roles and responsibilities (Implementation points 9-12) :

It is the responsibility of each acute hospital to have local antimicrobial guidelines that are readily available to clinicians at all times. These guidelines should be under the governance of the antimicrobial stewardship committee (HPSC, 2009). A clinical microbiologist or infectious disease specialist should be available for consultation on complex cases at a Consultant to Consultant level. It is the responsibility of treating clinicians to be familiar with accessing the local guideline and with its use in guiding empiric therapy.

Then focus

Implementation Point 13 (Recommendations 22 & 23)

Empiric antimicrobial therapy should be rationalized on the basis of ongoing clinical review and results of laboratory investigations and diagnostic imaging, as outlined in the Start Smart Then Focus care bundle (RCPI, 2012). All empiric antimicrobial therapy should be reviewed on a daily basis by the clinician responsible for the patient's care. To ensure continuity of care and in light of changing work practices in hospitals, it is recommended that all antimicrobial prescriptions have a documented review date and indication for the prescription to facilitate safe handover of patient care. It is recommended that local antimicrobial prescribing guidelines are consulted for the criteria for converting parenteral antimicrobial therapy to oral therapy once the patient's condition allows.

Implementation Point 14 (Recommendations 26, 27, 28, 29 & 30)

An essential component of antimicrobial stewardship is restricting antimicrobial prescription durations to the minimum duration required for clinical efficacy. As recommended previously in this NCG, all antimicrobial prescriptions should have the proposed duration documented and should be reviewed on a daily basis. Procalcitonin is a serum biomarker that is useful in distinguishing bacterial infection from other causes of infection or inflammation and may be useful in guiding duration of antimicrobial therapy (Rogić et al., 2017). Most data is from patients with lower respiratory infection in the critical care setting (Sager et al., 2017). In addition, procalcitonin does not replace clinical judgment and provides only supportive and supplemental data to clinical assessment (Huang et al., 2018). There are a number of limitations with procalcitonin as a stewardship tool, including suboptimal sensitivity and/or specificity, which makes a careful interpretation in the clinical context essential. In addition, they are not available widely and knowledge regarding their use is evolving.

Implementation Point 15 (Recommendation 24 & 25)

When a patient presents unwell or deteriorates, a list of potential diagnoses is formed, based on history and examination, and tests and investigations are ordered to help confirm the diagnosis. Sepsis screening recommends the Sepsis 6 bundle/Sepsis 6 +1 be administered to patients with a clinical suspicion of infection who are in one of the three high-risk groups. If a non-infectious diagnosis is identified, and there is no reasonable suspicion of a concurrent infection, antimicrobial therapy should be stopped.

Then focus: Roles and responsibilities (Implementation points, 13-15)

It is the responsibility of the treating team, or its delegate, to review the patient daily and to assess the antimicrobial therapy in terms of the patients' clinical response and laboratory results during the acute phase of the illness and to decide on and document the duration of treatment appropriate to the illness.

Implementation Point 16 (Recommendations 15)

Blood cultures are taken as part of the Sepsis 6 bundle prior to antimicrobial administration. This will maximize the yield of positive cultures, which can then be used to guide appropriate antimicrobial management, with reduced use of broad-spectrum empiric therapy and associated complications due to multi-drug resistant organisms and antibiotic-associated diarrhoea. Blood cultures should always be taken using an aseptic (non-touch) technique. Care should be taken to prevent contamination when obtaining cultures as this may lead to the initiation of unnecessary antimicrobial therapy and investigations, potential adverse events, as well as lengthening hospital stays and costs. The acceptable rate for contamination rates is < 3% (Snyder et al., 2012). It is recommended that units regularly audit their contamination rates and review their practices accordingly. Pre-packed blood culture sets and strategies to ensure aseptic technique have been shown to reduce contamination rates (Bentley et al., 2016). Practical considerations have to be taken into account, for example, if a unit has the practice that the blood cultures are drawn from the intravenous cannula, then that cannula must be inserted with aseptic technique and the blood culture be taken as the first draw and the culture bottle immediately inoculated. When possible, it is recommended that blood cultures be taken via a separate puncture.

Other specimens for culture will be based on the clinical history and examination and will target the suspected site of infection. This includes cultures being taken through potential infected central lines. If source is being controlled it is recommended that specimens (e.g. pus, joint fluid) be sent for microbiological assessment, this should not lead to a delay in administering antimicrobials in patients with sepsis and septic shock.

Roles and responsibilities (Implementation point 16):

Administering the Sepsis 6 bundle/Sepsis 6 +1 correctly and in a timely fashion requires multi-disciplinary cooperation and processes to be put in place to facilitate achieving this goal. Components of the bundle can be performed by different team members depending on their training and experience and the policies of different institutions. Local policies should be developed to facilitate this, in the best interest of the patient. Resources such as "Sepsis Trolleys", or similar, with all the components required for Sepsis 6/Sepsis 6+1 delivery and "blood culture packs" may facilitate timely and appropriate care.

It is the responsibility of the treating doctor to complete and sign off on the sepsis form. In the event of a handover occurring mid-treatment, a verbal handover of care and outstanding tasks should be given, and the handover section of the sepsis form filled. It is then the responsibility of the receiving doctor to complete and sign off the form.

It is the responsibility of hospital management to ensure that sepsis forms are available along with the necessary components of the Sepsis 6 bundle, in a time-accessible way, so that this intervention can be completed.

It is the responsibility of the treating team, or its delegate, to review the patient daily and to assess the antimicrobial therapy in terms of the patients' clinical response and laboratory results during the acute phase of the illness and to decide on and document the duration of treatment appropriate to the illness.

3.1.4 Source Control

Key question

- In patients with sepsis or septic shock, should we attempt early (within 12 hours) source control?

SSCG Rationale

The principles of source control in the management of sepsis and septic shock include rapid diagnosis of the specific site of infection and determination of whether that infection site is amenable to source control measures (specifically the drainage of an abscess, debridement of infected necrotic tissue, removal of a potentially infected device, and definitive control of a source of ongoing microbial contamination) (222). Foci of infection readily amenable to source control include intra-abdominal abscesses, gastrointestinal perforation, ischemic bowel or volvulus, cholangitis, cholecystitis, pyelonephritis associated with obstruction or abscess, necrotizing soft tissue infection, other deep space infection (e.g., empyema or septic arthritis), and implanted device infections.

Infectious foci suspected to cause septic shock should be controlled as soon as possible following successful initial resuscitation (223,224). A target of no more than 6 to 12 hours after diagnosis appears to be sufficient for most cases (223-229). Observational studies generally show reduced survival beyond that point. The failure to show benefit with even earlier source control implementation may be a consequence of the limited number of patients in these studies. Therefore, any required source control intervention in sepsis and septic shock should ideally be implemented as soon as medically and logically practical after the diagnosis is made.

Clinical experience suggests that, without adequate source control, some more severe presentations will not stabilize or improve despite rapid resuscitation and provision of appropriate antimicrobials. In view of this fact, prolonged efforts at medical stabilization prior to source control for severely ill patients, particularly those with septic shock, are generally not warranted (108).

The selection of optimal source control methods must weigh the benefits and risks of the specific intervention, risks of transfer for the procedure, potential delays associated with a specific procedure, and the probability of the procedure's success. Source control interventions may cause further complications, such as bleeding, fistulas, or inadvertent organ injury. In general, the least invasive effective option for source control should be pursued. Open surgical intervention should be considered when other interventional approaches are inadequate or cannot be provided in a timely fashion. Surgical exploration may also be indicated when diagnostic uncertainty persists despite radiologic evaluation or when the probability of success with a percutaneous procedure is uncertain and the mortality risk as a consequence of a failed procedure causing delays is high. Specific clinical situations require consideration of available choices, the patient's preferences, and the clinician's expertise. Logistic factors unique to each institution, such as surgical or interventional staff availability, may also play a role in the decision.

Intravascular devices such as central venous catheters can be the source of sepsis or septic shock. An intravascular device suspected to be a source of sepsis should generally be removed promptly after establishing another site for vascular access. In the absence of both septic shock and fungemia, some implanted, tunnelled catheter infections may be able to be treated effectively with prolonged antimicrobial therapy if removal of the catheter is not practical (67). However, catheter removal (with antimicrobial therapy) is definitive and is preferred where possible.

Recommendation 31. (SSCG Section E, Recommendation 1).

We recommend that a specific anatomic diagnosis of infection requiring emergent source control be identified or excluded as rapidly as possible in patients with sepsis or septic shock, and that any required source control intervention be implemented as soon as medically and logistically practical after the diagnosis is made.

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Recommendation 32. (SSCG Section E, Recommendation 2).

We recommend prompt removal of intravascular access devices that are a possible source of sepsis or septic shock after other vascular access has been established.

Quality/level of evidence: Low + **Strength of recommendation:** BPS

Implementation Point 17 (Recommendation 31 & 32)

To achieve compliance with these recommendations a number of steps need to occur:

1. Identification of the need for source control
2. Early consultation with appropriate surgical team
3. Access to diagnostics
4. Feasibility of achieving source control
5. Identifying the best method available
6. Access to interventional radiology/ surgery

Infected collections and devitalised tissues cannot be effectively managed by antimicrobials alone and thus need to be drained or debrided. In patients with sepsis and/or septic shock antimicrobials should not be delayed more than 1 hour from differential diagnosis (Time Zero) to facilitate microbiological sampling of the collection. Patients with suspicion of an infectious collection but with no evidence of acute organ dysfunction or shock should be managed according to usual pathways and monitored for deterioration. If deterioration occurs, as evidenced by a new INEWS score ≥ 4 , the development of acute organ dysfunction or exercising professional judgment, the Sepsis 6 bundle should be administered, and source control achieved as soon as practicable but ideally within 12 hours of deterioration.

Patients whose infection is not settling on appropriate antimicrobials need to be re-assessed for source control including reviewing implanted devices and catheters as potential sources. If such devices are potential sources, they should be removed or treated where possible and sent for culture and antimicrobial susceptibility testing.

- Early consultation with an appropriate surgical team is extremely important. Definitive source control, where appropriate, should be performed at the first available opportunity. Logistic and scheduling issues that might delay surgery may be reduced when the likely need for surgical intervention can be planned as far ahead as possible.
- While less invasive techniques (such as radiologically guided drainage) may be more appropriate, this decision should be made in a multidisciplinary setting with an appropriate surgical opinion obtained before intervention. Inappropriate radiological drainage may delay adequate source control.
- Appropriate access to an emergency operating theatre is required to ensure safe care for patients

- In certain circumstances (rarely), particularly where patients are very unstable or have specific supports in place that preclude transfer, some surgical procedures may be performed in the ICU. Appropriate equipment (lighting etc) and standard operating procedures should be developed in advance to ensure timely treatment is not delayed.

Maternity only

If the need for source control involves evacuation of the uterus, it is recommended that this be performed as soon as practicable following usual communication and procedural pathways. Inform consultant obstetrician, anaesthetist, clinical microbiologist and as applicable, neonatologist.

Roles and responsibilities (Implementation Point 17):

It is the responsibility of the treating clinician to assess and refer for source control as indicated. It is the responsibility of the effector of source control (surgery, interventional radiology, other) to take into consideration the severity of illness and the time of presentation when organizing the time for source control which should be done as soon as practical.

It is the responsibility of the hospital management to ensure sufficient resources are in place to enable clinicians to achieve source control in a timely manner.

3.1.5 Vasoactive medications

Key questions

- In patients with septic shock requiring vasopressors, should we use norepinephrine versus other agents?
- In patients with septic shock not responding to single vasopressors, should we add epinephrine?
- In patients with septic shock requiring vasopressors, should we use norepinephrine alone versus combination with vasopressin?
- In patients with septic shock requiring vasopressors, should we use of vasopressin versus other agents?
- In patients with septic shock requiring vasopressors, should we use dopamine versus other agents?
- In patients with septic shock and persistent hypoperfusion, should we use alternative inotropic agents to increase cardiac output?

SSCG Rationale

The physiologic effects of vasopressors and combined inotrope/vasopressor selection in septic shock are outlined in an extensive number of literature reviews (252-261). Norepinephrine increases MAP due to its vasoconstrictive effects, with little change in heart rate and less increase in stroke volume compared with dopamine. Dopamine increases MAP and cardiac output, primarily due to an increase in stroke volume and heart rate. Norepinephrine is more potent than dopamine and may be more effective at reversing hypotension in patients with septic shock. Dopamine may be particularly useful in patients with compromised systolic function but causes more tachycardia and may be more arrhythmogenic than norepinephrine (262). It may also influence the endocrine response via the hypothalamic pituitary axis and may have immunosuppressive effects (263). However, a recent systematic review and meta-analysis that included 11 randomized trials ($n = 1,710$) comparing norepinephrine to dopamine does not support the routine use of dopamine in the management of septic shock (264). Indeed, norepinephrine use resulted in lower mortality (RR, 0.89; 95% CI, 0.81–0.98, high-quality evidence) and lower risk of arrhythmias (RR, 0.48; 95% CI, 0.40–0.58; high-quality evidence) compared with dopamine (Supplemental Digital Content 8, <http://links.lww.com/CCM/C329>).

Human and animal studies suggest that the infusion of epinephrine may have deleterious effects on the splanchnic circulation and produces hyperlactatemia. However, clinical trials do not demonstrate worsening of clinical outcomes. One RCT comparing norepinephrine to epinephrine demonstrated no difference in mortality but an increase in adverse drug-related events with epinephrine (265). Similarly, a meta-analysis of four randomized trials ($n = 540$) comparing norepinephrine to epinephrine found no significant difference in mortality (RR, 0.96; CI, 0.77–1.21; low-quality evidence) (Supplemental Digital Content 9, <http://links.lww.com/CCM/C330>) (254). Epinephrine may increase aerobic lactate production via stimulation of skeletal muscle β_2 -adrenergic receptors and thus may preclude the use of lactate clearance to guide resuscitation.

Vasopressin levels in septic shock have been reported to be lower than anticipated for a shock state (266). Low doses of vasopressin may be effective in raising blood pressure in patients refractory to other vasopressors and may have other potential physiologic benefits (266–271). Terlipressin has similar effects but is long-acting (272). Studies show that vasopressin concentrations are elevated in early septic shock but decrease to normal range in most patients between 24 and 48 hours as shock continues (273). This finding has been called relative vasopressin deficiency because, in the presence of hypotension, vasopressin would be expected to be elevated. The significance of this finding is unknown. The VASST trial, an RCT comparing norepinephrine alone to norepinephrine plus vasopressin at 0.03 U/min, showed no difference in outcome in the intent-to-treat population (274). An a priori defined subgroup analysis demonstrated improved survival among patients receiving <15 μ g/min norepinephrine at randomization with the addition of vasopressin; however, the pretrial rationale for this stratification was based on exploring potential benefit in the population requiring ≥ 15 μ g/min norepinephrine. Higher doses of vasopressin have been associated with cardiac, digital, and splanchnic ischemia and should be reserved for situations in which alternative vasopressors have failed (275). In the VANISH trial, 409 patients with septic shock were randomized in a factorial (2×2) design to receive vasopressin with placebo or hydrocortisone, or norepinephrine with placebo or hydrocortisone. There was no significant difference in kidney failure-free days or death; however, the vasopressin group had less use of RRT (276). We conducted an updated meta-analysis to include the results of the VANISH trial. Data from nine trials ($n = 1,324$ patients with septic shock), comparing norepinephrine with vasopressin (or terlipressin) demonstrated no significant difference in mortality (RR, 0.89; 95% CI, 0.79–1.00; moderate-quality evidence) (Supplemental Digital Content 10, <http://links.lww.com/CCM/C331>) (268,271,272,277–279). Results were similar after excluding trials that used a combination of norepinephrine and vasopressin in the intervention arm (RR, 0.89; 95% CI, 0.77–1.02). Large studies comparing vasopressin to other vasopressors in septic shock are lacking; most of the data regarding vasopressin support a sparing effect on norepinephrine dose, and there is uncertainty about the effect of vasopressin on mortality. Norepinephrine, therefore, remains the first-choice vasopressor to treat patients with septic shock. We do not recommend the use of vasopressin as a first-line vasopressor for the support of MAP and would advocate caution when using it in patients who are not euvolemic or at doses higher than 0.03 U/min.

Phenylephrine is a pure α -adrenergic agonist. Clinical trial data in sepsis are limited. Phenylephrine has the potential to produce splanchnic vasoconstriction (280). A network meta-analysis resulted in imprecise estimates (wide confidence intervals) when phenylephrine was compared to other vasopressors (281). Therefore, the impact on clinical outcomes is uncertain, and phenylephrine use should be limited until more research is available.

A large, randomized trial and meta-analysis comparing low-dose dopamine to placebo found no difference in need for RRT, urine output, time to renal recovery, survival, ICU stay, hospital stay, or arrhythmias (282,283). Thus, the available data do not support administration of low doses of dopamine solely to maintain renal function.

Myocardial dysfunction consequent to infection occurs in a subset of patients with septic shock, but cardiac output is usually preserved by ventricular dilation, tachycardia, and reduced vascular resistance (284). Some portion of these patients may have diminished cardiac reserve and may not be able to achieve a cardiac output adequate to support oxygen delivery. Recognition of such reduced cardiac reserve can be challenging; imaging studies that show decreased ejection fraction may not necessarily indicate inadequate cardiac output. Concomitant measurement of cardiac output along with a measure of the adequacy of perfusion is preferable.

Routinely increasing cardiac output to predetermined “supranormal” levels in all patients clearly does not improve outcomes, as shown by two large prospective clinical trials of critically ill ICU patients with sepsis treated with dobutamine (285–287). Some patients, however, may have improved tissue perfusion with inotropic therapy aimed at increasing oxygen delivery. In this situation, dobutamine is the first-choice inotrope for patients with measured or suspected low cardiac output in the presence of adequate left ventricular filling pressure (or clinical assessment of adequate fluid resuscitation) and adequate MAP. Monitoring the response of indices of perfusion to measured increases in cardiac output is the best way to target such a therapy (287).

The data supporting dobutamine are primarily physiologic, with improved haemodynamics and some improvement in indices of perfusion, which may include clinical improvement, decreasing lactate levels, and improvement in ScvO₂. No randomized controlled trials have compared the effects of dobutamine versus placebo on clinical outcomes. Mortality in patients randomized to dobutamine added to norepinephrine was no different compared to epinephrine (287), although the trial may have been underpowered. Dobutamine was used as the first-line inotrope as part of standard care in clinical trials of EGDT (16,19,288,289), and adverse effects on mortality were not detected with its use.

Although there are only a few studies, alternative inotropic agents might be used to increase cardiac output in specific situations. Phosphodiesterase inhibitors increase intracellular cyclic AMP and thus have inotropic effects independent of β-adrenergic receptors. The phosphodiesterase inhibitor milrinone was shown to increase cardiac output in one small, randomized trial of 12 paediatric patients, but the trial was underpowered for assessment of outcomes (290). Levosimendan increases cardiac myocyte calcium responsiveness and opens ATP-dependent potassium channels, giving the drug both inotropic and vasodilatory properties. Given the potential role for abnormal calcium handling in sepsis-induced myocardial depression, the use of levosimendan has been proposed in septic shock as well. In a trial of 35 patients with septic shock and acute respiratory distress syndrome (ARDS) randomized to levosimendan or placebo, levosimendan improved right ventricular performance and mixed venous oxygen saturation compared to placebo (291). Trials comparing levosimendan with dobutamine are limited but show no clear advantage for levosimendan (292). Levosimendan is more expensive than dobutamine and is not available in many parts of the world. Six small RCTs (116 patients in total) compared levosimendan to dobutamine; pooled estimates showed no significant effect on mortality (RR, 0.83; 95% CI, 0.66–1.05; low quality) (Supplemental Digital Content 11, <http://links.lww.com/CCM/C332>). Given the low-quality evidence available and the higher cost associated with levosimendan, dobutamine remains the preferred choice in this population. An RCT enrolled 516 patients with septic shock who were randomized to receive either levosimendan or placebo; there was no difference in mortality. However, levosimendan led to significantly higher risk of supraventricular tachyarrhythmia than placebo (absolute difference, 2.7%; 95% CI, 0.1%–5.3%) (293). The results of this trial question the systematic use of this agent in patients with septic shock. Of note, cardiac function was not evaluated in that trial, and inotropic stimulation may be of benefit in patients with a low cardiac output due to impaired cardiac function.

In shock states, estimation of blood pressure using a cuff, especially an automated measurement system, may be inaccurate. Use of an arterial cannula provides a more accurate and reproducible measurement of arterial pressure (287,294) and allows beat-to-beat analysis so that decisions regarding therapy can be based on immediate and reproducible blood pressure information (295). Insertion of radial arterial catheters is generally safe; a systematic review of observational studies showed an incidence of limb ischemia and bleeding to be less than 1%, with the most common complication being localized hematoma (14%) (296). Complication rates may be lower if an ultrasound-guided technique is used (297). A recent systematic review showed higher risk of infections when femoral arterial catheters were used compared to radial artery catheters (RR, 1.93; 95% CI, 1.32–2.84), and the overall pooled incidence of bloodstream infection was 3.4 per 1,000 catheters (298). Large randomized trials that compare arterial blood pressure monitoring versus non-invasive methods are lacking.

In view of the low complication rate and likely better estimation of blood pressure but potentially limited resources in some countries, and the lack of high-quality studies, the benefits of arterial catheters probably outweigh the risks. Therefore, we issued a weak recommendation in favour of arterial catheter placement.

Arterial catheters should be removed as soon as continuous hemodynamic monitoring is not required to minimize the risk of complications.

Recommendation 33. (SSCG Section G, Recommendation 1).

We recommend norepinephrine as the first-choice vasopressor.

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 34. (SSCG Section G, Recommendation 2).

We suggest adding either vasopressin (up to 0.03 U/min) (weak recommendation, moderate quality of evidence) or epinephrine (weak recommendation, low quality of evidence) to norepinephrine with the intent of raising MAP to target or adding vasopressin (up to 0.03 U/min).

Quality/level of evidence: Moderate + **Strength of recommendation:** Weak

Recommendation 35. (SSCG Section G, Recommendation 3).

We suggest using dopamine as an alternative vasopressor agent to norepinephrine only in highly selected patients (e.g. patients with low risk of tachyarrhythmias and absolute or relative bradycardia).

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 36. (SSCG Section G, Recommendation 4).

We recommend against using low-dose dopamine for renal protection.

Quality/level of evidence: High + **Strength of recommendation:** Strong

Recommendation 37. (SSCG Section G, Recommendation 5).

We suggest using dobutamine in patients who show evidence of persistent hypoperfusion despite adequate fluid loading and the use of vasopressor agents.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Remarks: If initiated, vasopressor dosing should be titrated to an end point reflecting perfusion, and the agent reduced or discontinued in the face of worsening hypotension or arrhythmias

Recommendation 38. (SSCG Section G, Recommendation 6).

We suggest that all patients requiring vasopressors have an arterial catheter placed as soon as practical if resources are available.

Quality/level of evidence: Very low + **Strength of recommendation:** Weak

Recommendation 38a. (SSCG 2021, Recommendation 44).

We suggest starting vasopressors peripherally to restore mean arterial pressure rather than delaying initiation until central venous access is secured for patients with septic shock. See Appendix 17 (in this document) and refer to local guidelines [new 2025].

Quality/level of evidence: Low + **Strength of recommendation:** Weak [new 2025]

Implementation Point 18 (Recommendations 33-38a)

Patients who present with profound shock may require simultaneous pressor/inotrope and fluid administration. The end point of resuscitation is to restore flow rather than pressure, however, available monitors measure pressure rather than flow so surrogates are used which assess organ and tissue perfusion. These include urinary output, point of care lactate (venous or arterial), capillary refill, mental status and central venous oxygen saturations.

Persistently high serum lactates and central venous oxygen saturations despite adequate fluid resuscitation may represent established cellular dysfunction and an inability to extract or utilise oxygen rather than hypoperfusion due to sepsis or other causes (Andersen et al., 2013) and as such will not respond to further fluid administration. Lactate physiology is complex and should be used only as one of a number of markers of tissue perfusion.

The suggested approach to resuscitation is early aggressive fluid resuscitation aiming to restore tissue perfusion and then a conservative post resuscitation phase avoiding excessive fluid accumulation with careful monitoring of input and output and assessing for de-resuscitation by diuresis/fluid removal as soon as tolerated using perfusion parameters (Levy et al., 2018) (Yealy et al., 2014) (Mouncey et al., 2015) (Peake, 2014) (Wiedemann, 2006) (Hjortrup et al., 2016).

Roles and responsibilities (Implementation point 18)

Vasopressors and inotropes are most usually prescribed by critical care staff and unless familiar with them, it is prudent to obtain critical care support when starting them. Phenylephrine is not the first line pressor for septic shock (Rhodes et al., 2017). Noradrenaline is the first line agent. It has both α and β receptor effects, so it maintains cardiac output as well as having a vasoconstrictor effect. Phenylephrine, if used urgently as a temporary pressor, should be replaced by noradrenaline as soon as possible.

Starting vasopressors requires multidisciplinary support for central venous access, constitution and delivery of the vasopressors and aseptic technique.

It is the responsibility of hospital management to ensure the appropriate equipment and staff is available to provide this service.

It is the responsibility of the clinicians to be familiar with the procedures and to know the advantages and limitations of any advanced haemodynamic monitoring equipment deployed.

It is the responsibility of the hospital and laboratory management to ensure that all point of care equipment is subjected to laboratory governance and including internal quality control and external quality assurance.

3.1.6 Corticosteroids

Key question

- In patients with septic shock, should we use intravenous corticosteroids (versus not)?

SSCG Rationale

The response of septic shock patients to fluid and vasopressor therapy seems to be an important factor in selection of patients for optional hydrocortisone therapy. One French multicentre RCT of patients in vasopressor-unresponsive septic shock (systolic blood pressure < 90 mm Hg despite fluid resuscitation and vasopressors for more than one hour) showed significant shock reversal and reduction of mortality rate in patients with relative adrenal insufficiency (defined as a maximal post-adrenocorticotropic hormone [ACTH] cortisol increase $\leq 9 \mu\text{g}/\text{dL}$) (299). Two smaller RCTs also showed significant effects on shock reversal with steroid therapy (300,301). In contrast, a large, European multicentre trial (CORTICUS) that enrolled patients with systolic blood pressure of < 90 mm Hg despite adequate fluid replacement or need for vasopressors had a lower risk of death than the French trial and failed to show a mortality benefit with steroid therapy (302). There was no difference in mortality in groups stratified by ACTH response.

Several systematic reviews have examined the use of low-dose hydrocortisone in septic shock with contradictory results. Annane et al (299) analysed the results of 12 studies and calculated a significant reduction in 28-day mortality with prolonged low-dose steroid treatment in adult septic shock patients (RR, 0.84; 95% CI, 0.72–0.97; $p = 0.02$). In parallel, Sligl et al (303) used a similar technique, but identified only eight studies for their meta-analysis, six of which had a high-level RCT design with low risk of bias. In contrast to the aforementioned review, this analysis revealed no statistically significant difference in mortality (RR, 1.00; 95% CI, 0.84–1.18).

Both reviews, however, confirmed the improved shock reversal by using low-dose hydrocortisone. More recently, Annane et al included 33 eligible trials ($n = 4,268$) in a new systematic review (304). Of these 33 trials, 23 were at low risk of selection bias; 22 were at low risk of performance and detection bias; 27 were at low risk of attrition bias; and 14 were at low risk of selective reporting. Corticosteroids reduced 28-day mortality (27 trials; $n = 3,176$; RR, 0.87; 95% CI, 0.76–1.00). Treatment with a long course of low-dose corticosteroids significantly reduced 28-day mortality (22 trials; RR, 0.87; 95% CI, 0.78–0.97). Corticosteroids also reduced ICU mortality (13 trials; RR, 0.82; 95% CI, 0.68–1.00) and in hospital mortality (17 trials; RR, 0.85; 95% CI, 0.73–0.98). Corticosteroids increased the proportion of shock reversal by day 7 (12 trials; RR, 1.31; 95% CI, 1.14–1.51) and by day 28 (7 trials; $n = 1,013$; RR, 1.11; 95% CI, 1.02–1.21). Finally, an additional systematic review by Volbeda et al including a total of 35 trials randomizing 4,682 patients has been published (all but two trials had high risk of bias) (305). Conversely, in this review, no statistically significant effect on mortality was found for any dose of steroids versus placebo or for no intervention at maximal follow-up. The two trials with low risk of bias also showed no statistically significant difference (random-effects model RR, 0.38; 95% CI, 0.06–2.42). Similar results were obtained in subgroups of trials stratified according to hydrocortisone (or equivalent) at high (> 500 mg) or low (≤ 500 mg) doses (RR, 0.87; trial sequential analysis [TSA]-adjusted CI; 0.38–1.99; and RR, 0.90; TSA-adjusted CI, 0.49–1.67, respectively). No statistically significant effects on serious adverse events other than mortality were reported (RR, 1.02; TSA-adjusted CI, 0.7–1.48). In the absence of convincing evidence of benefit, we issue a weak recommendation against the use of corticosteroids to treat septic shock patients if adequate fluid resuscitation and vasopressor therapy are able to restore hemodynamic stability.

In one study, the observation of a potential interaction between steroid use and ACTH test was not statistically significant (306). Furthermore, no evidence of this distinction was observed between responders and non-responders in a recent multicentre trial (302). Random cortisol levels may still be useful for absolute adrenal insufficiency; however, for septic shock patients who have relative adrenal insufficiency (no adequate stress response), random cortisol levels have not been demonstrated to be useful. Cortisol immunoassays may overestimate or underestimate the actual cortisol level, affecting the assignment of patients to responders or non-responders (307). Although the clinical significance is not clear, it is now recognized that etomidate, when used for induction for intubation, will suppress the hypothalamic-pituitary-adrenal axis (308,309). Moreover, a sub analysis of the CORTICUS trial revealed that the use of etomidate before application of low-dose steroids was associated with an increased 28-day mortality rate (302).

There has been no comparative study between a fixed-duration and clinically guided regimen or between tapering and abrupt cessation of steroids. Three RCTs used a fixed-duration protocol for treatment (300,302,306), and therapy was decreased after shock resolution in two RCTs (301,310). In four studies, steroids were tapered over several days (300–302, 310) and steroids were withdrawn abruptly in two RCTs (306,311). One crossover study showed hemodynamic and immunologic rebound effects after abrupt cessation of corticosteroids (312). Further, one study revealed no difference in outcome of septic shock patients if low-dose hydrocortisone is used for 3 or 7 days; hence, we suggest tapering steroids when vasopressors are no longer needed (313).

Steroids may be indicated when there is a history of steroid therapy or adrenal dysfunction, but whether low-dose steroids have a preventive potency in reducing the incidence of sepsis and septic shock in critically ill patients cannot be answered. A recent large multicentre RCT demonstrated no reduction in the development of septic shock in septic patients treated with hydrocortisone versus placebo (314); steroids should not be used in septic patients to prevent septic shock. Additional studies are underway that may provide additional information to inform clinical practice.

Several randomized trials on the use of low-dose hydrocortisone in septic shock patients revealed a significant increase of hyperglycaemia and hypernatremia (306) as side effects. A small prospective study demonstrated that repetitive bolus application of hydrocortisone leads to a significant increase in blood glucose; this peak effect was not detectable during continuous infusion. Further, considerable inter-individual variability was seen in this blood glucose peak after the hydrocortisone bolus (315). Although an association of hyperglycaemia and hypernatremia with patient outcome measures could not be shown, good practice includes strategies for avoidance and/or detection of these side effects.

Recommendation 39. (SSCG Section H, Recommendation 1).

We suggest against using IV hydrocortisone to treat septic shock patients if adequate fluid resuscitation and vasopressor therapy are able to restore hemodynamic stability. If this is not achievable, we suggest IV hydrocortisone at a dose of 200 mg per day (weak recommendation, low quality of evidence).

Quality/level of evidence: Low

+ Strength of recommendation: Weak

Implementation Point 19 (Recommendation 39)

Patients with fluid resistant, pressor-resistant shock should have a trial of IV hydrocortisone 50mg qds or by continuous infusion, consider adding fludrocortisone 50 micrograms once daily orally or via nasogastric tube (Annane, 2011) (Keh et al., 2016).

Do not routinely give systemic corticosteroids for the treatment of sepsis without shock outside of clinical trials unless they are indicated for other reasons.

Roles and Responsibilities

It is the responsibility of the clinicians to be familiar with the procedures and to know the advantages and limitations of corticosteroids in the treatment of septic shock.

3.1.7 Blood Products**Key questions**

- In patients with sepsis, should we use a restrictive transfusion strategy versus liberal transfusion?
- In patients with sepsis and anemia, should we use erythropoietin to treat anemia?
- In non-bleeding patients with sepsis and coagulation abnormalities, should we use prophylactic FFP?
- In non-bleeding patients with sepsis and thrombocytopenia, should we use prophylactic platelet transfusion based on specific platelet levels?

SSCG Rationale

Two clinical trials in septic patients evaluated specific blood transfusion thresholds. The Transfusion Requirements In Septic Shock (TRISS) trial addressed a transfusion threshold of 7 g/dL versus 9 g/dL in septic shock patients after admission to the ICU (316). Results showed similar 90-day mortality, ischemic events, and use of life support in the two treatment groups with fewer transfusions in the lower-threshold group. The haemoglobin targets in two of the three treatment arms in the Protocol-Based Care for Early Septic Shock (ProCESS) trial were a subpart of a more comprehensive sepsis management strategy (18). The EGDT group received transfusion at a hematocrit < 30% (haemoglobin 10 g/dL) when the ScvO₂ was < 70% after initial resuscitation interventions compared to the protocol-based standard care group that received blood transfusion only when the haemoglobin was < 7.5 g/dL. No significant differences were found between the two groups for 60-day in-hospital mortality or 90-day mortality. Although the ProCESS trial is a less direct assessment of blood transfusion therapy, it does provide important information in regard to transfusion in the acute resuscitative phase of sepsis. We judge the evidence to be high certainty that there is little difference in mortality, and, if there is, that it would favour lower haemoglobin thresholds.

No specific information regarding erythropoietin use in septic patients is available, and clinical trials of erythropoietin administration in critically ill patients show a small decrease in red cell transfusion requirement with no effect on mortality (317,318). The effect of erythropoietin in sepsis and septic shock would not be expected to be more beneficial than in other critical conditions. Erythropoietin administration may be associated with an increased incidence of thrombotic events in the critically ill.

Patients with sepsis and septic shock may have coexisting conditions that meet indications for the use of erythropoietin or similar agents.

No RCTs exist related to prophylactic fresh frozen plasma transfusion in septic or critically ill patients with coagulation abnormalities. Current recommendations are based primarily on expert opinion that fresh frozen plasma be transfused when there is a documented deficiency of coagulation factors (increased prothrombin time, international normalized ratio, or partial thromboplastin time) and the presence of active bleeding or before surgical or invasive procedures (319). In addition, transfusion of fresh frozen plasma usually fails to correct the prothrombin time in nonbleeding patients with mild abnormalities. No studies suggest that correction of more severe coagulation abnormalities benefits patients who are not bleeding.

No RCTs of prophylactic platelet transfusion in septic or critically ill patients exist. Current recommendations and guidelines for platelet transfusion are based on clinical trials of prophylactic platelet transfusion in patients with therapy-induced thrombocytopenia (usually leukaemia and stem cell transplant) (320-327). Thrombocytopenia in sepsis is likely due to a different pathophysiology of impaired platelet production and increased platelet consumption. Factors that may increase the bleeding risk and indicate the need for a higher platelet count are frequently present in patients with sepsis.

Recommendation 40. (SSCG Section I, Recommendation 1).

We recommend that Red Blood Cell (RBC) transfusion occur only when hemoglobin concentration decreases to < 7.0g/dL in adults in the absence of extenuating circumstances, such as myocardial ischemia, severe hypoxemia, or acute hemorrhage.

Quality/level of evidence: High **+ Strength of recommendation:** Strong

Recommendation 41. (SSCG Section I, Recommendation 2).

We **recommend against** the use of erythropoietin for treatment of anemia associated with sepsis.

Quality/level of evidence: Moderate **+ Strength of recommendation:** Strong

Recommendation 42. (SSCG Section I, Recommendation 3).

We **suggest against** the use of fresh frozen plasma* to correct clotting abnormalities in the absence of bleeding or planned invasive procedures.

*Known as frozen plasma in Ireland and often by a tradename.

Quality/level of evidence: Very low **+ Strength of recommendation:** Weak

Recommendation 43. (SSCG Section I, Recommendation 4).

We suggest prophylactic platelet transfusion when counts are < $10 \times 10^9/L$ (10,000/mm³) in the absence of apparent bleeding and when counts are < $20 \times 10^9/L$ (20,000/mm³) if the patient has a significant risk of bleeding. Higher platelet counts $\geq 50 \times 10^9/L$ (50,000/mm³) are advised for active bleeding, surgery, or invasive procedures

Quality/level of evidence: Very low **+ Strength of recommendation:** Weak

3.1.8 Immunoglobulins

Key question

- In adult patients with sepsis or septic shock, should we use intravenous immunoglobulins (versus not)?

SSCG Rationale

There were no new studies informing this guideline recommendation. One larger multicentre RCT ($n = 624$) (328) in adult patients found no benefit for IV immunoglobulin (IVIg). The most recent Cochrane meta-analysis (329) differentiates between standard polyclonal IV immunoglobulins (IVIgG) and immunoglobulin M-enriched polyclonal Ig (IVIgGM). In 10 studies with IVIgG (1,430 patients), mortality between 28 and 180 days was 29.6% in the IVIgG group and 36.5 % in the placebo-group (RR, 0.81; 95% CI, 0.70–0.93), and for the seven studies with IVIgGM (528 patients), mortality between 28 and 60 days was 24.7% in the IVIgGM group and 37.5% in the placebo-group (RR, 0.66; 95% CI, 0.51–0.85). The certainty of the studies was rated as low for the IVIgG trials, based on risk of bias and heterogeneity, and as moderate for the IVIgGM trials, based on risk of bias. Comparable results were found in other meta-analyses (330). However, after excluding low-quality trials, the recent Cochrane analysis (329) revealed no survival benefit.

These findings are in accordance with those of two older meta-analyses (331,332) from other Cochrane authors. One systematic review (332) included a total of 21 trials and showed a reduction in death with immunoglobulin treatment (RR, 0.77; 95% CI, 0.68–0.88); however, the results of only high-quality trials (total of 763 patients) did not show a statistically significant difference (RR, 1.02; 95% CI, 0.84–1.24). Similarly, Laupland et al. (331) found a significant reduction in mortality with the use of IVIg treatment (OR, 0.66; 95% CI, 0.53–0.83; $p < 0.005$). When only high-quality studies were pooled, the results were no longer statistically significant (OR, 0.96); OR for mortality was 0.96 (95% CI, 0.71–1.3; $p = 0.78$). Two meta-analyses that used less strict criteria to identify sources of bias or did not state their criteria for the assessment of study quality found significant improvement in patient mortality with IVIg treatment (333–335). Finally, there are no cut-offs for plasma IgG levels in septic patients, for which substitution with IVIgG improves outcome data (334).

Most IVIg studies are small, and some have a high risk of bias; the only large study ($n = 624$) showed no effect (328). Subgroup effects between IgM-enriched and non-enriched formulations reveal significant heterogeneity. Indirectness and publication bias were considered, but not invoked in grading this recommendation. The low certainty of evidence led to the grading as a weak recommendation. The statistical information that comes from the high-quality trials does not support a beneficial effect of polyclonal IVIg. We encourage conduct of large multicentre studies to further evaluate the effectiveness of other IV polyclonal immunoglobulin preparations in patients with sepsis.

Recommendation 44. (SSCG Section J, Recommendation 1).

We suggest against the use of IV immunoglobulins in patients with sepsis or septic shock.

Quality/level of evidence: Low

+ Strength of recommendation: Weak

3.1.9 Blood purification

Key questions

- In patients with sepsis, should we use plasma filtration therapy?
- In patients with sepsis, should we use a hemoperfusion therapy?

SSCG Rationale

Blood purification includes various techniques, such as high-volume hemofiltration and hemadsorption (or hemoperfusion), where sorbents, removing either endotoxin or cytokines, are placed in contact with blood; plasma exchange or plasma filtration, through which plasma is separated from whole blood, removed, and replaced with normal saline, albumin, or fresh frozen plasma; and the hybrid system: coupled plasma filtration adsorption (CPFA), which combines plasma filtration and adsorption by a resin cartridge that removes cytokines. When these modalities of blood purification are considered versus conventional treatment, the available trials are, overall, small, unblinded, and with high risk of bias. Patient selection was unclear and differed with the various techniques. Hemadsorption is the technique most largely investigated, in particular with polymyxin B-immobilized polystyrene-derived fibres to remove endotoxin from the blood. A recent meta-analysis demonstrated a favourable effect on overall mortality with this technique (336). The composite effect, however, depends on a series of studies performed in a single country (Japan), predominantly by one group of investigators. A recent large RCT performed on patients with peritonitis related to organ perforation within 12 hours after emergency surgery found no benefit of polymyxin B hemoperfusion on mortality and organ failure, as compared to standard treatment (337). Illness severity of the study patients, however, was low overall, which makes these findings questionable. A multicentre blinded RCT is ongoing, which should provide stronger evidence regarding this technique (338).

Few RCTs evaluated plasma filtration, alone or combined with adsorption for cytokine removal (CPFA). A recent RCT comparing CPFA with standard treatment was stopped for futility (339). About half of the patients randomized to CPFA were undertreated, primarily because of clotting of the circuit, which raises doubts about CPFA feasibility.

In consideration of all these limitations, our confidence in the evidence is very low either in favour of or against blood purification techniques; therefore, we do not provide a recommendation. Further research is needed to clarify the clinical benefit of blood purification techniques.

Recommendation 45. (SSCG Section K, Recommendation 1).

We make no recommendation regarding the use of blood purification techniques.

Quality/level of evidence: N/A + Strength of recommendation: N/A

3.1.10 Anticoagulants

Key question

- In adult patients with sepsis or septic shock, should we use antithrombin (versus not)?

SSCG Rationale

Antithrombin is the most abundant anticoagulant circulating in plasma. The decrease of its plasma activity at onset of sepsis correlates with disseminated intravascular coagulation (DIC) and lethal outcome. However, a phase III clinical trial of high dose antithrombin for adults with sepsis and septic shock as well as systematic reviews of antithrombin for critically ill patients did not demonstrate any beneficial effect on overall mortality. Antithrombin was associated with an increased risk of bleeding (340,341). Although post hoc subgroup analyses of patients with sepsis associated with DIC showed better survival in patients receiving antithrombin, this agent cannot be recommended until further clinical trials are performed.

Most RCTs of recombinant soluble thrombomodulin have been targeted for sepsis associated with DIC, and a systematic review suggested a beneficial effect on survival without an increase of bleeding risk (342,343). A phase III RCT is ongoing for sepsis associated with DIC. The guideline panel has elected to make no recommendation pending these new results. Two systematic reviews showed a potential survival benefit of heparin in patients with sepsis without an increase in major bleeding (344). However, overall impact remains uncertain, and heparin cannot be recommended until further RCTs are performed.

Recombinant activated protein C, which was originally recommended in the 2004 and 2008 SSC guidelines, was not shown to be effective for adult patients with septic shock by the PROWESS-SHOCK trial and was withdrawn from the market (345).

Recommendation 46. (SSCG Section L, Recommendation 1).

We recommend against the use of antithrombin for the treatment of sepsis and septic shock

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 47. (SSCG Section L, Recommendation 2).

We make no recommendation regarding the use of thrombomodulin or heparin for the treatment of sepsis or septic shock.

Quality/level of evidence: N/A

+ **Strength of recommendation:** N/A

3.1.11 Mechanical Ventilation

Key questions

- In patients with sepsis induced ARDS, should we use low tidal volume ventilation?
- In patients with sepsis induced ARDS who are mechanically ventilated, should we use plateau pressures less than 30 cm H₂O?
- In patients with sepsis induced ARDS who are mechanically ventilated, should we use high PEEP strategy?
- In patients with sepsis induced ARDS, should we use recruitment manoeuvres?
- In patients with sepsis induced severe ARDS, should we use prone ventilation?
- In patients with sepsis who are mechanically ventilated, should we elevate the head of the bed?
- In patients with sepsis induced ARDS, should we use non-invasive ventilation?
- In patients with sepsis who are mechanically ventilated and ready for weaning, should we use weaning protocol versus physician guided weaning?
- In patients with sepsis who are mechanically ventilated and ready for weaning, should we use spontaneous breathing trials (SBT)?
- In patients with sepsis induced ARDS, should we use a Pulmonary Artery Catheter (PAC)?
- In patients with sepsis induced ARDS, should we use a conservative fluid strategy?
- In patients with sepsis induced ARDS, should we use inhaled Beta agonists?
- In patients with sepsis induced ARDS, should we use ECMO treatment?
- In patients with sepsis induced ARDS, should we use High Frequency Oscillation (HFO) versus conventional ventilation?
- In patients with sepsis induced respiratory failure without ARDS, should we use low tidal volume ventilation?
- In patients with severe ARDS who are mechanically ventilated, should we use neuromuscular blocking agents?

SSCG Rationale

This recommendation is unchanged from the previous guidelines. Of note, the studies that guide the recommendations in this section enrolled patients using criteria from the American-European Consensus Criteria Definition for Acute Lung Injury and ARDS (346). For the current document, we used the 2012 Berlin definition and the terms mild, moderate, and severe ARDS ($\text{PaO}_2/\text{FIO}_2 \leq 300$, ≤ 200 , and ≤ 100 mm Hg, respectively) (347). Several multicentre randomized trials have been performed in patients with established ARDS to evaluate the effects of limiting inspiratory pressure through moderation of tidal volume (348-351). These studies showed differing results, which may have been caused by differences in airway pressures in the treatment and control groups (347,350,352). Several meta-analyses suggest decreased mortality in patients with a pressure- and volume-limited strategy for established ARDS (353,354).

The largest trial of a volume- and pressure-limited strategy showed 9% absolute decrease in mortality in ARDS patients ventilated with tidal volumes of 6 mL/kg compared with 12 mL/kg PBW and aiming for plateau pressure ≤ 30 cm H₂O (350). The use of lung-protective strategies for patients with ARDS is supported by clinical trials and has been widely accepted; however, the precise tidal volume for an individual ARDS patient requires adjustment for factors such as the plateau pressure, the selected positive end-expiratory pressure (PEEP), thoracoabdominal compliance, and the patient's breathing effort. Patients with profound metabolic acidosis, high minute ventilation, or short stature may require additional manipulation of tidal volumes. Some clinicians believe it may be safe to ventilate with tidal volumes > 6 mL/kg PBW as long as plateau pressure can be maintained ≤ 30 cm H₂O (355),356). The validity of this ceiling value will depend on the patient's effort because those who are actively breathing generate higher transpulmonary pressures for a given plateau pressure than patients who are passively inflated. Conversely, patients with very stiff chest/abdominal walls and high pleural pressures may tolerate plateau pressures > 30 cm H₂O because transpulmonary pressures will be lower. A retrospective study suggested that tidal volumes should be lowered even with plateau pressures ≤ 30 cm H₂O (357) because lower plateau pressures were associated with reduced hospital mortality (358). A recent patient-level mediation analysis suggested that a tidal volume that results in a driving pressure (plateau pressure minus set PEEP) below 12–15 cm H₂O may be advantageous in patients without spontaneous breathing efforts (359). Prospective validation of tidal volume titration by driving pressure is needed before this approach can be recommended. High tidal volumes coupled with high plateau pressures should be avoided in ARDS. Clinicians should use as a starting point the objective of reducing tidal volume over 1 to 2 hours from its initial value toward the goal of a "low" tidal volume (≈ 6 mL/kg PBW) achieved in conjunction with an end-inspiratory plateau pressure ≤ 30 cm H₂O. If plateau pressure remains > 30 cm H₂O after reduction of tidal volume to 6 mL/kg PBW, tidal volume may be further reduced to as low as 4 mL/kg PBW. Respiratory rate should be increased to a maximum of 35 breaths/minute during tidal volume reduction to maintain minute ventilation. Volume- and pressure-limited ventilation may lead to hypercapnia even with these maximum tolerated set respiratory rates; this appears to be tolerated and safe in the absence of contraindications (e.g., high intracranial pressure, sickle cell crisis).

No single mode of ventilation (pressure control, volume control) has consistently been shown to be advantageous when compared with any other that respects the same principles of lung protection.

Raising PEEP in ARDS may open lung units to participate in gas exchange. This may increase PaO₂ when PEEP is applied through either an endotracheal tube or a face mask (360-362). In animal experiments, avoidance of end-expiratory alveolar collapse helps minimize ventilator-induced lung injury when relatively high plateau pressures are in use. Three large multicentre trials and a pilot trial using higher versus lower levels of PEEP in conjunction with low tidal volumes did not show benefit or harm (363-366). A patient-level meta-analysis showed no benefit in all patients with ARDS; however, patients with moderate or severe ARDS ($\text{PaO}_2/\text{FIO}_2 \leq 200$ mm Hg) had decreased mortality with the use of higher PEEP, whereas those with mild ARDS did not (367). A patient-level analysis of two of the randomized PEEP trials suggested a survival benefit if $\text{PaO}_2/\text{FIO}_2$ increased with higher PEEP and harm if $\text{PaO}_2/\text{FIO}_2$ fell (368). A small, randomized trial suggested that adjusting PEEP to

obtain a positive transpulmonary pressure as estimated by oesophageal manometry improved outcomes; a confirmatory trial is underway (369). An analysis of nearly all the randomized trials of lung-protective ventilation suggested a benefit of higher PEEP if driving pressure fell with increased PEEP, presumably indicating increased lung compliance from opening of lung units (359).

While moderate-quality evidence suggests that higher PEEP improves outcomes in moderate to severe ARDS, the optimal method for selecting a higher PEEP level is unclear. One option is to titrate PEEP according to bedside measurements of thoracopulmonary compliance with the objective of obtaining the best compliance or lowest driving pressure, reflecting a favourable balance of lung recruitment and overdistension (370). The second option is to titrate PEEP upward on a tidal volume of 6 mL/kg PBW until the plateau airway pressure is 28 cm H₂O (365). A third option is to use a PEEP/FIO₂ titration table that titrates PEEP based on the combination of FIO₂ and PEEP required to maintain adequate oxygenation (350, 363-365,368). A PEEP > 5 cm H₂O is usually required to avoid lung collapse (371).

Many strategies exist for treating refractory hypoxemia in patients with severe ARDS (372). Temporarily raising transpulmonary pressure may facilitate opening atelectatic alveoli to permit gas exchange (371), but could also over distend aerated lung units, leading to ventilator-induced lung injury and transient hypotension. The application of sustained continuous positive airway pressure (CPAP) appears to improve survival (RR, 0.84; 95% CI, 0.74–0.95) and reduce the occurrence of severe hypoxia requiring rescue therapy (RR, 0.76; 95% CI, 0.41–1.40) in patients with ARDS. Although the effects of recruitment manoeuvres improve oxygenation initially, the effects can be transient (373). Selected patients with severe hypoxemia may benefit from recruitment manoeuvres in conjunction with higher levels of PEEP, but little evidence supports the routine use in all ARDS patients (373). Any patient receiving this therapy should be monitored closely and recruitment manoeuvres discontinued if deterioration in clinical variables is observed.

In patients with ARDS and a PaO₂/FIO₂ ratio < 150, the use of prone compared with supine position within the first 36 hours of intubation, when performed for > 16 hours a day, showed improved survival (374). Meta-analysis including this study demonstrated reduced mortality in patients treated with prone compared with supine position (RR, 0.85; 95% CI, 0.71–1.01) as well as improved oxygenation as measured by change in PaO₂/FIO₂ ratio (median 24.03 higher, 95% CI, 13.3–34.7 higher) (375). Most patients respond to the prone position with improved oxygenation and may also have improved lung compliance (374,376-379). While prone position may be associated with potentially life-threatening complications including accidental removal of the endotracheal tube, this was not evident in pooled analysis (RR, 1.09; 95% CI, 0.85–1.39). However, prone position was associated with an increase in pressure sores (RR, 1.37; 95% CI, 1.05–1.79) (375), and some patients have contraindications to the prone position (374).

In patients with refractory hypoxia, alternative strategies, including airway pressure release ventilation and extracorporeal membrane oxygenation, may be considered as rescue therapies in experienced centres (372, 380-383).

HFOV has theoretical advantages that make it an attractive ventilator mode for patients with ARDS. Two large RCTs evaluating routine HFOV in moderate-severe ARDS have been recently published (384,385). One trial was stopped early because the mortality was higher in patients randomized to HFOV (384). Including these recent studies, a total of five RCTs (1,580 patients) have examined the role of HFOV in ARDS. Pooled analysis demonstrates no effect on mortality (RR, 1.04; 95% CI, 0.83–1.31) and an increased duration of mechanical ventilation (MD, 1.1 days higher; 95% CI, 0.03–2.16) in patients randomized to HFOV. An increase in barotrauma was seen in patients receiving HFOV (RR, 1.19; 95% CI, 0.83–1.72); however, this was based on very low-quality evidence.

The role of HFOV as a rescue technique for refractory ARDS remains unclear; however, we recommend against its early use in moderate-severe ARDS given the lack of demonstrated benefit and a potential signal for harm. NIV may have theoretical benefits in patients with sepsis-induced respiratory failure, such as better

communication abilities, reduced need for sedation, and avoidance of intubation. However, NIV may preclude the use of low tidal volume ventilation or achieving adequate levels of PEEP, two ventilation strategies that have shown benefit even in mild-moderate ARDS (365,386). Also, in contrast to indications such as cardiogenic pulmonary oedema or chronic obstructive pulmonary disease exacerbation where NIV use is brief, ARDS often takes days or weeks to improve, and prolonged NIV use may lead to complications such as facial skin breakdown, inadequate nutritional intake, and failure to rest respiratory muscles.

A few small RCTs have shown benefit with NIV for early or mild ARDS or de novo hypoxic respiratory failure; however, these were in highly selected patient populations (387,388). More recently, a larger RCT in patients with hypoxic respiratory failure compared NIV to traditional oxygen therapy or high-flow nasal cannula (389). This study demonstrated improved 90-day survival with high-flow oxygen compared with standard therapy or NIV; however, the NIV technique was not standardized, and the experience of the centres varied. Although high-flow oxygen has not been addressed here, it is possible that this technique may play a more prominent role in the treatment of hypoxic respiratory failure and ARDS moving forward.

Given the uncertainty regarding whether clinicians can identify ARDS patients in whom NIV might be beneficial, we have not made a recommendation for or against this intervention. If NIV is used for patients with ARDS, we suggest close monitoring of tidal volumes.

The most common indication for NMBA use in the ICU is to facilitate mechanical ventilation (390). When appropriately used, these agents may improve chest wall compliance, prevent respiratory dyssynchrony, and reduce peak airway pressures (391). Muscle paralysis may also reduce oxygen consumption by decreasing the work of breathing and respiratory muscle blood flow (392). However, a placebo-controlled RCT in patients with severe sepsis demonstrated that oxygen delivery, oxygen consumption, and gastric intramucosal pH were not improved during deep neuromuscular blockade (393).

An RCT of continuous infusions of cisatracurium in patients with early ARDS and a $\text{PaO}_2/\text{FIO}_2 < 150 \text{ mm Hg}$ showed improved adjusted survival rates and more organ failure-free days without an increased risk in ICU-acquired weakness compared with placebo-treated patients (394). The investigators used a high fixed dose of cisatracurium without train-of-four monitoring; half of the patients in the placebo group received at least a single NMBA dose. Of note, groups in both the intervention and control groups were ventilated with volume-cycled and pressure-limited mechanical ventilation. Although many of the patients in this trial appeared to meet sepsis criteria, it is not clear whether similar results would occur in sepsis patients or in patients ventilated with alternate modes. Pooled analysis including three trials that examined the role of NMBA in ARDS, including the one above, showed improved survival (RR, 0.72; 95% CI, 0.58–0.91) and a decreased frequency of barotrauma (RR, 0.43; 95% CI, 0.20–0.90) in those receiving NMBA (395).

An association between NMBA use and myopathies and neuropathies has been suggested by case studies and prospective observational studies in the critical care population (391,396–399), but the mechanisms by which NMBA produce or contribute to myopathies and neuropathies in these patients are unknown. Pooled analysis of the RCT data did not show an increase in neuromuscular weakness in those who received NMBA (RR, 1.08; 95% CI, 0.83–1.41); however, this was based on very low quality of evidence (395). Given the uncertainty that still exists pertaining to these important outcomes and the balance between benefits and potential harms, the panel decided that a weak recommendation was most suitable. If NMBA are used, clinicians must ensure adequate patient sedation and analgesia (400,401); recently updated clinical practice guidelines are available for specific guidance (402).

Mechanisms for the development of pulmonary oedema in patients with ARDS include increased capillary permeability, increased hydrostatic pressure, and decreased oncotic pressure (403). Small prospective studies in patients with critical illness and ARDS have suggested that low weight gain is associated with improved oxygenation (404) and fewer days of mechanical ventilation (405,406). A fluid-conservative strategy to minimize

fluid infusion and weight gain in patients with ARDS, based on either a CVP or a pulmonary artery (PA) catheter (PA wedge pressure) measurement, along with clinical variables to guide treatment, led to fewer days of mechanical ventilation and reduced ICU LOS without altering the incidence of renal failure or mortality rates (407). This strategy was only used in patients with established ARDS, some of whom had shock during their ICU stay, and active attempts to reduce fluid volume were conducted only outside periods of shock.

Patients with sepsis-induced ARDS often develop increased vascular permeability; preclinical data suggest that β -adrenergic agonists may hasten resorption of alveolar oedema (408). Three RCTs (646 patients) evaluated β -agonists in patients with ARDS (408-410). In two of these trials, salbutamol (15 μ g/kg of ideal body weight) delivered intravenously (408,409) was compared with placebo, while the third trial compared inhaled albuterol versus placebo (410). Group allocation was blinded in all three trials, and two trials were stopped early for futility or harm (409,411). More than half of the patients enrolled in all three trials had pulmonary or non-pulmonary sepsis as the cause of ARDS.

Pooled analysis suggests β -agonists may reduce survival to hospital discharge in ARDS patients (RR, 1.22; 95% CI, 0.95–1.56) while significantly decreasing the number of ventilator-free days (MD, –2.19; 95% CI, –3.68 to –0.71) (412). β -agonist use also led to more arrhythmias (RR, 1.97; 95% CI, 0.70–5.54) and more tachycardia (RR, 3.95; 95% CI, 1.41–11.06).

β -2 agonists may have specific indications in the critically ill, such as the treatment of bronchospasm and hyperkalaemia. In the absence of these conditions, we recommend against the use of β -agonists, either in IV or aerosolized form, for the treatment of patients with sepsis-induced ARDS.

This recommendation is unchanged from the previous guidelines. Although insertion of a PA catheter may provide useful information regarding volume status and cardiac function, these benefits may be confounded by differences in interpretation of the results (413,414), poor correlation of PA occlusion pressures with clinical response (415), and lack of a PA catheter-based strategy demonstrated to improve patient outcomes (416). Pooled analysis of two multicentre randomized trials, one with 676 patients with shock or ARDS (417) and another with 1,000 patients with ARDS (418), failed to show any benefit associated with PA catheter use on mortality (RR, 1.02; 95% CI, 0.96–1.09) or ICU LOS (mean difference 0.15 days longer; 95% CI, 0.74 days fewer – 1.03 days longer) (407,419-421) This lack of demonstrated benefit must be considered in the context of the increased resources required. Notwithstanding, selected sepsis patients may be candidates for PA catheter insertion if management decisions depend on information solely obtainable from PA catheter measurements.

Low tidal volume ventilation (4–6 mL/kg) has been shown to be beneficial in patients with established ARDS (422) by limiting ventilator-induced lung injury. However, the effect of volume- and pressure-limited ventilation is less clear in patients with sepsis who do not have ARDS. Meta-analysis demonstrates the benefits of low tidal volume ventilation in patients without ARDS, including a decrease in the duration of mechanical ventilation (MD, 0.64 days fewer; 95% CI, 0.49–0.79) and the decreased development of ARDS (RR, 0.30; 95% CI, 0.16–0.57) with no impact on mortality (RR, 0.95; 95% CI, 0.64–1.41). Importantly, the certainty in this data is limited by indirectness because the included studies varied significantly in terms of populations enrolled, mostly examining perioperative patients and very few focusing on ICU patients. The use of low tidal volumes in patients who undergo abdominal surgery, which may include sepsis patients, has been shown to decrease the incidence of respiratory failure, shorten LOS, and result in fewer postoperative episodes of sepsis (423). Subgroup analysis of only the studies that enrolled critically ill patients (424) suggests similar benefits of low tidal volume ventilation on duration of mechanical ventilation and development of ARDS but is further limited by imprecision given the small number of studies included. Despite these methodologic concerns, the benefits of low tidal volume ventilation in patients without ARDS are thought to outweigh any potential harm. Planned RCTs may inform future practice.

The semi-recumbent position has been demonstrated to decrease the incidence of VAP (425). Enteral feeding increased the risk of developing VAP; 50% of the patients who were fed enterally in the supine position

developed VAP, compared with 9% of those fed in the semi-recumbent position (425). However, the bed position was monitored only once a day, and patients who did not achieve the desired bed elevation were not included in the analysis (425). One study did not show a difference in incidence of VAP between patients maintained in supine and semi-recumbent positions (426); patients assigned to the semi-recumbent group did not consistently achieve the desired head-of-bed elevation, and the head-of-bed elevation in the supine group approached that of the semi-recumbent group by day 7 (426). When necessary, patients may be laid flat when indicated for procedures, hemodynamic measurements, and during episodes of hypotension. Patients should not be fed enterally while supine. There were no new published studies since the last guidelines that would inform a change in the strength of the recommendation for the current iteration. The evidence profile for this recommendation demonstrated low quality of evidence. The lack of new evidence, along with the low harms of head-of-bed and high feasibility of implementation given the frequency of the practice resulted in the strong recommendation. There is a small subgroup of patients, such as trauma patients with a spine injury, for whom this recommendation would not apply.

Spontaneous breathing trial options include a low level of pressure support, CPAP (≈ 5 cm H₂O), or use of a T-piece. A recently published clinical practice guideline suggests the use of inspiratory pressure augmentation rather than T-piece or CPAP for an initial spontaneous breathing trial for acutely hospitalized adults on mechanical ventilation for more than 24 hours (427). Daily spontaneous breathing trials in appropriately selected patients reduce the duration of mechanical ventilation and weaning duration both in individual trials as well as with pooled analysis of the individual trials (428–430). These breathing trials should be conducted in conjunction with a spontaneous awakening trial (431). Successful completion of spontaneous breathing trials leads to a high likelihood of successful early discontinuation of mechanical ventilation with minimal demonstrated harm.

Protocols allow for standardization of clinical pathways to facilitate desired treatment (432). These protocols may include both spontaneous breathing trials, gradual reduction of support, and computer-generated weaning. Pooled analysis demonstrates that patients treated with protocolized weaning compared with usual care experienced shorter weaning duration (-39 hours; 95% CI, -67 hours to -11 hours), and shorter ICU LOS (-9 hours; 95% CI, -15 to -2). There was no difference between groups in ICU mortality (OR, 0.93; 95% CI, 0.58–1.48) or need for reintubation (OR, 0.74; 95% CI, 0.44–1.23) (428).

Recommendation 48. (SSCG Section M, Recommendation 1).

We recommend using a target tidal volume of 6mL/kg predicted body weight (PBW) compared with 12 mL/kg in adult patients with sepsis-induced ARDS.

Quality/level of evidence: High + **Strength of recommendation:** Strong

Recommendation 48a. (SSCG 2021, Recommendation 47)

We suggest the use of high flow nasal oxygen over non-invasive ventilation for patients with sepsis-induced hypoxic respiratory failure. [new 2025]

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 49. (SSCG Section M, Recommendation 2).

We recommend using an upper limit goal for plateau pressures of 22mmHg (30cm H₂O) over higher plateau pressures in adult patients with sepsis-induced severe ARDS.

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 50. (SSCG Section M, Recommendation 3).

We suggest using higher PEEP over lower PEEP in adult patients with sepsis-induced moderate to severe ARDS.

Quality/level of evidence: Moderate + **Strength of recommendation:** Weak

Recommendation 51. (SSCG Section M, Recommendation 4).

We suggest using recruitment maneuvers in adult patients with sepsis-induced, severe ARDS.

Quality/level of evidence: Moderate + **Strength of recommendation:** Weak

Recommendation 52. (SSCG Section M, Recommendation 5).

We recommend using prone over supine position in adult patients with sepsis-induced ARDS and a PaO₂/FIO₂ ratio < 20 KPA (150 mmHg).

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 53. (SSCG Section M, Recommendation 6).

We recommend against using high-frequency oscillatory ventilation (HFOV) in adult patients with sepsis-induced ARDS.

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 54. (SSCG Section M, Recommendation 7).

We make no recommendation regarding the use of noninvasive ventilation (NIV) for patients with sepsis-induced ARDS.

Quality/level of evidence: N/A + **Strength of recommendation:** N/A

Recommendation 55. (SSCG Section M, Recommendation 8).

We suggest using neuromuscular blocking agents (NMAs) for ≤ 48 hours in adult patients with sepsis-induced ARDS and a PaO₂/ FIO₂ ratio < 20 KPA (150 mmHg).

Quality/level of evidence: Moderate + **Strength of recommendation:** Weak

Recommendation 56. (SSCG Section M, Recommendation 9).

We recommend a conservative fluid strategy for patients with established sepsis-induced ARDS who do not have evidence of tissue hypoperfusion.

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 57. (SSCG Section M, Recommendation 10).

We recommend against the use of β-2 agonists for the treatment of patients with sepsis-induced ARDS without bronchospasm.

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Recommendation 58. (SSCG Section M, Recommendation 11).

We recommend against the routine use of the PA catheter for patients with sepsis-induced ARDS.

Quality/level of evidence: High + **Strength of recommendation:** Strong

Recommendation 59. (SSCG Section M, Recommendation 12).

We suggest using lower tidal volumes over higher tidal volumes in adult patients with sepsis-induced respiratory failure without ARDS.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

Recommendation 60. (SSCG Section M, Recommendation 13).

We recommend that mechanically ventilated sepsis patients be maintained with the head of the bed elevated between 30 and 45 degrees to limit aspiration risk and to prevent the development of Ventilator Associated Pneumonia (VAP).

Quality/level of evidence: Low + **Strength of recommendation:** Strong

Recommendation 61. (SSCG Section M, Recommendation 14).

We recommend using spontaneous breathing trials in mechanically ventilated patients with sepsis who are ready for weaning.

Quality/level of evidence: High + **Strength of recommendation:** Strong

Recommendation 62. (SSCG Section M, Recommendation 15).

We recommend using a weaning protocol in mechanically ventilated patients with sepsis-induced respiratory failure who can tolerate weaning.

Quality/level of evidence: Moderate + **Strength of recommendation:** Strong

Implementation Point 20 (Recommendation 48)

Ventilated patients should be routinely measured for height to facilitate ideal body weight-based calculations of tidal volumes and where possible, for weight to facilitate drug dosing and nutritional requirements calculations.

Role and Responsibilities

It is the responsibility of all clinicians to routinely assess patient's height and body weight to facilitate drug dosing and nutritional requirement calculations.

3.1.12 Sedation and Analgesia**Key question**

- In mechanically ventilated patients with sepsis, should we use sedation targets?

SSCG Rationale

Limiting the use of sedation in critically ill ventilated patients reduces the duration of mechanical ventilation and ICU and hospital LOS and allows for earlier mobilization (433,434). While these data arise from studies performed in a wide range of critically ill patients, there is little reason to believe that septic patients will not derive the same benefits from sedation minimization.

Several strategies have been shown to reduce sedative use and the duration of mechanical ventilation. Nurse-directed protocols that incorporate a sedation scale likely result in improved outcomes; however, the benefit depends on the existing local culture and practice (435,436). Another option for systematically limiting the use of sedation is the administration of intermittent rather than continuous sedation (437,438). Daily sedation interruption (DSI) was associated with improved outcomes in a single-centre randomized trial compared with usual care (430); however, in a multicentre RCT there was no advantage to DSI when patients were managed with a sedation protocol whilst nurses perceived a higher workload (439). A recent Cochrane meta-analysis did not find strong evidence that DSI alters the duration of mechanical ventilation, mortality, ICU or hospital LOS, adverse event rates, or drug consumption for critically ill adults receiving mechanical ventilation compared to sedation strategies that do not include DSI; however, interpretation of the results is limited by imprecision and clinical heterogeneity (440). Another strategy is the primary use of opioids alone and avoidance of sedatives, which was shown to be feasible in the majority of ventilated patients in a single-centre trial and was associated with more rapid liberation from mechanical ventilation (441). Finally, the use of short-acting drugs such as propofol and dexmedetomidine may result in better outcomes than the use of benzodiazepines (442-444). Recent pain, agitation, and delirium guidelines provide additional detail on implementation of sedation management, including nonpharmacologic approaches for the management of pain, agitation, and delirium (445).

Regardless of approach, a large body of indirect evidence is available demonstrating the benefit of limiting sedation in those requiring mechanical ventilation and without contraindication. As such, this should be best practice for any critically ill patient, including those with sepsis.

Recommendation 63. (SSCG Section N, Recommendation 1).

We recommend that continuous or intermittent sedation be minimized in mechanically ventilated sepsis patients, targeting specific titration end points.

Quality/level of evidence: Low

+ Strength of recommendation: BPS

Implementation Point 21 (Recommendation 63)

Practice guidelines for the management of pain, agitation and delirium should be adopted in all intensive care units.

Roles and Responsibilities (Implementation point 21)

Clinicians are responsible to ensure patients receive the minimum sedation necessary to reduce delirium and facilitate early rehabilitation. The aims of sedation should be outlined, and levels monitored. Pain, agitation and delirium are common complications among sepsis patients admitted to the ICU and are associated with extended ICU length of stay and increased risk of developing neuropathic pain, cognitive impairment, and post-traumatic stress disorder (Barr et al., 2013). Implementation of care bundles recommended by clinical practice guidelines could improve clinical outcomes in this domain (Mansouri et al., 2013) (Trogrić et al., 2015).

3.1.13 Glucose Control

Key questions

- Should we use intensive insulin therapy in patients with sepsis or septic shock?
- Should we use arterial blood glucose level (versus point of care testing) in critically ill patients with severe sepsis or septic shock on insulin infusion?

SSCG Rationale

A large single-centre RCT in 2001 demonstrated a reduction in ICU mortality with intensive IV insulin (Leuven protocol) targeting blood glucose to 80–110 mg/dL (446). A second randomized trial of intensive insulin therapy using the Leuven protocol enrolled medical ICU patients with an anticipated ICU LOS of more than three days in three medical ICUs; overall mortality was not reduced (447).

Since these studies (446,447) appeared, several RCTs (448-455) and meta-analyses (456-462) of intensive insulin therapy have been performed. The RCTs studied mixed populations of surgical and medical ICU patients and found that intensive insulin therapy did not significantly decrease mortality, whereas the NICE-SUGAR trial demonstrated an increased mortality (451). All studies reported a much higher incidence of severe hypoglycaemia (glucose \leq 40 mg/dL) (6%–29%) with intensive insulin therapy. Several meta-analyses confirmed that intensive insulin therapy was not associated with a mortality benefit in surgical, medical, or mixed ICU patients. The meta-analysis by Song et al (462) evaluated only septic patients and found that intensive insulin therapy did not change 28-day or 90-day mortality but was associated with a higher incidence of hypoglycaemia. The trigger to start an insulin protocol for blood glucose levels $>$ 180 mg/dL with an upper target blood glucose level $<$ 180 mg/dL derives from the NICE-SUGAR trial, which used these values for initiating and stopping therapy. The NICE-SUGAR trial is the largest, most compelling study to date on glucose control in ICU patients given its inclusion of multiple ICUs and hospitals and a general patient population. Several medical organizations, including the American Association of Clinical Endocrinologists, American Diabetes Association, American Heart Association, American College of Physicians, and Society of Critical Care Medicine, have published consensus statements for glycaemic control of hospitalized patients (463,464). These statements usually targeted glucose levels between 140 and 180 mg/dL. Because there is no evidence that targets between 140 and 180 mg/dL are different from targets of 110 to 140 mg/dL, the present recommendations use an upper target blood glucose \leq 180 mg/dL without a lower target other than hypoglycaemia. Stricter ranges, such as 110–140 mg/dL, may be appropriate for selected patients if this can be achieved without significant hypoglycaemia (463,465). Treatment should avoid hyperglycaemia ($>$ 180 mg/dL), hypoglycaemia, and wide swings in glucose levels that have been associated with higher mortality (466-471). The continuation of insulin infusions, especially with the cessation of nutrition, has been identified as a risk factor for hypoglycaemia (454). Balanced nutrition may be associated with a reduced risk of hypoglycaemia (472). Hyperglycaemia and glucose variability seem to be unassociated

with increased mortality rates in diabetic patients compared to nondiabetic patients (473-475). Patients with diabetes and chronic hyperglycaemia, end-stage renal failure, or medical versus surgical ICU patients may require higher blood glucose ranges (476,477).

Several factors may affect the accuracy and reproducibility of point-of-care testing of blood capillary blood glucose, including the type and model of the device used, user expertise, and patient factors, including haematocrit (false elevation with anaemia), PaO₂, and drugs (478). Plasma glucose values by capillary point-of-care testing have been found to be potentially inaccurate, with frequent false elevations (479-481) over the range of glucose levels, but especially in the hypoglycaemic and hyperglycaemic ranges (482) and in shock patients (receiving vasopressors) (478,480). A review of studies found the accuracy of glucose measurements by arterial blood gas analysers and glucose meters by using arterial blood significantly higher than measurements with glucose meters using capillary blood (480). The U.S. Food and Drug Administration has stated that “critically ill patients should not be tested with a glucose meter because results may be inaccurate,” and Centres for Medicare and Medicaid Services have plans to enforce the prohibition of off-label use of point-of-care capillary blood glucose monitor testing in critically ill patients (483). Several medical experts have stated the need for a moratorium on this plan (484). Despite the attempt to protect patients from harm because of inaccurate capillary blood testing, a prohibition might cause more harm because a central laboratory test may take significantly longer to provide results than point-of-care glucometer testing.

A review of 12 published insulin infusion protocols for critically ill patients showed wide variability in dose recommendations and variable glucose control (485). This lack of consensus about optimal dosing of IV insulin may reflect variability in patient factors (severity of illness, surgical versus medical settings), or practice patterns (e.g., approaches to feeding, IV dextrose) in the environments in which these protocols were developed and tested. Alternatively, some protocols may be more effective than others, a conclusion supported by the wide variability in hypoglycaemia rates reported with protocols. Thus, the use of established insulin protocols is important not only for clinical care, but also for the conduct of clinical trials to avoid hypoglycaemia, adverse events, and premature termination of trials before the efficacy signal, if any, can be determined. Several studies have suggested that computer-based algorithms result in tighter glycaemic control with a reduced risk of hypoglycaemia (486,487). Computerized decision support systems and fully automated closed-loop systems for glucose control are feasible, but not yet standard care. Further study of validated, safe, and effective protocols and closed-loop systems for controlling blood glucose concentrations and variability in the sepsis population is needed.

Recommendation 64. (SSCG Section O, Recommendation 1).

We recommend a protocolized approach to blood glucose management in ICU patients with sepsis, commencing insulin dosing when two consecutive blood glucose levels are >10mmol/L (180mg/dL). This approach should target an upper blood glucose level ≤10mmol/L (180mg/dL) rather than an upper target blood glucose level ≤6.1mmol/L (110mg/dL).

Quality/level of evidence: High **+ Strength of recommendation:** Strong

Recommendation 65. (SSCG Section O, Recommendation 2).

We recommend that blood glucose values be monitored every 1 to 2 hours until glucose values and insulin infusion rates are stable, then every 4 hours thereafter in patients receiving insulin infusions.

Quality/level of evidence: Low **+ Strength of recommendation:** BPS

Recommendation 66. (SSCG Section O, Recommendation 3).

We recommend that glucose levels obtained with point-of-care testing of capillary blood be interpreted with caution because such measurements may not accurately estimate arterial blood or plasma glucose values.

Quality/level of evidence: Low **+ Strength of recommendation:** BPS

Recommendation 67. (SSCG Section O, Recommendation 4).

We suggest the use of arterial blood rather than capillary blood for point-of-care testing using glucose meters if patients have arterial catheters.

Quality/level of evidence: Low

+ Strength of recommendation: Weak

Implementation Point 22 (Recommendation 64)

Practice guidelines for the management of diabetes should be adopted outside of intensive care units.

Role and Responsibilities (Implementation Point 22)

Clinicians are responsible to ensure that guidelines for the management of diabetes are adopted outside of the intensive care units.

3.1.14 Renal replacement therapy**Key questions**

- In patients with sepsis and indication for haemodialysis, should we use CRRT versus intermittent haemodialysis?
- In patients with sepsis and AKI with no indication for hemodialysis, should we use renal replacement therapy versus not?

SSCG Rationale

Although numerous nonrandomized studies have reported a nonsignificant trend toward improved survival using continuous methods (488–494), two meta-analyses (495, 496) reported the absence of significant differences in hospital mortality between patients who receive CRRT and intermittent RRT. This absence of apparent benefit of one modality over the other persists even when the analysis is restricted to RCTs (496). To date, five prospective RCTs have been published (497–501); four found no significant difference in mortality (497, 498, 500, 501), whereas one found significantly higher mortality in the continuous treatment group (499); but imbalanced randomization had led to a higher baseline severity of illness in this group. When a multivariable model was used to adjust for severity of illness, no difference in mortality was apparent between the groups. Most studies comparing modes of RRT in the critically ill have included a small number of outcomes and had a high risk of bias (e.g., randomization failure, modifications of therapeutic protocol during the study period, combination of different types of CRRT, small number of heterogeneous groups of enrolees). The most recent and largest RCT (501) enrolled 360 patients and found no significant difference in survival between the continuous and intermittent groups. We judged the overall certainty of the evidence to be moderate and not in support of continuous therapies in sepsis independent of renal replacement needs.

For this revision of the guidelines, no additional RCTs evaluating the hemodynamic tolerance of continuous versus intermittent RRT were identified. Accordingly, the limited and inconsistent evidence persists. Two prospective trials (497, 502) have reported a better hemodynamic tolerance with continuous treatment, with no improvement in regional perfusion (502) and no survival benefit (497). Four other studies did not find any significant difference in MAP or drop in systolic pressure between the two methods (498, 500, 501, 503). Two studies reported a significant improvement in goal achievement with continuous methods (497, 499) regarding fluid balance management.

Two additional RCTs reporting the effect of dose of CRRT on outcomes in patients with acute renal failure were identified in the current literature review (504, 505). Both studies enrolled patients with sepsis and acute kidney injury and did not demonstrate any difference in mortality associated with a higher dose of RRT. Two large,

multicentre, randomized trials comparing the dose of renal replacement (Acute Renal Failure Trial Network in the United States and RENAL Study in Australia and New Zealand) also failed to show benefit of more aggressive renal replacement dosing (506, 507). A meta-analysis of the sepsis patients included in all relevant RCTs ($n = 1,505$) did not demonstrate any significant relationship between dose and mortality; the point estimate, however, favours CRRT doses $> 30 \text{ mL/kg/hr}$. Because of risk of bias, inconsistency, and imprecision, confidence in the estimate is very low; further research is indicated. A typical dose for CRRT would be 20–25 mL/kg/hr of effluent generation.

One small trial from 2002 (504) evaluated early versus “late” or “delayed” initiation of RRT; it included only four patients with sepsis and did not show any benefit of early CRRT. Since then, two relevant RCTs (508, 509) were published in 2016. Results suggest the possibility of either benefit (509) or harm (508) for mortality, increased use of dialysis, and increased central line infections with early RRT. Enrolment criteria and timing of initiation of RRT differed in the two trials. Results were judged to be of low certainty based on indirectness (many non-septic patients) and imprecision for mortality. The possibility of harm (e.g., central line infections) pushes the balance of risk and benefit against early initiation of RRT. Meanwhile, the undesirable effects and costs appear to outweigh the desirable consequences; therefore, we suggest not using RRT in patients with sepsis and acute kidney injury for increase in creatinine or oliguria without other definitive indications for dialysis.

Recommendation 68. (SSCG Section P, Recommendation 1).

We suggest that either continuous RRT (CRRT) or intermittent RRT be used in patients with sepsis and acute kidney injury.

Quality/level of evidence: Moderate + **Strength of recommendation:** Weak

Recommendation 69. (SSCG Section P, Recommendation 2).

We suggest using CRRT to facilitate management of fluid balance in hemodynamically unstable septic patients.

Quality/level of evidence: Very low + **Strength of recommendation:** Weak

Recommendation 70. (SSCG Section P, Recommendation 3).

We suggest against the use of RRT in patients with sepsis and acute kidney injury for increase in creatinine or oliguria without other definitive indications for dialysis.

Quality/level of evidence: Low + **Strength of recommendation:** Weak

3.1.15 Bicarbonate therapy

Key question

- In patients with sepsis or septic shock and hypoperfusion-induced lactic acidosis, should we use sodium bicarbonate therapy?

SSCG Rationale

Although sodium bicarbonate therapy may be useful in limiting tidal volume in ARDS in some situations of permissive hypercapnia, no evidence supports the use of sodium bicarbonate therapy in the treatment of hypoperfusion-induced lactic acidemia associated with sepsis. Two blinded, crossover RCTs that compared equimolar saline and sodium bicarbonate in patients with lactic acidosis failed to reveal any difference in hemodynamic variables or vasopressor requirements (510, 511). The number of patients with $< 7.15 \text{ pH}$ in these studies was small, and we downgraded the certainty of evidence for serious imprecision; further, patients did not exclusively have septic shock, but also had other diseases, such as mesenteric ischemia. Bicarbonate administration has been associated with sodium and fluid overload, an increase in lactate and Paco_2 , and a

decrease in serum ionized calcium, but the directness of these variables to outcome is uncertain. The effect of sodium bicarbonate administration on haemodynamics and vasopressor requirements at lower pH, as well as the effect on clinical outcomes at any pH level, is unknown. No studies have examined the effect of bicarbonate administration on outcomes. This recommendation is unchanged from the 2012 guidelines.

Recommendation 71. (SSCG Section Q, Recommendation 1).

We **suggest against** the use of sodium bicarbonate therapy to improve haemodynamics or to reduce vasopressor requirements in patients with hypoperfusion-induced lactic acidaemia with pH ≥ 7.15

Quality/level of evidence: Moderate

+ Strength of recommendation: Weak

3.1.16 Venous thromboembolism prophylaxis

Key questions

- Should we use pharmacologic VTE prophylaxis (UFH or LMWH) in critically ill patients with sepsis or septic shock?
- Should we use LMWH (versus UFH) for VTE prophylaxis in critically ill patients with sepsis or septic shock?
- Should we use mechanical VTE prophylaxis in critically ill patients with sepsis or septic shock?
- Should we use a combination of pharmacologic and mechanical prophylaxis vs. either alone in critically ill patients with sepsis or septic shock?

SSCG Rationale

ICU patients are at risk for deep vein thrombosis (DVT) as well as pulmonary embolism (PE). The incidence of DVT acquired in the ICU may be as high as 10% (512); the incidence of acquired PE may be 2%–4% (513, 514). Patients with sepsis and septic shock are likely at increased risk for this complication. Vasopressor use, which is frequent in these patients, has been found to be an independent risk factor for ICU-acquired DVT.

A meta-analysis of pharmacologic prophylaxis with UFH or LMWH in critically ill patients showed significant reductions in both DVT and PE, with no significant increase in bleeding complications. Mortality was lower in the patients receiving prophylaxis, although this did not reach statistical significance (514). All studies included in the meta-analysis were cited in the 2012 guideline, which recommended pharmacologic prophylaxis. No additional prospective randomized controlled trials related to this topic have been identified since the meta-analysis and the previous guideline were published (Supplemental Digital Content 12, <http://links.lww.com/CCM/C333>). Data in support of pharmacologic prophylaxis are considered somewhat indirect. Except for a large prospective randomized controlled trial comparing VTE in septic patients treated with drotrecogin alfa who were randomized to receive placebo versus UFH versus LWMH (515), all studies have been in an undifferentiated population of critically ill patients. Overall, we made a strong recommendation in favour of pharmacologic prophylaxis against VTE in critically ill patients based on the overall efficacy of this intervention, although the evidence was downgraded to moderate because of indirectness of the populations studied.

A number of studies have also compared use of LMWH to UFH for prevention of VTE prophylaxis in critically ill patients. Four trials were included in the meta-analysis of Alhazzani et al (514). We did not identify any new trials since then. In this meta-analysis, the overall rate of DVT was lower in patients receiving LWMH compared to UFH, and overall mortality was reduced by 7%; however, these differences did not reach statistical significance. In those trials evaluating PE, the rates were significantly lower in patients receiving LWMH. As with all studies of pharmacologic VTE prophylaxis, only one trial (515) was restricted to septic patients, and that trial utilized drotrecogin alfa in all patients. An additional meta-analysis found that LWMH was more effective than UFH in

reducing the incidence of DVT and PE in critically ill patients (516). However, the authors of this meta-analysis included studies of critically ill trauma patients.

All studies of LMWH have compared these agents against UFH administered twice daily. No high-quality studies in critically ill patients have directly compared LMWH against UFH administered thrice daily. An indirect comparison meta-analysis published in 2011 failed to identify a significant difference in efficacy between twice-daily and thrice-daily heparin in medical patients (517). However, another review and meta-analysis (also using indirect comparison) suggested greater efficacy but higher rates of bleeding with thrice-daily UFH (518). A Cochrane review demonstrated a substantial decrease in the incidence of HIT in postoperative patients receiving LMWH compared to UFH (519), although the studies were not specific to either septic or critically ill patients. Finally, a cost-effectiveness analysis based on one trial of LMWH versus UFH (520) suggested that use of LMWH resulted in an overall decrease in costs of care, despite the higher acquisition cost of the pharmaceutical agent (521). Overall, the desirable consequences (i.e., reduction in PE, HIT, cost savings, and ease of administration) of using LMWH clearly outweigh the undesirable consequences; therefore, we made a strong recommendation in favour of LMWH instead of UFH, whenever feasible. However, the evidence for this was considered only of moderate quality because of indirectness, both with respect to the populations studied and also because LMWH has only been systematically compared to UFH administered twice daily and not thrice daily.

Precautions are generally suggested regarding use of LMWH in patients with renal dysfunction. In a preliminary trial, no accumulation of anti-Xa levels was demonstrated with dalteparin in patients with a calculated creatinine clearance < 30 mL/min (522). Thus, these patients were included in the PROTECT study (520). In the actual trial, 118 patients with renal failure were analysed, 60 of whom were randomized to dalteparin and 58 to UFH. There was no evidence of untoward reactions in patients receiving dalteparin compared to UFH. However, dalteparin was not more efficacious than UFH in this small number of patients. These investigators speculated that other types of LMWH might be safe to use in patients with renal failure but acknowledged no other high-quality data to support this theory. Thus, use of LMWH in septic patients with renal dysfunction might be an option, but data in support of that remain quite limited.

Combined pharmacologic prophylaxis and mechanical prophylaxis with intermittent pneumatic compression (IPC) and/or graduated compression stockings (GCS) is a potential option in critically ill patients with sepsis and septic shock. No high-quality studies of this approach in septic patients, or even critically ill patients in general, exist; however, further research is ongoing (523). A Cochrane review (524) of 11 studies in surgical patients suggested that combined prophylaxis was more effective than either modality used alone. However, the quality of evidence was low due to indirectness of population and imprecision of estimates. Therefore, we can make only a weak recommendation for combined modality therapy for VTE prophylaxis in critically ill patients with sepsis or septic shock. Recent American College of Chest Physicians guidelines made no recommendation regarding the use of combined modality in critically ill patients but do suggest use of combined mechanical and pharmacologic prophylaxis in high-risk surgical patients (525, 526).

A significant number of septic patients may have relative contraindications to the use of pharmacologic prophylaxis. These patients may be candidates for mechanical prophylaxis using IPC and/or GCS. However, relatively little data exist regarding this approach in critically ill patients. Two meta-analyses have been published comparing use of mechanical prophylaxis with no prophylaxis in combined patient groups, primarily those undergoing orthopaedic surgery (527, 528). The former meta-analysis focused on use of GCS and the latter on use of IPC. In these analyses, both modalities appeared more effective than no mechanical prophylaxis, but variable numbers of patients received pharmacologic prophylaxis in both arms, making this evidence indirect. A cohort study of 798 patients using propensity scores for risk adjustment concluded that IPC was the only effective means for mechanical VTE prophylaxis in critically ill patients; however, there was heavy use of pharmacologic prophylaxis in all groups (529). Overall, based on these data, we made a weak recommendation for using mechanical prophylaxis in critically ill septic patients with contraindications to use of pharmacologic prophylaxis. Very limited evidence indicates that IPC may be more effective than GCS alone in critically ill patients, making it the preferred modality for mechanical prophylaxis.

Recommendation 72. (SSCG Section R, Recommendation 1).

We recommend pharmacologic prophylaxis (unfractionated heparin [UFH] or low-molecular-weight heparin [LMWH]) against venous thromboembolism (VTE) in the absence of contraindications to the use of these agents (SSCG Section G, Recommendation 6).

Quality/level of evidence: Moderate**+ Strength of recommendation:** Strong**Recommendation 73.** (SSCG Section R, Recommendation 2).

We recommend LMWH rather than UFH for VTE prophylaxis in the absence of contraindications to the use of LMWH (SSCG Section G, Recommendation 6).

Quality/level of evidence: Moderate**+ Strength of recommendation:** Strong**Recommendation 74.** (SSCG Section R, Recommendation 3).

We suggest combination pharmacologic VTE prophylaxis and mechanical prophylaxis, whenever possible (SSCG Section G, Recommendation 6).

Quality/level of evidence: Low**+ Strength of recommendation:** Weak**Recommendation 75.** (SSCG Section R, Recommendation 4).

We suggest mechanical VTE prophylaxis when pharmacologic VTE is contraindicated (SSCG Section G, Recommendation 6).

Quality/level of evidence: Low**+ Strength of recommendation:** Weak**Implementation Point 23 (Recommendations 72-75)**

VTE prophylaxis for unwell pregnant women with sepsis should be in line with existing VTE guidelines considering risk factors as outlined in the RCOG and RCPI guidelines (RCOG, 2015) (RCPI, 2016). If there is evidence of coagulopathy a haematologist should be consulted for guidance on how best to manage care.

Roles and responsibility (Implementation 23)

Clinicians are responsible to ensure that VTE prophylaxis is in line with existing VTE guidelines and that a haematologist is consulted if there is evidence of coagulopathy.

3.1.17 Stress ulcer prophylaxis**Key questions**

- Should we use stress ulcer prophylaxis in critically ill septic patients?
- Should we use PPIs (versus H2RA) for stress ulcer prophylaxis in critically ill septic patients?

SSCG Rationale

Stress ulcers develop in the GI tract of critically ill patients and can be associated with significant morbidity and mortality (530). The exact mechanism is not completely understood but is believed to be related to disruption of protective mechanisms against gastric acid, gastric mucosal hypoperfusion, increased acid production, and oxidative injury to the digestive track (531). The strongest clinical predictors of GI bleeding risk in critically ill patients are mechanical ventilation for > 48 hours and coagulopathy (532). A recent international cohort study showed that pre-existing liver disease, need for RRT, and higher organ failure scores were independent predictors of GI bleeding risk (533).

A multicentre prospective cohort study found the incidence of clinically important GI bleeding to be 2.6% (95% CI, 1.6%–3.6%) in critically ill patients (533); however, other observational studies showed lower rates of GI bleeding (534–537).

A recent systematic review and meta-analysis of 20 RCTs examined the efficacy and safety of stress ulcer prophylaxis (538). Moderate quality of evidence showed that prophylaxis with either H2RAs or PPIs reduced the risk of GI bleeding compared to no prophylaxis (RR, 0.44; 95% CI, 0.28–0.68; low quality of evidence showed a nonsignificant increase in pneumonia risk (RR, 1.23; 95% CI, 0.86–1.78) (538). Recently, a large, retrospective cohort study examined the effect of stress ulcer prophylaxis in patients with sepsis and found no significant difference in the risk of *C difficile* infection compared to no prophylaxis (539) (Supplemental Digital Content 13, <http://links.lww.com/CCM/C334>). The choice of prophylactic agent should depend on patients' characteristics, patients' values and preferences, and the local incidence of *C difficile* infections and pneumonia.

Although published RCTs did not exclusively include septic patients, risk factors for GI bleeding are frequently present in patients with sepsis and septic shock (532); therefore, using the results to inform our recommendations is acceptable. Based on the available evidence, the desirable consequences of stress ulcer prophylaxis outweigh the undesirable consequences; therefore, we made a strong recommendation in favour of using stress ulcer prophylaxis in patients with risk factors. Patients without risk factors are unlikely to develop clinically important GI bleeding during their ICU stay (532); therefore, stress ulcer prophylaxis should only be used when risk factors are present, and patients should be periodically evaluated for the continued need for prophylaxis.

While there is variation in practice worldwide, several surveys showed that PPIs are the most frequently used agents in North America, Australia, and Europe, followed by H2RAs (540–544). A recent meta-analysis including 19 RCTs ($n = 2,177$) showed that PPIs were more effective than H2RAs in preventing clinically important GI bleeding (RR, 0.39; 95% CI, 0.21–0.71; $p = 0.002$; moderate quality) but led to a nonsignificant increase in pneumonia risk (RR, 1.17; 95% CI, 0.88–1.56; $p = 0.28$; low quality) (544) prior meta-analyses reached a similar conclusion (545,546). None of the RCTs reported the risk of *C difficile* infection; nonetheless, a large retrospective cohort study demonstrated a small increase in the risk of *C difficile* infection with PPIs compared to H2RAs (2.2% vs. 3.8%; $p < 0.001$; very low-quality evidence). Studies reporting patients' values and preferences concerning the efficacy and safety of these agents are essentially lacking. Furthermore, cost-effectiveness analyses reached different conclusions (547,548).

Consequently, the benefit of preventing GI bleeding (moderate-quality evidence) must be weighed against the potential increase in infectious complications (very low- to low-quality evidence). The choice of prophylactic agent will largely depend on individual patients' characteristics; patients' values; and the local prevalence of GI bleeding, pneumonia, and *C difficile* infection. Because of the uncertainties, we did not recommend one agent over the other. Ongoing trials aim to investigate the benefit and harm of withholding stress ulcer prophylaxis (clinicaltrials.gov registration NCT02290327, NCT02467621). The results of these trials will inform future recommendations.

Recommendation 76. (SSCG Section S, Recommendation 1).

We recommend that stress ulcer prophylaxis be given to patients with sepsis or septic shock who have risk factors for gastrointestinal (GI) bleeding.

Quality/level of evidence: Low

+ Strength of recommendation: Strong

Recommendation 77. (SSCG Section S, Recommendation 2).

We suggest using either proton pump inhibitors (PPIs) or histamine-2 receptor antagonists (H2RAs) when stress ulcer prophylaxis is indicated.

Quality/level of evidence: Low

+ Strength of recommendation: Weak

Recommendation 78. (SSCG Section S, Recommendation 3).

We recommend against stress ulcer prophylaxis in patients without risk factors for GI bleeding.

Quality/level of evidence: Low

+ Strength of recommendation: BPS

3.1.18 Nutrition

Key questions

- Should we use early TPN versus early full enteral feeding in critically ill patients with sepsis or septic shock who can be fed enterally?
- Should we use early TPN versus no or early trophic enteral feeding in critically ill patients with sepsis or septic shock who have contraindications for early full enteral feeding?
- Should we use early full enteral feeding versus no initial enteral feeding (except IV glucose/dextrose) in critically ill patients with sepsis or septic shock without contraindications to enteral feeding?
- Should we use early full enteral feeding versus early trophic enteral feeding in patients with sepsis or septic shock without contraindications to enteral feeding?
- Should we use early trophic enteral feeding versus no early enteral feeding (except IV glucose/dextrose) in patients with sepsis or septic shock without contraindications to enteral feeding?
- Should we use omega-3 supplementation in patients with sepsis or septic shock?
- Should we measure gastric residuals when enterally feeding critically ill patients with sepsis or septic shock?
- Should we use enteral feeding via a gastric tube versus a post-pyloric tube in patients with sepsis or septic shock?
- Should we use prokinetic agents for enterally fed patients with sepsis or septic shock?
- Should we use selenium therapy in patients with severe sepsis or septic shock?
- Should we recommend glutamine therapy in critically ill patients with severe sepsis or septic shock?
- Should we use arginine therapy in patients with sepsis or septic shock?
- Should we use carnitine therapy patients with sepsis or septic shock?

SSCG Rationale

PARENTERAL NUTRITION DELIVERY CAN SECURE THE INTENDED NUMBER OF CALORIES. THIS MAY REPRESENT AN ADVANTAGE OVER ENTERAL NUTRITION, ESPECIALLY WHEN PATIENTS MAY BE UNDERFED DUE TO GI INTOLERANCE, WHICH MAY BE PERTINENT OVER THE FIRST DAYS OF CARE IN THE ICU. HOWEVER, PARENTERAL DELIVERY IS MORE INVASIVE AND HAS BEEN ASSOCIATED WITH COMPLICATIONS, INCLUDING AN INCREASED RISK OF INFECTIONS. FURTHER, PURPORTED PHYSIOLOGIC BENEFITS ARE ASSOCIATED WITH ENTERAL FEEDING, WHICH MAKE THIS STRATEGY THE MAINSTAY OF CARE (549). TO ADDRESS THE QUESTION OF THE SUPERIORITY OF PARENTERAL NUTRITION FOR PATIENTS WITH SEPSIS AND SEPTIC SHOCK, WE EVALUATED THE EVIDENCE FOR PATIENTS WHO COULD BE FED ENTERALLY EARLY VERSUS THOSE FOR WHOM EARLY ENTERAL FEEDING WAS NOT FEASIBLE.

Our first systematic review examined the impact of an early parenteral feeding strategy alone or in combination with enteral feeding versus enteral feeding alone on mortality in patients who could be fed enterally. We identified a total of 10 trials with 2,888 patients that were conducted in heterogeneous critically ill and surgical patients, trauma and traumatic brain injury, and those with severe acute pancreatitis (550–559). No evidence showed that early parenteral nutrition reduced mortality (RR 0.97; 95% CI, 0.87–1.08; n = 2,745) or infection risk (RR, 1.52; 95% CI, 0.88–2.62; n = 2,526), but ICU LOS was increased (MD, 0.90; 95% CI, 0.38–1.42; n = 46).

The quality of the evidence was graded as moderate to very low. In the largest randomized trial that addressed this study question (CALORIES, n = 2,400), there were fewer episodes of hypoglycaemia and vomiting in the early parenteral group, but no differences in death between the study groups (553, 560). Due to the lack of mortality benefit, the added cost of parenteral nutrition in absence of clinical benefit (550, 551, 555, 560), and the potential physiologic benefits of enteral feeding (549, 561, 562), we recommend early enteral nutrition as the preferred route of administration in patients with sepsis or septic shock who can be fed enterally.

In some patients with sepsis or septic shock, feeding enterally early may not be feasible because of contraindications related to surgery or feeding intolerance. These patients represent another subgroup of critically ill patients for whom the clinician may question whether to start parenteral nutrition early with or without some enteral feeding to meet nutritional goals, versus trophic/hypocaloric enteral feeding alone, or nothing except the addition of IV glucose/dextrose for the provision of some calories. To address this question, we conducted a systematic review, which included a total of four trials and 6,087 patients (563–566). Two of the included trials accounted for 98.5% of the patients included in the review and, of these trials, more than 65% of the patients were surgical critically ill patients (564, 567). Seven (20%) of the patients from these two trials were considered septic and patients with malnourishment were either excluded or represented a very small fraction (n = 46, 3.3%) of the included patients. In three of the included trials, parenteral nutrition was initiated if enteral feeding was not tolerated after the first 7 days of care (564, 566, 567). Our review found that early parenteral nutrition with or without supplementation of enteral nutrition was not associated with reduced mortality (RR, 0.96; 95% CI, 0.79–1.16; n = 6,087; moderate-quality evidence) but was associated with increased risk of infection (RR, 1.12; 95% CI, 1.02–1.24; 3 trials; n = 6,054; moderate-quality evidence) (Supplemental Digital Content 14, <http://links.lww.com/CCM/C335>). Length of ventilation outcomes were reported divergently in the two large trials, with one suggesting an increase (567) and the other a decrease (564) in ventilation time associated with early parenteral nutrition. One trial also reported less muscle wasting and fat loss in the early parenteral nutrition group according to a Subjective Global Assessment Score (564). In summary, due to the lack of mortality benefit, the increased risk of infection, and the extra cost for parenteral nutrition in the absence of clinical benefit (568), current evidence does not support the initiation of early parenteral nutrition over the first 7 days of care for patients with contraindications or intolerance to enteral nutrition. Specific patient groups may benefit more or incur more harm with early initiation of parenteral nutrition in this context. We encourage future research according to individual patient level meta-analyses to characterize these subgroups and plan for future randomized trials. It is important to note that patients who were malnourished were either excluded or rarely represented in the included trials from our systematic review. Since so few malnourished patients were enrolled, evidence to guide practice is lacking. Malnourished patients may represent a subgroup of critically ill patients for whom the clinician may consider initiating parenteral nutrition early when enteral feeding is not feasible.

The early administration of enteral nutrition in patients with sepsis and septic shock has potential physiologic advantages related to the maintenance of gut integrity and prevention of intestinal permeability, dampening of the inflammatory response, and modulation of metabolic responses that may reduce insulin resistance (561,562). To examine evidence for this nutrition strategy, we asked if early full feeding (started within the first 48 hours and feeding goals to be met within 72 hours of ICU admission or injury) as compared to a delayed strategy (feeds delayed for at least 48 hours) improved the outcome of our critically ill patients. In our systematic review, we identified a total of 11 trials in heterogeneous critically ill patient populations (n = 412 patients) (569–579). Only one trial was specifically conducted in patients with sepsis (n = 43 patients) (577). The risk of death was not significantly different between the groups (RR, 0.75; 95% CI, 0.43–1.31; n = 188 patients), and infections were not significantly reduced (RR, 0.60; 95% CI, 0.34–12.07; n = 122 patients). Other recent systematic reviews in the critically ill focused specifically on trauma (3 trials, n = 126 patients) or more heterogeneous critically ill populations (6 trials, n = 234 patients) and found that early enteral feeding reduced death and pneumonia (580,581). However, in contrast to our systematic review, these latter reviews did not include studies in which enteral feeding in the intervention arm was both early and full and where the control arm feeding strategy was

delayed for at least the first 48 hours. We also examined whether the provision of an early trophic/hypocaloric feeding strategy (defined by enteral feeding started within the first 48 hours and up to 70% of target caloric goals for at least 48 hours) was superior to a delayed enteral feeding strategy. In the two trials that fit these criteria, there were no statistical differences in death (RR, 0.67; 95% CI, 0.35–1.29; n = 229; low-quality evidence) or infection (RR, 0.92; 95% CI, 0.61–1.37; n = 229; very low-quality evidence) between the groups (582,583). Since the present evidence does not suggest harm with early versus delayed institution of enteral feeding, and there is possible benefit from physiologic evidence suggesting reduced gut permeability, inflammation, and infection risk, the committee issued a weak recommendation to start feeding early in patients with sepsis and septic shock.

Some evidence suggests that intentional early underfeeding as compared to early full feeding of critically ill patients may lead to immune hyporesponsiveness and an increase in infectious complications (549). Further, because critical illness is associated with loss of skeletal mass, it is possible that not administering adequate protein may lead to challenges weaning from the ventilator and more general weakness. However, a biological rationale for a trophic/hypocaloric or hypocaloric feeding strategy exists, at least as the initial approach to feeding the critically ill as compared to a fully fed strategy. Limiting caloric intake stimulates autophagy, which is considered a defence mechanism against intracellular organisms and therefore raises the possibility that this approach could reduce infection risk (584,585).

We defined feeds as trophic/hypocaloric if goal feeds were 70% or less of standard caloric targets for at least a 48-hour period before they were titrated toward goal. Our systematic review identified seven randomized trials and 2,665 patients studied (584,586–591). Patient populations included heterogeneous critically ill patients and those with acute lung injury and/or ARDS. Patients who were malnourished were excluded from four of the trials (588–591) and the average body mass index in the remaining three trials ranged from 28 to 30 (584,586,587). Targets for trophic/hypocaloric feeding groups ranged from 10 to 20 kcal/hr to up to 70% of target goal. Study intervention periods ranged from 6 to 14 days (or until ICU discharge). In three of the trials, protein (0.8–1.5 g/kg/d) was administered to the trophic/hypocaloric group to meet protein requirements (584,586,587). Overall, there were no differences in mortality (RR, 0.95; 95% CI, 0.82–1.10; n = 2,665; high-quality evidence), infections (RR, 0.96; 95% CI, 0.83–1.12; n = 2,667; moderate-quality evidence), or ICU LOS (MD, –0.27 days; 95% CI, –1.40 to 0.86, n = 2,567; moderate-quality evidence between the study groups) (Supplemental Digital Content 15, <http://links.lww.com/CCM/C336>). One trial that instituted hypocaloric feeding (goal 40%–60% target feeds for up to 14 days) reported a subgroup of 292 patients with sepsis; there were also no detectable differences in death at 90 days between the study groups (RR, 0.95; 95% CI, 0.71–1.27; p = 0.82 for interaction) (584). A recently published systematic review of normocaloric versus hypocaloric feeding also found no differences in hospital mortality, infections, ICU LOS, or ventilator-free days between the study groups (585). Some evidence also suggests a lack of adverse consequences even with longer-term outcomes. A trophic/hypocaloric feeding trial of 525 patients, which instituted the most significant restrictions in enteral feeding (20% of caloric goal) for up to 6 days, found no differences in muscle strength, muscle mass, and 6-minute walk test at 6 months or 1 year, although patients in the trophic/hypocaloric feeding group were more likely to be admitted to a rehabilitation facility during the first 12 months of follow-up (592). The current evidence base would suggest that a trophic/hypocaloric or early full enteral feeding strategy is appropriate. However, for patients with sepsis or septic shock who are not tolerating enteral feeds, trophic/hypocaloric feeding may be preferred, with feeds titrated over time according to patient tolerance. There is insufficient evidence to confirm that a trophic/hypocaloric feeding strategy is effective and safe in patients who are malnourished (body mass index < 18.5) because these patients were either excluded or rarely represented in the clinical trials from our systematic review. Until further clinical evidence is generated for this subpopulation, the clinician may consider titrating enteral feeds more aggressively in accordance with patient tolerance while monitoring for re-feeding syndrome. Current evidence did not specifically address patients with high vasopressor requirements, and the decision about withholding the feeds should be individualized.

Use of omega-3 fatty acids in the context of clinical trials in the critically ill has been a subject of interest during the past several years because of the immunomodulatory potential (593). However, systematic reviews of parenteral or enteral omega-3 supplementation in critically ill and ARDS patients have not confirmed their therapeutic benefit (594,595). Further, a recent randomized trial of 272 patients with acute lung injury found excess harm related to mortality as well as fewer ventilator- and ICU-free days in the omega-3 arm as compared to the control arm (596). A limitation of this trial as well as several other omega-3 trials is that the intervention arm also contained vitamins and trace mineral supplementation, making omega-3 fatty acids alone difficult to isolate as the cause for harm or benefit. For these reasons, we conducted a systematic review of clinical trials in the critically ill that administered omega-3 alone in the intervention arm. In a total of 16 trials ($n = 1,216$ patients), there were no significant reductions in death (RR, 0.86; 95% CI, 0.71–1.03; low quality evidence); however, ICU LOS was significantly reduced in the omega-3 group (MD, −3.84 days; 95% CI, −5.57 to −2.12, very low-quality evidence). The overall quality of the evidence was graded as low. Due to the uncertainty of benefit, the potential for harm, and the excess cost and varied availability of omega-3 fatty acids, we make a strong recommendation against the use of omega-3 fatty acids for patients with sepsis and septic shock outside the conduct of RCTs.

Critically ill patients are at significant risk for GI dysmotility, which may then predispose them to regurgitation or vomiting, aspiration, and the development of aspiration pneumonia. The rationale for measurement of GRVs is to reduce the risk for aspiration pneumonia by either ceasing or modifying the enteral feeding strategy based on the detection of excess gastric residuals. The inherent controversy is that observational and interventional studies have not consistently confirmed a relationship between the measurement of GRVs (with thresholds ranging from 200 mL to no monitoring of GRVs) and outcomes of vomiting, aspiration, or pneumonia (597–603). In our systematic review, we identified one multicentre non-inferiority trial of 452 critically ill patients who were randomized to not monitoring GRVs versus monitoring GRVs at 6-hour intervals (602). Intolerance to feeds was defined as vomiting in the intervention group versus a GRV of > 250 mL, vomiting, or both in the control group. Although vomiting was more frequent (39.6% versus 27%; median difference, 12.6; 95% CI, 5.4–19.9) in the group in which GRVs were not monitored, a strategy of not monitoring GRVs was found to be non-inferior compared to monitoring at 6-hour intervals with regard to the primary outcome of VAP (16.7% versus 15.8% respectively; difference, 0.9%; 95% CI, −4.8% to 6.7%). No detectable differences in death were shown between the study groups at 28 and 90 days. Patients who had surgery up to one month prior to study eligibility were not included in this study, so these results should not be applied to surgical critically ill patients. However, the results of this trial question the need to measure GRVs as a method to reduce aspiration pneumonia in all critically ill patients. Due to the absence of harm and the potential reduction in nursing resources needed to monitor patients, we suggest against routine monitoring of GRVs in all patients with sepsis unless the patient has demonstrated feeding intolerance (e.g., vomiting, reflux of feeds into the oral cavity) or for patients who are considered to be at high risk for aspiration (e.g., surgery, hemodynamic instability). We recommend the generation of further evidence through the conduct of future randomized controlled trials targeted to higher-risk patient groups such as the surgical population or those in shock to determine the threshold and frequency with which GRVs should be monitored.

Feeding intolerance is defined as vomiting, aspiration of gastric contents, or high GRVs. For multiple reasons, feeding intolerance commonly develops in critically ill patients. Patients with pre-existing gastroparesis or diabetes or those who are receiving sedatives and vasopressors are at risk. Prokinetic agents, including metoclopramide, domperidone, and erythromycin, are frequently used in the ICU. Each of these agents has different pharmacodynamics and pharmacokinetic properties; however, these agents may be associated with prolongation of QT interval and ventricular arrhythmias. A large case-control study in non-ICU patients showed a threefold increase in risk of sudden cardiac death with domperidone use at doses > 30 mg/day (604). Another retrospective cohort study showed that outpatient use of erythromycin is associated with a twofold increase in the risk of sudden cardiac death, especially if concomitantly used with other CYP3A inhibitors (605). The impact on ventricular arrhythmias in ICU patients is less clear.

A recent systematic review and meta-analysis included 13 RCTs enrolling 1,341 critically ill patients showed that prokinetic agent use was associated with lower risk of feeding intolerance (RR, 0.73; 95% CI, 0.55–0.97; moderate-quality evidence). This was equivalent to an absolute risk reduction of 17%. The use of prokinetic agents did not significantly increase mortality (RR, 0.97; 95% CI, 0.81–1.1; low-quality evidence); however, the incidence of fatal or nonfatal cardiac arrhythmias was not consistently reported across studies. There was no significant effect on the risk of pneumonia or vomiting. The majority of trials examined the effect of metoclopramide or erythromycin; subgroup analysis by drug class was underpowered to detect important subgroup differences (606). We considered the desirable consequences (lower risk of feeding intolerance) and the low quality of evidence showing no difference in mortality or pneumonia, and issued a weak recommendation for using prokinetic agents (metoclopramide or erythromycin) to treat feeding intolerance in patients with sepsis. Future large comparative trials are needed to determine the relative efficacy and safety of different agents.

Monitoring the QT interval with serial electrocardiograms is required when these agents are used in the ICU, especially if concomitantly used with other agents that could prolong the QT interval (607). The need for prokinetic agents should be assessed daily, and they should be stopped when clinically not indicated.

Feeding intolerance is defined as vomiting, abdominal distention, or high GRVs that result in interruption of enteral nutrition. Critically ill patients are at risk of gastroparesis and feeding intolerance; evidence of delayed gastric emptying can be found in approximately 50% of critically ill patients (608). The proportion of patients who will progress to develop clinical symptoms is less clear. Feeding intolerance can result in interruption of nutritional support, vomiting, aspiration of gastric contents, or pneumonia (609). The pathophysiology is not completely understood and is likely to be multifactorial. Gastroparesis can be caused by pharmacologic agents that are frequently used in the ICU (e.g., sedatives, opioids, or NMBAs), gastric hypoperfusion in the context of shock, hyperglycaemia, or vasopressor use (610–612).

Post-pyloric tubes have the theoretical advantage of improving feeding intolerance in patients with gastroparesis, consequently improving the delivery of nutrition into the gut. Post-pyloric feeding tubes, although safe, are not always available, and require technical skill for successful insertion. Gastric air insufflation and prokinetic agents are both effective strategies to facilitate the insertion of post-pyloric tubes in critically ill patients (613). Endoscopy and an external magnet device can also be used to guide post-pyloric tube insertion, but are not always available, are expensive, and require a higher level of expertise.

We conducted a systematic review and meta-analysis of randomized trials to examine the effect of post-pyloric (compared to gastric) feeding on patient-important outcomes. We identified 21 eligible RCTs enrolling 1,579 patients. Feeding via post-pyloric tube reduced the risk of pneumonia compared to gastric tube feeding (RR, 0.75; 95% CI, 0.59–0.94; low-quality evidence). This translates into a 2.5% (95% CI, 0.6%–4.1%) absolute reduction in pneumonia risk. However, there was no significant effect on the risk of death, aspiration, or vomiting (Supplemental Digital Content 16, <http://links.lww.com/CCM/C337>). This is consistent with the results of older meta-analyses (614,615). Although the use of post-pyloric tubes reduced risk of pneumonia, the quality of evidence was low, the magnitude of benefit was small, and there was uncertainty about the effect on other patient-important outcomes. Cost-effectiveness studies that describe the economic consequences of using post-pyloric feeding tubes are lacking. Therefore, we decided that the balance between desirable and undesirable consequences was unclear in low-risk patients; however, the use of post-pyloric feeding tubes may be justified in patients at high risk of aspiration (i.e., patients with history of recurrent aspiration, severe gastroparesis, feeding intolerance, or refractory medical treatment).

Selenium was administered in the hope that it could correct the known reduction of selenium concentration in sepsis patients and provide a pharmacologic effect through an antioxidant defence. Although some RCTs are available, the evidence for the use of IV selenium is not convincing. Two recent meta-analyses suggest, with weak findings, a potential benefit of selenium supplementation in sepsis (616,617). However, a recent large

RCT also examined the effect on mortality rates (618). Overall pooled odds ratio (0.94; CI, 0.77–1.15) suggests no significant impact on mortality with sepsis. Also, no differences in secondary outcomes of development of nosocomial pneumonia or ICU LOS were found. When updating our meta-analysis to include the results of this recent study, there was no difference in mortality between both groups (Supplemental Digital Content 17, <http://links.lww.com/CCM/C338>).

Arginine availability is reduced in sepsis, which can lead to reduced nitric oxide synthesis, loss of microcirculatory regulation, and enhanced production of superoxide and peroxynitrite. However, arginine supplementation could lead to unwanted vasodilation and hypotension (619,620). Human trials of L-arginine supplementation have generally been small and reported variable effects on mortality (621–624). The only study in septic patients showed improved survival but had limitations in study design (623). Other studies suggested no benefit or possible harm in the subgroup of septic patients (621,624,625). Some authors found improvement in secondary outcomes in septic patients, such as reduced infectious complications and hospital LOS, but the relevance of these findings in the face of potential harm is unclear.

Glutamine levels are also reduced during critical illness. Exogenous supplementation can improve gut mucosal atrophy and permeability, possibly leading to reduced bacterial translocation. Other potential benefits are enhanced immune cell function, decreased proinflammatory cytokine production, and higher levels of glutathione and antioxidative capacity (619,620). However, the clinical significance of these findings is not clearly established.

Although a previous meta-analysis showed mortality reduction (626), several other meta-analyses did not (627–630). Four recent well-designed studies also failed to show a mortality benefit in the primary analyses, although none focused specifically on septic patients (631–634). Two small studies on septic patients showed no benefit in mortality rates (635,636) but showed a significant reduction in infectious complications (636) and a faster recovery of organ dysfunction.

Massive disruption in energy metabolism contributes to sepsis severity and end organ failure. The magnitude of the energy shift, and, possibly more importantly, the host's metabolic adaptiveness to the shift in energy demand, likely influence patient survival. Carnitine, endogenously manufactured from lysine and methionine, is required for the transport of long-chain fatty acids into the mitochondria and the generation of energy. As such, carnitine utilization is essential for enabling the switch from glucose to long-chain fatty acid metabolism during the sepsis energy crisis. This is the basis for the rationale of employing L-carnitine as a therapeutic in sepsis. One small, randomized trial in patients with sepsis reported a 28-day mortality decrease in septic shock patients treated with IV L-carnitine therapy within 24 hours of shock onset; however, the trial was underpowered to detect such a difference (637). Larger, ongoing trials should provide more evidence of the usefulness of carnitine supplementation.

Recommendation 79. (SSCG Section T, Recommendation 1).

We **recommend against** the administration of early parenteral nutrition alone or parenteral nutrition in combination with enteral feedings (but rather initiate early enteral nutrition) in critically ill patients with sepsis or septic shock who can be fed enterally.

Quality/level of evidence: Moderate

+ Strength of recommendation: Strong

Recommendation 80. (SSCG Section T, Recommendation 2).

We **recommend against** the administration of parenteral nutrition alone or in combination with enteral feeds (but rather to initiate IV glucose and advance enteral feeds as tolerated) over the first 7 days in critically ill patients with sepsis or septic shock for whom early enteral feeding is not feasible.

Quality/level of evidence: Moderate

+ Strength of recommendation: Strong

Recommendation 81. (SSCG Section T, Recommendation 3).

We suggest the early initiation of enteral feeding rather than a complete fast or only IV glucose in critically ill patients with sepsis or septic shock who can be fed enterally.

Quality/level of evidence: Low**+ Strength of recommendation:** Weak**Recommendation 82.** (SSCG Section T, Recommendation 4).

We suggest either early trophic/hypocaloric or early full enteral feeding in critically ill patients with sepsis or septic shock; if trophic/hypocaloric feeding is the initial strategy, then feeds should be advanced according to patient tolerance.

Quality/level of evidence: Moderate**+ Strength of recommendation:** Weak**Recommendation 83.** (SSCG Section T, Recommendation 5).

We **recommend against** the use of omega-3 fatty acids as an immune supplement in critically ill patients with sepsis or septic

Quality/level of evidence: Low**+ Strength of recommendation:** Strong**Recommendation 84.** (SSCG Section T, Recommendation 6).

We **suggest against** routinely monitoring gastric residual volumes (GRVs) in critically ill patients with sepsis or septic shock (weak recommendation, low quality of evidence). However, we suggest measurement of gastric residuals in patients with feeding intolerance or who are considered to be at high risk of aspiration.

Quality/level of evidence: Very low**+ Strength of recommendation:** Weak

Remarks: This recommendation refers to nonsurgical critically ill patients with sepsis or septic shock

Recommendation 85. (SSCG Section T, Recommendation 7).

We suggest the use of prokinetic agents in critically ill patients with sepsis or septic shock and feeding intolerance.

Quality/level of evidence: Low**+ Strength of recommendation:** Weak**Recommendation 86.** (SSCG Section T, Recommendation 8).

We suggest placement of post-pyloric feeding tubes in critically ill patients with sepsis or septic shock with feeding intolerance or who are considered to be at high risk of aspiration.

Quality/level of evidence: Low**+ Strength of recommendation:** Weak**Recommendation 87.** (SSCG Section T, Recommendation 9).

We **recommend against** the use of IV selenium to treat sepsis and septic shock.

Quality/level of evidence: Moderate**+ Strength of recommendation:** Strong**Recommendation 88.** (SSCG Section T, Recommendation 10).

We **suggest against** the use of arginine to treat sepsis and septic shock.

Quality/level of evidence: Low**+ Strength of recommendation:** Weak**Recommendation 89.** (SSCG Section T, Recommendation 11).

We **recommend against** the use of glutamine to treat sepsis and septic shock.

Quality/level of evidence: Moderate**+ Strength of recommendation:** Strong**Recommendation 90.** (SSCG Section T, Recommendation 12).

We make no recommendation about the use of carnitine for sepsis and septic shock.

Quality/level of evidence: N/A**+ Strength of recommendation:** N/A

Implementation Points for Nutrition Support Provision in ICU Patients with Sepsis were provided by a subgroup of the ICU Dietitians Group of INDI (Irish Nutrition and Dietetic Institute)

Implementation point 23 - Overall

Critically ill patients including those with sepsis have complex nutritional needs and require intensive nutritional input. The importance of recognising different phases of critical illness when considering route, timing and dose of nutrition support is an essential component of managing nutrition support in individual ICU patients. For implementation and further details on nutritional care of critically ill patients, see the Critical Care Programme Intensive Care Nutrition Support Algorithm (CCP,2020).

Implementation point 24 (Recommendation 79)

All patients should be screened on admission to ICU to assess their nutrition risk and the need for nutrition support (Singer et al., 2019) (McClave et al., 2016). This should be followed by a nutritional assessment. See Tables 6 and 7 from the Critical Care Programme Intensive Care Nutrition Support Algorithm (CCP, 2020) for general principles around early enteral nutrition and guidance on delaying, commencing low dose or commencing early progressive enteral nutrition.

Implementation point 25 (Recommendation 80)

Optimal timing of initiation of parenteral nutrition in ICU patients remains unclear. In light of conflicting evidence, a pragmatic approach to commencing Parenteral Nutrition (PN) in ICU patients would be to start on day 3-4 when enteral feeding has failed or is contraindicated. Malnourished patients are not represented in available RCTs, as highlighted above. Consideration should be given to commencing PN earlier than day 7 in patients at high nutrition risk or severely malnourished, where EN is contraindicated (Singer et al., 2019).

Implementation Point 26 (Recommendation 84)

Traditionally in the ICU setting, a measurement of Enteral Nutrition (EN) tolerance using Gastric Residual Volume (GRV) monitoring is carried out at regular intervals and feed rate is reduced or suspended if levels are above an agreed cut-off. Abandoning this practice as routine care has been suggested in recent nutrition support guidelines (McClave et al., 2016). GRV measurement correlates poorly with gastric emptying, as well as incidence of regurgitation and aspiration and has been shown to contribute to reduce EN delivery. However, evidence for omission of GRV measurement is largely based on one trial where difficult to feed patients, such as those with multi-organ failure, and surgical patients were under-represented. For this reason, Canadian (Nutrition, 2015) and European (Singer et al., 2019) guidelines still recommend a GRV cut off level between 250-500ml and that measurement is done at 4-8 hourly intervals. When EN is established continued monitoring of GRVs may not be necessary.

Implementation Point 27 (Recommendation 85)

Monitoring the QT interval with serial electrocardiograms is required when prokinetic agents are used in the ICU, especially if concomitantly used with other agents that could prolong the QT interval (607). The need for prokinetic agents should be assessed daily, and they should be stopped when clinically not indicated.

Roles and Responsibilities (Implementation points 23-26)

Clinicians are responsible for engaging dietetics and seeking advice on nutritional management for critically ill patients.

3.1.19 Setting goals of care**Key questions**

- In patients with sepsis, should we recommend discussion of goals of care and prognosis with family?
- In patients with sepsis, should we recommend incorporating palliative and end-of-life care?
- Should we recommend addressing goals of care early (within 72 hours) during ICU stay?

SSCG Rationale

Patients with sepsis and multiple organ system failure have a high mortality rate; some will not survive or will have a poor quality of life. Although the outcome of intensive care treatment in critically ill patients may be difficult to prognosticate accurately, establishing realistic ICU treatment goals is paramount (638), especially because inaccurate expectations about prognosis are common among surrogates (639). Nonbeneficial ICU advanced life-prolonging treatment is not consistent with setting goals of care (640, 641). Models for structuring initiatives to enhance care in the ICU highlight the importance of incorporating goals of care, along with prognosis, into treatment plans (642). The use of proactive family care conferences to identify advance directives and treatment goals within 72 hours of ICU admission has been demonstrated to promote communication and understanding between the patient's family and the treating team; improve family satisfaction; decrease stress, anxiety, and depression in surviving relatives; facilitate end-of-life decision-making; and shorten ICU LOS for patients who die in the ICU (643, 644). Promoting shared-decision-making with patients and families is beneficial in ensuring appropriate care in the ICU and that futile care is avoided (641, 645, 646).

Palliative care is increasingly accepted as an essential component of comprehensive care for critically ill patients regardless of diagnosis or prognosis (642, 647). Use of palliative care in the ICU enhances the ability to recognize pain and distress; establish the patient's wishes, beliefs, and values, and their impact on decision-making; develop flexible communication strategies; conduct family meetings and establish goals of care; provide family support during the dying process; help resolve team conflicts; and establish reasonable goals for life support and resuscitation (648).

A recent systematic review of the effect of palliative care interventions and advanced care planning on ICU utilization identified that, despite wide variation in study type and quality among nine randomized control trials and 13 nonrandomized controlled trials, patients who received advance care planning or palliative care interventions consistently showed a pattern toward decreased ICU admissions and reduced ICU LOS (649).

However, significant inter-hospital variation in ratings and delivery of palliative care is consistent with prior studies showing variation in intensity of care at the end of life (650). Despite differences in geographic location, legal system, religion, and culture, there is worldwide professional consensus for key end-of-life practices in the ICU (651).

Promoting patient and family-centred care in the ICU has emerged as a priority and includes implementation of early and repeated care conferencing to reduce family stress and improve consistency in communication; open flexible visitation; family presence during clinical rounds, resuscitation, and invasive procedures; and attention to cultural and spiritual support (652–655).

Recommendation 91. (SSCG Section U, Recommendation 1).

We recommend that goals of care and prognosis be discussed with patients and families.

Quality/level of evidence: Low

+ Strength of recommendation: BPS

Recommendation 92. (SSCG Section U, Recommendation 2).

We recommend that goals of care be incorporated into treatment and end-of-life care planning, utilizing palliative care principles where appropriate.

Quality/level of evidence: Moderate

+ Strength of recommendation: Strong

Recommendation 93. (SSCG Section U, Recommendation 3).

We suggest that goals of care be addressed as early as feasible, but no later than within 72 hours of ICU admission.

Quality/level of evidence: Low

+ Strength of recommendation: Weak

3.2 Rehabilitation and post-discharge care

The evidence base behind the benefits of structured rehabilitation for post sepsis patients is still evolving and further research is on-going. A summary of the findings to date with suggested good practice points are outlined below. These good practice points are divided in hospital practices aimed at preventing long-term morbidity, and post-hospital discharge strategies designed to screen, evaluate and manage clinical conditions among sepsis survivors.

Hospital practices for preventing long-term morbidity:

The GDG recognises that the good practice points for hospital practices below are already current practice and anticipates that no additional funding will be required for implementing in a more standardised way.

- Awareness of the long-term sequelae of sepsis and septic shock should be promoted amongst healthcare providers, patients and/or next of kin.
- Mobilisation and physical rehabilitation should start as early as clinically possible during hospital stay, basing rehabilitation goals on the clinical assessment of healthcare professionals experienced in critical care and rehabilitation.
- The approach to sepsis patients admitted to the ICU should align with international practice guidelines for the management of pain, agitation, delirium and sleep disruption.
- Sepsis information booklets should be made available to the relatives and friends of patients admitted to a critical care area with sepsis. The latest version can be downloaded from <https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/>
- The option of starting a diary should be considered.
- Pre-discharge assessment of sepsis patients should include checking for ongoing dietetics, physiotherapy and psychosocial requirements and referral for community follow-up based on their clinical need.
- Pre-discharge medication reconciliation.
- The discharge letter provided to Primary Care Physicians should include ongoing dietetic, physiotherapy and psychosocial requirements as well as hospital diagnoses, treatment and ongoing medication.

Post-hospital discharge strategies for assessment and management of clinical sequelae

The GDG recognises that additional funding will be required to implement the good practice points for post-hospital discharge outlined below. However, these good practice points support the Government policy direction for Ireland's healthcare system - Slaintecare (DOH, 2017b) and should be considered as part of the expansion of capacity to deliver healthcare closer to the patient in the community.

- The utilisation of a structured clinical evaluation method such as the 'Framework for evaluating and treating patients in the 90 days after hospitalization for sepsis' (Prescott and Angus, 2018), aimed at screening for common mental and physical impairments after sepsis at outpatient clinic review post discharge or by GP's.
- Individualising protocols of physical rehabilitation aimed at improving function in activities of daily living (ADL), functional exercise capacity, aerobic capacity, and skeletal muscle strength, with focus on respiratory muscles.
- Self-management practices and peer-support as valuable resources to mitigate mental health impairments.

Rationale:

A recent meta-analysis of epidemiological studies estimated yearly worldwide hospital survival after sepsis to be as high as 73% (Fleischmann et al., 2016). A considerable proportion of sepsis survivors, however, manifest an increased likelihood of long-term morbidity when compared to matched cohorts (Iwashyna et al., 2010) (Shah et al., 2013) (Yende et al., 2014) (Zielske et al., 2014) (Prescott et al., 2015) (Ou et al., 2016). Common long-term sequelae after sepsis include the following: cognitive impairment with decline in cognitive functions such as verbal fluency, memory and attention, and executive functioning; deterioration of mental health status related to depression (Davydow et al., 2013) (Rabiee et al., 2016), anxiety (Nikayin et al., 2016), and post-traumatic stress disorder (Wintermann et al., 2015) (Parker et al., 2015); physical disabilities that result in swallowing difficulties (Zielske et al., 2014) and functional limitations of activities of daily living (ADLs) (Iwashyna et al., 2010); increased predisposition to recurrent infections (Prescott et al., 2015) (Shen et al., 2016); progression and aggravation of chronic medical conditions such as congestive heart failure, chronic kidney disease, and chronic obstructive pulmonary disease (Prescott et al., 2015); and occurrence of acute or acute-on-chronic events such as myocardial infarction, stroke, ventricular arrhythmias and sudden death (Zielske et al., 2014) (Ou et al., 2016). Overall, a combination of long-term sequelae often results in a reduction of physical and psychological quality of life among sepsis survivors (Winters et al., 2010) (Yende et al., 2016). Importantly, performance in the workplace may decrease, and social interactions may be subtly undermined (Davydow et al., 2013).

Given these considerable human and socioeconomic implications, it is necessary to define a conceptual framework of practices aimed at reducing long-term morbidity in septic patients (Prescott and Angus, 2018). As a general paradigm, recovery after sepsis could be enhanced by adopting both hospital practices aimed at preventing long-term morbidity, and post-hospital discharge strategies designed to screen, evaluate and manage clinical conditions among sepsis survivors (Prescott and Angus, 2018) (Prescott and Costa, 2018).

Among the hospital practices for preventing long-term morbidity, we recognise the importance of adhering to international practice guidelines for the management of pain, agitation and delirium in ICU, and to perform early mobilisation and physical rehabilitation as early as clinically possible.

Pain, agitation and delirium are common complications among sepsis patients admitted to the ICU and are associated with extended ICU length of stay and increased risk of developing neuropathic pain, cognitive impairment, and post-traumatic stress disorder (Barr et al., 2013) Implementation of care bundles recommended by clinical practice guidelines could improve clinical outcomes in this domain (Mansouri et al., 2013) (Trogrlić et al., 2015).

A recent Cochrane review on the effects of early mobilisation for critically ill adults concluded that the evidence for the effectiveness of such practices for short-term clinical outcomes is inconsistent and uncertain (Doiron et al., 2018). Despite the majority of published RCTs showed improvement in short-term physical and neurological outcomes, their quality of evidence is low to moderate due to small sample sizes, lack of blinding of participants and personnel, variation in the interventions and outcomes used to measure their effect and inadequate descriptions of the interventions delivered as usual care (Doiron et al., 2018). Moreover, no RCTs provide high quality evidence on the effectiveness of early mobilisation during ICU stay in reducing the long-term risk of acquiring physical and mental disabilities after hospital discharge. Nevertheless, given the positive results of most studies and the strong theoretical rationale for benefit, we recommend performing mobilisation and physical rehabilitation as early as clinically possible. In agreement with the National Institute for Health and Care Excellence guidelines, rehabilitation goals should be patient-specific, and based on the clinical assessment of healthcare professionals experienced in critical care and rehabilitation (NICE, 2017) (NICE, 2009).

Among the post-hospital discharge strategies for assessment and management of clinical sequelae we recognise the importance of clinical follow-up of sepsis survivors, including the adoption of a structured clinical evaluation method aimed at screening for common mental and physical impairments after sepsis. We also recognise the role of individualised protocols of physical rehabilitation and self-management practices and peer-support as valuable resources to mitigate mental health impairments.

To date, very little research has focused on strategies to improve rehabilitation after hospital discharge specifically among sepsis survivors. One retrospective propensity score-matched cohort study of sepsis survivors showed that engaging in rehabilitation within 90 days of hospital discharge was associated with a significantly lower risk of 10-year mortality (Chao et al., 2014). In that study, rehabilitation consisted of individualised protocols constructed by physicians and psychiatrists and delivered by a multidisciplinary team which included physical and/or occupational therapists, speech therapists, social workers, and/or athletic trainers. These protocols were patient-specific, and aimed at improving muscle strengthening and movement, activities of daily living, cardiovascular capacity, functional ability, and occupational and communication therapy (Chao et al., 2014). Only one RCT was designed to examine the effects of specific primary care-based interventions on long-term quality of life after sepsis (Schmidt et al., 2016). Such interventions included education for primary care physicians and patients about long-term disabilities after sepsis, case management provided by trained nurses, and clinical decision-making support for primary care physicians provided by consulting physicians. Of all the outcomes measured, marginal positive findings were noted on functional outcomes such as physical function and disability at 6 months, ADL limitations at 6 and 12 months, and quality of sleep at 12 months. Despite the paucity of high-quality evidence for rehabilitation among sepsis survivors, indirect evidence can be derived from the literature on rehabilitation from critical illness (Mehlhorn et al., 2014), as many of the clinical sequelae after sepsis have been associated to the ICU stay. In this field, interventions proposed in different low-quality RCTs have yielded inconsistent findings regarding a beneficial effect on functional exercise capacity, or on health-related quality of life, of an exercise-based intervention initiated after ICU discharge for survivors of critical illness (Connolly et al., 2015).

Peer support groups for ICU survivors have been recently proposed as a strategy to relieve psychological distress (Mikkelsen et al., 2016) and ICU diaries have been shown to reduce PTSD symptoms among patients and caregivers (Jones et al., 2010) (Jones et al., 2012).

ICUsteps Dublin is a voluntary support group open to former intensive care patients, family and carers. Informal “drop-in” meetings facilitated by former patients, relatives and ICU nurses are held one evening every 8 weeks where people recovering from critical illness can share experiences and lend support to one another. (www.icusteps.ie).

3.3 Summary budget impact analysis

Methodology

The guideline development group systematically reviewed all 93 recommendations to determine if any had a budget impact for the implementation of the guideline update. Each recommendation statement was discussed and determined as either having no budget impact if the recommendation was currently practiced, or as having a requirement for a budget resource. The costs were then determined for the latter. Michelle O'Neill (HIQA) and Susan Ahern (HIQA) both with expertise in health economics were consulted to inform this section of the guideline.

Key findings relating to costs

Only 1 of 93 recommendations was determined to have a potential budgetary impact. In addition, the GDG suggest that research be undertaken to determine the burden of chronic sequelae associated with sepsis survival. However as this is a suggestion, it has not been included in the analysis.

Recommendation 1: Hospitals and hospital systems have a performance improvement programme for sepsis including sepsis screening for acutely ill high-risk patients.

Recommendation 1 - Budget Impact

The areas identified under recommendation 1 as having a budget impact for development are:

- a. National Sepsis Programme Costs
- b. National Quality Assurance and Improvement System (NQAIS) Sepsis
- c. Data extraction and analysis – Annual Report
- d. Sepsis Education
- e. Raising Awareness
 - i. Clinical – Sepsis Summit
 - ii. General Public – Sepsis Awareness

A) National Sepsis Programme Costs

A performance improvement programme for hospitals at both group and local level is provided by the National Sepsis Programme with the provision of audits and education to improve performance in the recognition and management of sepsis.

The fixed costs due to salary contribute to over 85% of the programme's costs. See table 20 for the breakdown of costs.

Table 20. Staffing of the national sepsis programme

Details	Annual Salary inclusive of PRSI, Pension, Overheads.*	
<i>*These are approximate values as salary could change in 2021/2022 but are based on mid-point salary scales from HSE pay scales. (HSE, 2014-2020)</i>		
National Clinical Lead	0.5 WTE	€63,677
Project Manager	0.5 WTE	€40,000
Hospital Groups Assistant Directors of Nursing	7 WTE €70,237(x7)	€491,659
Team WTE	7	
Total Cost	€595,336	

Future annual staff costs (including the appointment of a Paediatric Sepsis ADON in July 2020)
 0.5 WTE Clinical Lead, 0.5 WTE Programme Manager Grade VIII, 7 Assistant Directors of Nursing €595,336.

B) NQAIS Sepsis

NQAIS Clinical is a web-enabled feedback tool based on HIPE Data which would have the potential to be developed for Sepsis. Development of NQAIS SEPSIS would allow up to date national and local level data and would promote earlier detection of negative trends so that action can be taken sooner to improve any deficiencies in the early recognition and management of sepsis and therefore would enable performance improvement and improve patient safety. NQAIS Clinical could have the potential to:

- Improve audit and quality improvement initiatives that impact on patient safety.
- Save resources for the QID and Sepsis teams to allow more time for training and awareness.
- Provide clinical leadership with comparative performance metrics for the objective management of sepsis patients.
- Support the development of National Key Performance indicators for sepsis.
- Allow individual hospitals to view the national picture, hospital group and individual hospital discharge activity by diagnosis group, procedure group or specialty group.
- The NQAIS sepsis mortality prediction model and scoring system could facilitate comparison of age and co-morbidity adjusted hospital sepsis-associated mortality rates nationally and internationally and will provide real time data to the system.

The costs are outlined in Table 21.

C) Data extraction and analysis – Sepsis Annual Report

The publication of the annual National Sepsis Report aims to highlight the burden of sepsis to the community and to the healthcare system. It has allowed the monitoring of the impact of National Clinical Guideline No. 6: Sepsis Management and its implementation and will continue to perform this function with the update in 2021. The report also facilitates a review of the trends in the detection and reporting of sepsis along with the mortality rate in the adult, maternity and paediatric setting. The publication of the annual sepsis report is an important document for the monitoring of the recognition and detection of Sepsis nationally. It is used

by various hospital groups and sepsis committees as a reference. Whilst sepsis occurs in all age groups and all sectors of society, it most commonly occurs in the extremes of age and in individuals with co-morbidities. The report shows the pattern of sepsis incidence in Ireland and informs on the characteristics of individuals who are at an increased risk both of developing sepsis and of dying from sepsis. This allows heightened vigilance for sepsis amongst these individuals and provides evidence to support the use of preventative strategies, such as vaccination, in these at-risk people.

The costs are outlined in Table 21.

D) Sepsis education – E-Learning Module.

Currently there is an e-learning module for Sepsis which is housed on HSeLanD that was developed previously by the National Sepsis programme. This programme requires updating to reflect current best practice as outlined in this guideline. This programme is aimed at all HSE clinical staff in acute and maternity hospital settings.

The costs are outlined in Table 21.

E) Raising awareness

a. Sepsis Summit

The Sepsis Summits is a valuable learning opportunity where members of sepsis committees, senior leaders and managers in the acute sector, primary healthcare and maternity come together to focus on the learning and sharing of information around implementing the National Clinical Guideline No. 26 Sepsis Management for Adults (including maternity). International speakers are invited to share learning from other countries. The summit also allows a forum for networking and national support for all those implementing the sepsis tools with a main aim being to ensure that sepsis remains a priority on all hospital organisations agenda.

b. Public Campaign

A public awareness campaign aims to provide the general public with the tools to recognise the signs of sepsis and seek early medical intervention. The Sepsis programme will seek funding to promote sepsis awareness education to the public and also to Primary Care Facilities. Funding will pay for printing and distribution of sepsis education promotional material, i.e. make available patient information booklets to the general public; link with Healthy Ireland and communications dept. HSE; launch community awareness campaign & supporting leaflets/social media at GP surgeries, CHO pharmacies, primary healthcare centres. Social media should be used to target GP surgeries, schools and sporting events.

The costs are outlined in Table 21.

Variable costs:**Table 21.** Future variable costs of the guideline implementation

Future variable costs include VAT.	One off costs Year 1	Annual costs Year 2,3,4,5
• Education update: eLearning Approximately Cost applies to updating existing eLearning programme on HSeLand.	€54,000 Set up	€0 after set up
• NQAIS sepsis: Cost applies to initial construction of the platform year 1 and on-going annual maintenance cost approx. for years 2-5	€38,000 (Yr 1)	€50,000 (Yr 2,3,4,5)
• Annual outcome report design and printing costs.	€4,000	€4,000
• Data extraction for HIPE, interpretation and analysis. Approximate cost associated with QIT time.	€3,983	€3,983
• Annual sepsis summit: Costs include catering, international speakers (flights and accommodation), Audio Visual and promotion.	€15,000	€15,000
• Public awareness: Costs include social media interface for information materials including leaflets/posters/videos.	€30,000	€30,000
Total Future Variable Cost	€145,000	€103,000

Table 22. Total future costs over 5 years

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Future Variable Costs	€145,000	€103,000	€103,000	€103,000	€103,000	€557,000
Future Staff Costs	€595,336 (Approx)	€595,336 (Approx)	€595,336 (Approx)	€595,336 (Approx)	€595,336 (Approx)	€2,976,680
TOTAL	€740,336	€698,336	€698,336	€698,336	€698,336	€3,533,680

Conclusion

The budget impact analysis considers the additional resources required to implement the updated Sepsis Management National Clinical Guideline No 26. Over 5 years, the budget impact of the guideline recommendations is estimated to be €3,533,680 including staff costs. This is illustrated in Table 22.

It is also important to consider the cost savings that have been realised through the implementation of the guideline to date as demonstrated by the National Sepsis mortality data reported annually.

The mean in-hospital crude mortality rate for in-patients with a diagnosis of sepsis from 2011-2015 showed an average of 23.4% (NSR, 2016). For the period 2016-2018 (NSR 2017,2018,2019), this dropped to 18.7% representing a statistically significant improvement since the publication of the National Clinical Guideline (NCEC 2014). The mortality decrease suggests an additional 302 lives saved over the 3 years post implementation from this subpopulation.

In 2018 in Ireland, 4,002 patients admitted to ICU had a sepsis code on their hospital discharge. The hospital AvLOS for this subgroup decreased from 36.72 days in 2011-15 to 33.7 days in 2016-18, a gain of 12,086 bed days and a reduction in direct costs from €30,808 to €29,589 per patient. This represents a saving of €10.6million based on cost per day of €878 (Health Pricing Office, 2017), between 2011 and 2018.

3.4 Areas for Future Health Research

Many areas for future research are identified throughout the SSCG. This section serves to highlight these recommendations to inform future guideline updates on how to best manage sepsis in Ireland and to add to the existing knowledge base.

- **Initial Treatment**

The use of IV fluids in the resuscitation of patients is a cornerstone of modern therapy. Despite this, there is little available evidence from RCTs to support its practice; this is an area in which research is urgently needed.

- **Vasoactive Medications**

Phenylephrine is a pure α -adrenergic agonist. Clinical trial data in sepsis are limited. Phenylephrine has the potential to produce splanchnic vasoconstriction (280). A network meta-analysis resulted in imprecise estimates (wide confidence intervals) when phenylephrine was compared to other vasopressors (281). Therefore, the impact on clinical outcomes is uncertain, and phenylephrine use should be limited until more research is available.

- **Blood purification techniques**

The confidence in the evidence around blood purification techniques is very low either in favour of or against blood purification techniques; and as such they do not provide any recommendation but suggest further research is needed to clarify the clinical benefit of blood purification techniques.

- **Renal Replacement therapy**

More research is required on the effect of dose of CRRT. A meta-analysis of the sepsis patients included in all relevant RCTs ($n = 1,505$) did not demonstrate any significant relationship between dose and mortality; the point estimate, however, favours CRRT doses $> 30 \text{ mL/kg/hr}$. Because of risk of bias, inconsistency, and imprecision, confidence in the estimate is very low with further research indicated.

- **Venous thromboembolism prophylaxis**

Combined pharmacologic prophylaxis and mechanical prophylaxis with intermittent pneumatic compression (IPC) and/or graduated compression stockings (GCS) is a potential option in critically ill patients with sepsis and septic shock. There are currently no high-quality studies of this approach in septic patients, or even critically ill patients in general, exist; however, further research is ongoing.

- **Nutrition**

In summary, due to the lack of mortality benefit, the increased risk of infection, and the extra cost for parenteral nutrition in the absence of clinical benefit (568), current evidence does not support the initiation of early parenteral nutrition over the first 7 days of care for patients with contraindications or intolerance to enteral nutrition. Specific patient groups may benefit more or incur more harm with early initiation of parenteral nutrition in this context. Future research should be encouraged according to individual patient level meta-analyses to characterize these subgroups and plan for future randomized trials.

- **Rehabilitation**

Among the post-hospital discharge strategies for assessment and management of clinical sequelae importance of clinical follow-up of sepsis survivors is recognised including the adoption of a structured clinical evaluation method aimed at screening for common mental and physical impairments after sepsis. The role of individualised protocols for physical rehabilitation and self-management practices and peer-support as valuable resources to mitigate mental health impairments are also recognised. To date, very little research has focused on strategies to improve rehabilitation after hospital discharge specifically among sepsis survivors and the GDG suggest that research be undertaken to determine the burden of chronic sequelae associated with sepsis survival.

4

Appendices

Appendix 1: Guideline Development Group Terms of Reference

Guideline Development Group Terms of Reference

1. Purpose

The purpose of this Adult Guideline Development Group (GDG) is to update the existing NCG No.6 (Sepsis management) (November2014) to reflect current best evidence.

2. Objectives

The objectives of the GDG are to:

- Ensure adherence to the NCEC methodology in drafting the revised clinical guideline.
- Include a budget impact analysis in the updated guideline.
- Review current guidelines in peer reviewed journals since 2015 with a view to adopting or adapting a guideline.
- Include an implementation strategy in the revised guideline.
- Prepare a draft updated guideline.
- Circulate draft guideline for consultation and external review.
- Finalise and approve the updated clinical guideline.
- Submit to National Sepsis Steering Group for review and approval.
- Submit finalised updated guideline to NPSO/NCEC, DOH for appraisal, endorsement and ministerial launch.

3. Scope

The scope of the GDG is to revise and update the existing NCG No.6 (Sepsis Management Guideline) (2014) to reflect current best practice utilising Irish national data. The GDG will be cognisant of this throughout the guideline revision process and will consider adapting, adopting current guidelines or making recommendations based on a current literature review.

4. Membership

Membership nominations were sought from a wide range of experts so as to be as representative of all the relevant key stakeholders. The GDG may on occasion co-opt expertise from relevant sources as required.

5. Working Arrangements

- a) A schedule of meetings will be agreed with the Chair for the year. Work will be undertaken between meetings and members will contribute to, and approve work, via e-mail correspondence (and teleconference when available).

- b) The Chair and Deputy Chair will be responsible for circulating papers and minutes of meetings. Papers for meetings will be circulated no later than 3 working days before meetings and minutes will be circulated no later than 2 weeks after meetings.
- c) The group will be quorate if a third of total membership (8) are present.
- d) Apologies should be sent in advance of meetings. If a group member does not attend more than three consecutive meetings the Chair or Deputy Chair will contact him/her to seek confirmation of continued participation or if they would like to nominate a replacement.
- e) Members of the GDG will reflect the views of the specialist groups and individual organisations they represent and will communicate through the relevant organisation's governance structures.
- f) Decision-making: the agenda will identify items that require important decisions to be made at the meeting. Where group members are unable to attend, they may submit comments to the Chair/Deputy, by e-mail, by 5pm on the day prior to the meeting. The Chair/Deputy will bring forward all comments received for consideration by the group in attendance. Decisions will be made by the group attending the meeting. Meeting notes will detail such decisions to group members who are not in attendance.
- g) There may be a requirement to establish various working groups to advance actions as guideline development progresses. The Chair of the working group will report to the GDG on progress and outputs and seek further advice or decisions where appropriate.

Roles and Responsibilities (based on NCEC guidance and National SEPSIS Steering group TOR)**GDG Chairperson/Deputy Chairperson Role and Responsibility**

- Develop and agree terms of reference
- Ensure guideline is developed using NCEC methodology
- Set and agree timelines (using a standard project management approach where possible)
- Set and circulate the agenda of each meeting to members
- Encourage broad participation from members in discussion
- Identify and assign tasks
- Agree a process for dealing with conflicts of interest
- Identify and oversee the progress of specific sub-groups
- End each meeting with a summary of decisions and actions
- Act as a point of contact for GDG members

GDG Member Roles and Responsibilities

- Review and agree group membership to reflect all key stakeholders
- Agree timelines for meetings and the clinical guideline development process
- Convene as required
- Give consideration to each of the stages of the clinical guideline path
- Review existing policies, guidelines, national and international evidence of best practice, relevant scientific and clinical expert opinion pertaining to the clinical guideline area
- Determine whether to adapt, adopt or develop a new clinical guideline
- Draft clinical guideline using NCEC methodology

- Consult with relevant interested parties and the public
- Review and incorporate feedback from consultation process as appropriate
- Finalise and approve clinical guideline for submission to Steering Group

GDG Service user Roles and Responsibilities (in addition to above)

- Ensure that key questions are informed by issues that matter to the service user
- Identify outcome measures they think are important for each key question
- Assist the GDG with the collection of service user views e.g. by helping to prepare questions for focus groups
- Help the GDG with consultation arrangements
- Identify areas where service users' preferences and choices may need to be acknowledged in the clinical guideline
- Help write the information for the service users' section of the clinical guideline including identifying sources of further information
- Help ensure that the clinical guideline is clearly and sensitively worded

Conflict of Interest

- Each participant on the group will be asked to sign the relevant form in relation to conflict of interest. This is necessary to participate on the GDG.

External Reviewers

- Prof. Kevin Rooney, National Clinical Lead on Sepsis, Healthcare Improvement Scotland and Professor of Care Improvement, University of the West of Scotland
- Dr John Bates from the Joint Faculty of Intensive Care Medicine in Ireland

Appendix 2: Sepsis Steering Committee/Working Group Membership

National Sepsis Steering Committee membership – 2019 /2020

Name	Job title and affiliation
Dr Fidelma Fitzpatrick	Chair
Dr Martina Healy	Clinical Lead for Sepsis
Ciara Hughes	National Sepsis Programme Manager
Celine Conroy	Group Sepsis ADON - Ireland East Hospital Group
Dr Karn Cliffe	Group Sepsis ADON/M - Dublin Midlands
Fidelma Gallagher	Group Sepsis ADON - Saolta
Ronan O'Cathasaigh	Group Sepsis ADON - Saolta (From January 2021)
Mary Bedding	Group Sepsis ADON - RCSI Group
Yvonne Young	Group Sepsis ADON - UHL Group
Catherine (Kay) O'Mahony	Group Sepsis ADON - Sepsis – South / Southwest (January 2019-December 2019)
Sinead Horgan	Group Sepsis ADON - Sepsis – South / Southwest (From January 2020)
Dr Philip Crowley	Representative from Quality Improvement Division
Elaine Brown	Representative from Acute Hospitals Division
Dr Vida Hamilton	Representative from NCAGL office
Ger Shaw	Representative from ONMSD
Jacqui Curley	Representative from Health Pricing Office
Declan McKeown	Representative from HSE Health Intelligence Unit
Robert Cunney	Representative for HCAI – HPSC representative
Dr Gerry McCarthy / Fiona McDaid	Representative for Emergency Medicine
Dr Garry Courtney	Representative for Acute Medicine
Dr Michael Power	Representative for Critical Care
Dr Omar Tujjar	Representative for Anaesthesia
Dr Debbie McNamara / Jamie Logan	Representative for Surgery
Dr David O'Hanlon	Representative for Primary Care
Dr Karen Power	Representative for Women and Children's Health
Diarmuid O'Shea	Representative for Older Person
Dr John Fitzsimons	Representative for Paediatrics
Avilene Casey	Representative for Deteriorating Patient
Barbara Egan	Patient representative
Linda Dillon	Patient representative
Brian Power	Representative Pre-Hospital Emergency Care Council
Anne McCabe	Representative for NASCCRS (National Ambulance Service and Critical Care and Retrieval Services)
Dr Cathal O'Donnell	Representative for National Ambulance Service

National Sepsis Programme Working Group – 2019/2020

Name	Job Title and Affiliation
Martina Healy	National Sepsis Clinical Lead
Ciara Hughes	Programme Manager National Sepsis
Mary Bedding	Group Sepsis ADON RCSI Hospital Group
Dr Karn Cliffe	Group Sepsis ADON/M Dublin Midlands Hospital Group
Celine Conroy	Group Sepsis ADON Ireland East Hospital Group
Yvonne Young	Group Sepsis ADON University Limerick Hospital Group
Fidelma Gallagher	Group Sepsis ADON Saolta Hospital Group
Catherine (Kay) O'Mahony (2019) Sinead Horgan (2020)	Group Sepsis ADON South / South West Hospital Group
Nuala Clarke	Group Sepsis ADON Paediatrics (Children's Hospital Group / South West Hospital Group)

Appendix 3: Glossary of terms and abbreviations

Glossary of Terms

The HSE has issued a Code of Practice for Healthcare Records management which includes dosage abbreviation guidance which is available at the following link:

<https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/abbreviations.pdf>

Clinician: a registered nursing/midwifery, medical or health and social care professional.

Confusion (new): new onset confusion, acutely altered mental status or delirium.

Escalation of Care: the point at which a clinician successfully contacts/calls for a more senior clinical review - nursing or medical - of a patient.

EMEWS: a standardised Emergency Medicine early warning system to recognise and respond to clinical deterioration in adult patients in the ED waiting room, following Triage.

EWS: Early Warning System

Irish National Early Warning System (INEWS): a system which incorporates anticipation of deterioration, recognition, escalation, response and governance.

Irish Maternity Early Warning System (IMEWS): a system for pregnant women which incorporates anticipation of deterioration, recognition, escalation, response and governance.

Maternal sepsis is a life threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion or postpartum (WHO 2017).

Screening: the purpose of screening is to identify patients with a high-risk presentation e.g. clinically apparent acute organ dysfunction such as acute confusion, respiratory failure or a purpuric rash AND patients who because of their medical history, e.g. on chemotherapy or having chronic co-morbidities/additional factors, have a high mortality risk if they have sepsis.

Sepsis is life-threatening organ dysfunction caused by a dysregulated host response to infection.

Septic Shock is a subset of sepsis with circulatory and cellular/metabolic dysfunction associated with a higher risk of mortality (Singer et al., 2016)

- The sepsis definition taskforce has defined this as the requirement for vasopressors/inotropes to achieve a mean arterial pressure of $\geq 65\text{mmHg}$ AND a lactate $>2\text{mmols/l}$ despite adequate fluid resuscitation

SIRS: Systemic Inflammatory Response Syndrome

SEPSIS 1: First CCP/SCCM consensus definition 1991

SEPSIS 2: Second CCP/SCCM consensus definition 2001

SEPSIS 3: Third CCP/SCCM consensus definition 2016 (Updated 2018)

SEPSIS 6 is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis (Take 3 and Give 3). Sepsis 6 was developed by The UK Sepsis Trust (Daniels, Nutbeam & Laver, 2006) as a practical tool to help healthcare professionals deliver the SSCG 1 hour bundle.

SEPSIS 6+1: (+ 1 = Fetal wellbeing)

Resuscitating the mother will resuscitate the baby, however, it is important to assess fetal wellbeing and formulate a plan for delivery if required. Maternal sepsis with or without haemodynamic instability may present with fetal distress as the uteroplacental circulation is not auto-regulated (Chau, 2014). Thus, any maternal circulatory insufficiency arising from sepsis may result in compromised fetal perfusion.

Time zero: 1 hour is allowed for screening and medical review from trigger. If infection is included in the differential diagnosis following medical review and the patient is in one of the at-risk groups, this is TIME ZERO. All elements of the Sepsis 6 bundle are to be initiated within 1 hour of TIME ZERO.

Trigger: The trigger to prompt sepsis screening

- Emergency Department (ED) presents unwell due to suspected infection
- In-patient: deteriorates on the ward due to suspected infection, deterioration on the ward is suggested by a INEWS score that has risen to ≥ 4 (≥ 5 if already on supplementary oxygen therapy) (NCEC, 2013) or by exercising clinical judgment.

The patient should be screened to see if they fit into one of the high-risk groups and escalated to medical review as per the 'Think Sepsis at Triage' algorithm or the INEWS escalation and response protocol.

Abbreviations

ACVPU: Alert, Confusion, Voice, Pain, Unresponsive	EM: Emergency Medicine
ADON: Assistant Director of Nursing	EGDT: Early Goal-Directed Therapy
ADOM: Assistant Director of Midwifery	EMEWS: Emergency Medicine Early Warning System
AGREE: Appraisal of Guidelines for Research & Evaluation	EMT: Emergency Medicine Technician
AMAU: Acute Medical Assessment Unit	ESBL: Extended-Spectrum B-lactamase
AMU: Acute Medical Unit	ESICM: European Society of Intensive Care Medicine
APACHE: Acute Physiologic and Chronic Health Evaluation	ESRI: The Economic and Social Research Institute
ARDS: Adult Respiratory Distress Syndrome	GCS: Graduated Compression Stockings
ASAU: Acute Surgical Assessment Unit	GDG: Guideine Development Group
AvLOS: Average Length of Stay	GDH: Glutamate dehydrogenase
BIA: Budget Impact Analysis	GI: Gastrointestinal
BPS: Best Practice Statement	GP: General practitioner
CCU: Coronary care unit	GRADE: Grading of Recommendations Assessment, Development and Evaluation
CDC: Centre for Disease Control	GRV: Gastric Residual Volume
CDI: Clinical Design and Innovation	H2RA: Histamine 2 receptor antagonist
CDST: Clinical Decision Support Tool	HCAI: Healthcare-associated infection
CEMD: Confidential Enquiry into Maternal Deaths	HCW: Healthcare Worker
CEU: Clinical Effectiveness Unit	HDU: High Dependency Unit
CNS: Central Nervous System	HES: Hydroxyethyl starches
CPAP: Continuous Positive Airway Pressure	HFOV: High Frequency Oscillatory Ventilation
CPG: Clinical Practice Guideline	Hg: Mercury
CRRT: Continuous Renal Replacement Therapy	HIPE: Hospital Inpatient Enquiry
CVP: Central Venous Pressure	HIMA: Health Information and Quality Authority
DIC: Disseminated Intravascular Coagulation	HPA: Health Protection Agency
DoH: Department of Health	HPO: Healthcare Pricing Office
DOM: Director of Midwifery	HPSC: Health Protection Surveillance Centre
DON: Director of Nursing	HSCP: Health and Social Care Professionals
DRG: Diagnostic Related Group	HSE: Health Service Executive
DVT: Deep Vein Thrombosis	ICD: International Classification of Disease
Dx1: Primary Diagnosis	ICU: Intensive Care Unit
Dx2: Secondary Diagnosis	IDSA: Infectious Disease Society of America (IDSA)
ED: Emergency Department	IMEWS: Irish Maternity Early Warning System

Abbreviations (continued)

INEWS: Irish National Early Warning System	PAC: Pulmonary Artery Catheter
IPC(T): Infection Prevention and Control (Team)	PaCO ₂ : Partial Pressure of Carbon Dioxide
IPC: Intermittent Pneumatic Compression	PBW: Predicted Body Weight
ISBAR: Identify, Situation, Background, Assessment, Recommendation	PCEHM: Public Health Service Panel on Cost Effectiveness in Health and Medicine
IV: Intravenous	PDSA: Plan, Do, Study, Act
KPI: Key Performance Indicator	PE: Pulmonary Embolism
LMWH: Low Molecular Weight Heparin	PEEP: Positive End Expiratory Pressure
LOS: Length of Stay	PHECC: Pre- Hospital Emergency Care Council
MAP: Mean Arterial Pressure	PICO: Population Intervention Comparison Outcome
MBRRACE: Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries	PPI's: Proton Pump inhibitors
MDE: Maternal Death Enquiry	QA: Quality Assurance
MDRO: Multidrug Resistant Organisms	RBC: Red Blood Cell
MIC: Minimum Inhibitory Concentration	RCT: Randomised Controlled Trial
MN-CMS: Maternal & Newborn Clinical Management System	RRT: Renal Replacement Therapy
MRSA: Methicillin-Resistant Staphylococcus Aureus	SAC: Scientific Advisory Committee
MTS: Manchester Triage System	SCCM: Society of Critical Care Medicine
N/A: Not Applicable	ScvO ₂ : Central Venous Oxygen Saturation
NCEC: National Clinical Effectiveness Committee	SIRS: Systemic Inflammatory Response Syndrome
NCG: National Clinical Guideline	SOFA: Sequential Organ Failure Assessment
NPEU: National Perinatal Epidemiology Unit	SPC: Statistical Process Control
NSP: National Sepsis Programme	SPHM: Specialist in Public Health Medicine
INEWS: Irish National Early Warning System	SSC: Surviving Sepsis Campaign
NICE: National Institute for Health and Care Excellence	SSCG: Surviving Sepsis Campaign Guideline
NIV: Non-Invasive Ventilation	UFH: Unfractionated Heparin
NMBA: Neuromuscular Blocking Agents	UK: United Kingdom
NQAIS: National Quality Assurance and Improvement System	US: United States
ONMSD: The Office of the Nursing and Midwifery Services	VAP: Ventilator Associated Pneumonia
OPD: Out-patient Department	VTE: Venous Thromboembolism
	WHO: World Health Organisation

Appendix 4: Economic assessment of Sepsis Management in adults (including maternity)

Economic evidence methodology

Report completed by Gethin White, Clinical Librarian.

Introduction

The search strategy is based on the developed PICOS (population, interventions, comparisons and outcomes) and a schema of concepts as outlined in Figure 15.

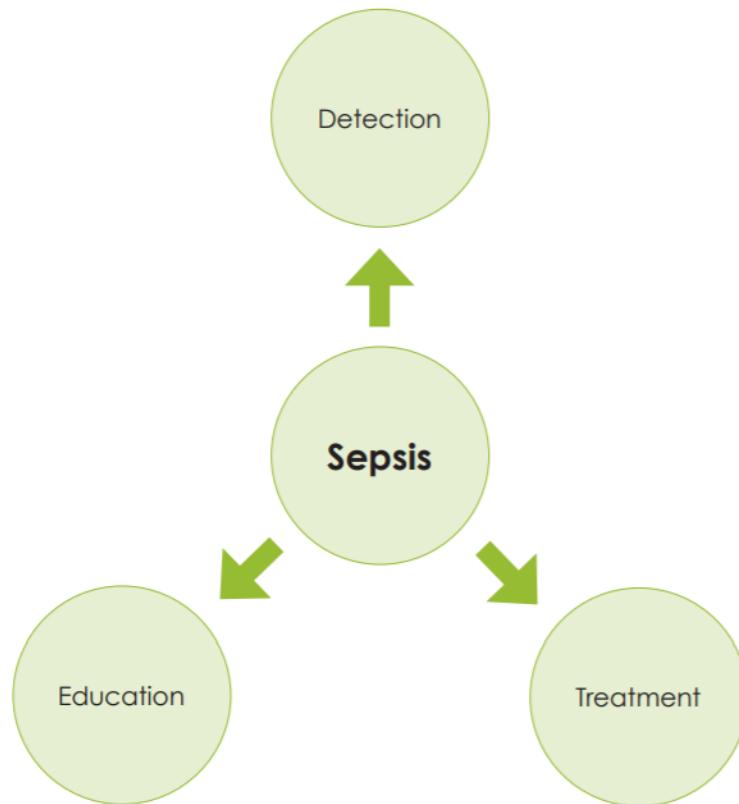


Figure 15. Concepts for systematic review of economic impact report of sepsis management

PICO Search Terms

Intervention 1: Sepsis detection

Population: All patients who may be at risk of or may have sepsis in acute hospitals including obstetrics

Intervention: Sepsis detection options

Comparison: Between sepsis detection techniques and no sepsis detection techniques; between different options applied

Outcomes: Resources and costs

Concepts and key words

1. Early recognition of Sepsis
 - a. Deteriorating
 - b. SIRS criteria (Systemic Inflammatory Response criteria)
 - c. Suspected infection, blood stream infection
 - d. Septic shock, Septicaemia
2. Sepsis screening
3. Electronic Early Warning Score (EWS) generation
4. Point of care lactate
 - a. POC LAC
 - b. POC lactate
 - c. Emergency department triage, ED triage
 - d. Acute medical unit (AMU)
 - e. Critical Care Units; Intensive Care Unit (ICU), High Dependency Unit (HDU), Coronary Care Unit (CCU), Maternity Unit, Acute wards.
5. Sepsis Six, Sepsis 6
6. Surviving Sepsis
 - a. One-hour bundle
7. Acute hospitals
 - a. Acute Care
 - b. Secondary Care
 - c. Tertiary Care
 - d. Inpatients

Intervention 2: Sepsis education

Population: All patients who may be at risk of or may have sepsis in acute hospitals including obstetrics.

Intervention: Sepsis education techniques

Comparison: Sepsis education interventions applied to target population compared with no sepsis education intervention applied

Outcomes: Resources and costs

Concepts and key words

1. Sepsis education programmes:
 - a. Suspected infection; sepsis; septic shock; septicaemia, blood stream infection, SIRS criteria
 - b. Techniques; programmes
 - c. Surviving Sepsis Campaign
 - d. ESICM (European Society of Intensive Care Medicine) PACT (Patient Centred Acute Care Training) modular learning programmes.

2. Specialist sepsis education coordinator:
 - a. Audit
 - b. Implementation.
3. Electronic learning tools for Sepsis
4. Smart phone applications for Sepsis
5. Undergraduate and post graduate sepsis training programmes
6. Acute hospitals
 - a. Acute Care
 - b. Secondary Care
 - c. Tertiary Care
 - d. Inpatients

Intervention 3: Sepsis treatment

Population: All patients who may be at risk of or may have sepsis in acute hospitals including obstetrics.

Intervention: Care options for Sepsis

Comparison: Between care options and no care options.

Outcomes: Resources and costs

Concepts and key words

1. Sepsis; infection, blood stream infection, septicaemia
2. Early recognition of Sepsis
 - a. Deteriorating
 - b. SIRS criteria (Systemic Inflammatory Response criteria)
 - c. Suspected infection
 - d. Septic shock
3. Early intervention
 - a. Sepsis Six: Cultures; lactate; oxygen; fluids; crystalloids; Urine output; antibiotics; antimicrobials, antibacterial
 - b. One- hour bundle
 - c. Vasopressin, Central Venous Oxygen (SCVO2), Corticosteroids, Haemoglobin transfusion, PEEP (Positive End Expiratory Pressure)
4. Critical Care; Intensive Care Unit (ICU), High Dependency Unit(HDU),
 - a. Intensive Care Unit (ICU), Coronary Care Unit (CCU),
 - b. Ventilator
 - c. Dopamine

Information sources

1. With economic filter

- EmbaseClassic+Embase June 2014 to August 2018
- Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) June 2014 to present, run through OVID in August 2018

2. Without economic filter (built into database type)

- Database of abstracts of Reviews of Effects
- NHS Economic Evaluation Database
- Health Technology Assessment Database
- Cochrane Central Register of Controlled Trials
- Cochrane Database of Systematic Reviews
- Grey literature websites:

www.eunethta.eu/

www.inahta.org/

<https://htai.org/>

www.euroscan.org.uk

The economic literature review was undertaken using the same search terms as derived from the clinical literature review but with the economic filter applied. A systematic search for evidence relating to the cost-effectiveness of implementing sepsis protocols similar to the guideline was carried out. After the search 14 full text articles were reviewed but none were considered applicable and therefore were not referenced. This strategy is outlined in Table 23 and Figure 16.

Table 23. Search strategy for economic assessment of sepsis management

ID	Search Date 13/11/2017	Hits
6	*Economics/	766968
7	*Economics, Medical/	14138
8	*Economics, Pharmaceutical/	2895
9	exp "Costs and Cost Analysis"/	230098
10	exp Health Care Costs/	62978
11	exp decision support techniques/	75183
12	exp models, economic/	14509
13	markov chains.sh.	13806
14	montecarlo method.sh.	27395
15	uncertainty.sh.	11754
16	quality of life.sh.	184222
17	quality-adjusted life years.sh.	11568
18	exp health economics/	14138
19	exp economic evaluation/	78598
25	(economic impact or economic value or pharmaco-economics or health care cost or economic factors or cost analysis or economic analysis or cost or cost- effectiveness or cost effectiveness or costs or health care cost or cost savings or cost-benefit analysis or hospital costs or medical costs or quality-of-life).sh.	150,8074
26	(econom\$ or cost or costly or costing or costed or price or prices or pricing or priced or discount or discounts or discounted or discounting or expenditure or expenditures or budget\$ or afford\$ or pharmacoeconomic or pharmaco- economic\$).ti,ab.	1063611
27	(cost\$ adj1 (util\$ or effective\$ or efficac\$ or benefit\$ or consequence\$ or analy\$ or minimi\$ or saving\$ or breakdown or lowering or estimate\$ or variable\$ or allocation or control or illness or sharing or life or lives or affordabl\$ or instrument\$ or technolog\$ or day\$ or fee or fees or charge or charges).ti,ab.	13199057
28	Decision tree OR decision model	60,141
30	(qol or qoly or qolys or hrqol or qaly or qalys or qale or qales).ti,ab.	522,318
31	(sensitivity analys\$ or quality-adjusted life year\$ or quality adjusted life year\$ or quality-adjusted life expectanc\$ or quality adjusted life expectanc\$).ti,ab.	665,367
32	(unit cost or unit-cost or unit-costs or unit costs or drug cost or drug costs or hospital costs or health-care costs or health care cost or medical cost or medical costs).ti,ab.	366,301
33	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32 <i>N.B Extractions 1-5 are outlined in table 23</i>	14706441
34	Sepsis OR blood poisoning OR septicaemia OR sirs OR systemic inflammatory response system OR septic shock OR severe sepsis Filters; Publication date from 2014/01/01 to 2019/06/30	55212
35	Sepsis OR blood poisoning OR septicaemia OR sirs OR systemic inflammatory response system OR septic shock OR severe sepsis Filters; Publication date from 2014/01/01 to 2019/06/30, Guideline/Practice Guideline	92
36	33 AND 35	68

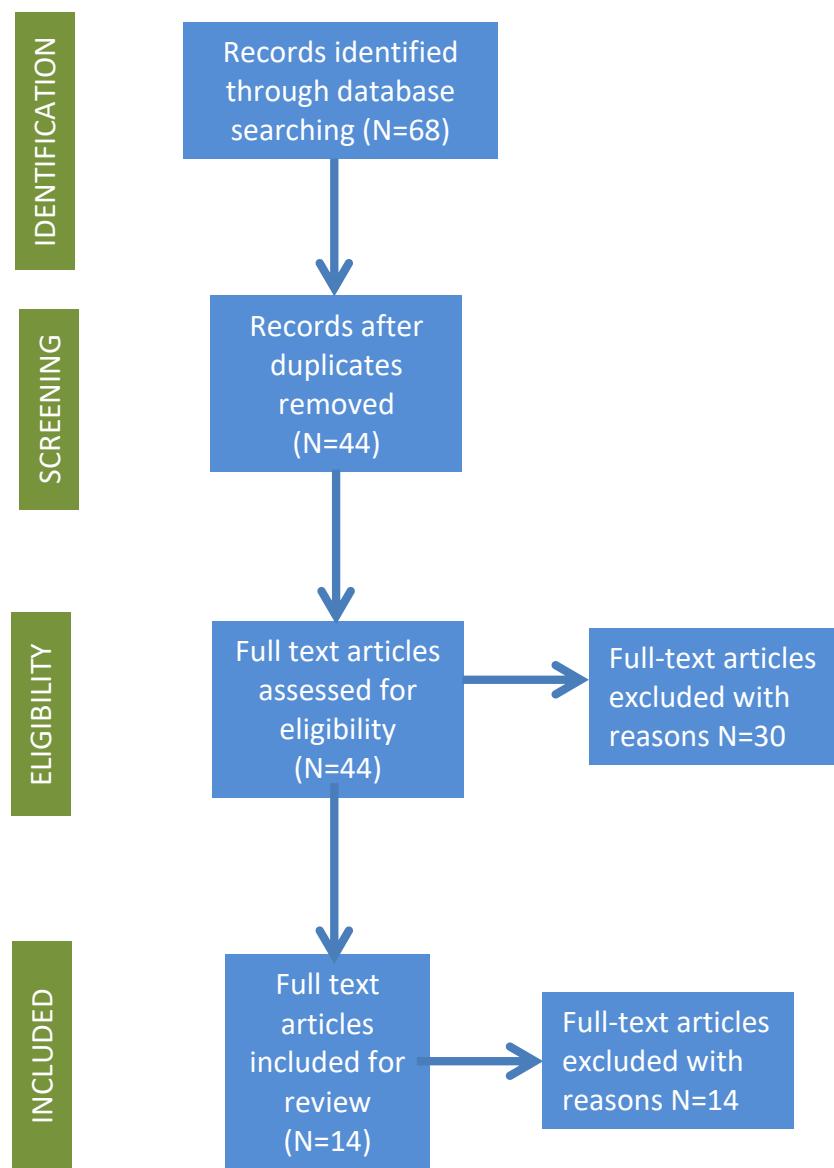


Figure 16. PRISMA Flow diagram: Included and excluded studies for economic literature review

Appendix 5: The Coding Process

The source document for coding in Ireland for HIPE is the medical record or chart. The clinical coder uses the entire chart to extract the conditions and procedures to provide a complete record of the patient and their health care encounter. The clinical coder, the person who translates medical terminology into alphanumeric code, performs an essential function in providing quality, accurate, and uniform medical information and greatly contributes to the continuous growth of medical knowledge and data. In addition to the discharge summary or letter, additional documentation referenced for coding a case include nursing notes, consultation reports, progress notes, operative reports, pre- and post-operative reports, pathology reports and more recently the sepsis screening form.

Fully completed and signed sepsis screening forms greatly assist in the coding and recognition of sepsis in acute hospitals. The classification used is ICD-10-AM/ACHI/ACS 8th Edition (International Classification of Diseases, 10th Revision, Australian Modification/ Australian Classification of Health Interventions/Australian Coding Standards). The Australian Coding Standards have to be adhered to by clinical coders in their work. These are complemented by the Irish Coding Standards (ICS). The ICS are developed to complement the Australian Coding Standards (ACS) and are revised regularly to reflect changing clinical practice.

ACS 0010 General Abstraction Guidelines states that coders cannot infer diagnoses from laboratory results and that “The listing of diagnoses on the front sheet and/or the discharge summary of the clinical record is the responsibility of the clinician”. It further states, “Unless a clinician can indicate that a test result is significant and/or indicates the relationship between an unclear test result and a condition, such test results should not be coded”.

The diagnosis of sepsis and documentation of the underlying cause by the medical team, if known, allows for greater specificity in coding.

All HIPE data are keyed in at the hospital using the HIPE Portal data entry system that runs an extensive number of validation edit checks to ensure the quality of the data. Other data quality activities and data quality tools are in use at local and national HPO level.

Appendix 6: Literature search strategy

A literature search was undertaken by the HSE Library Service to identify any national and international sepsis clinical guidelines published since the previous Sepsis NCG was published in 2014 which could be adopted or adapted for use in the Irish Healthcare setting.

The database searches are outlined in Table 24 and the search strategy using search terms related to the management of sepsis and septic shock and guidelines are shown in table 25. The websites of key organisations were also searched.

N.B A change in clinical leadership and programme manager position in 2018 in the National Sepsis Programme resulted in a delay in the progression of the guideline. The GDG were reconvened and in June 2019 the literature search was repeated to ensure that there were no additional publications in the interim period.

Table 24. Databases searched

Date	Database
13/11/2017	Pubmed, Web of Science, Scopus, Google Scholar, Google Scholar, Cinahl, GIN, Guidelines Clearinghouse, NICE, Trip, Scopus, Web of Science, Up to Date, Clinical Key
19/6/2019	Pubmed, Embase, National Guideline Clearinghouse, Trip, GIN, Guidelines Clearinghouse, NICE, Trip, Scopus, Up to Date, Clinical Key)

Table 25. Search strategy for sepsis management

ID	Search	Hits
1	Sepsis OR blood poisoning OR septicaemia OR sirs OR systemic inflammatory response system OR septic shock OR severe sepsis	238947
2	Sepsis OR blood poisoning OR septicaemia OR sirs OR systemic inflammatory response system OR septic shock OR severe sepsis Filters: Guideline, Meta-analysis, Practice Guideline, Systematic Review	1317
3	Sepsis OR blood poisoning OR septicaemia OR sirs OR systemic inflammatory response system OR septic shock OR severe sepsis Filters: Guideline, Practice Guideline, Systematic Review	1075
4	Sepsis OR blood poisoning OR septicaemia OR sirs OR systemic inflammatory response system OR	92
5	Excluding foreign language, specific types of sepsis e.g. acute meningitis and meningococcal sepsis	11

The Prisma flow diagram in Figure 17 illustrates the process undertaken in narrowing down the guidelines for appraisal.

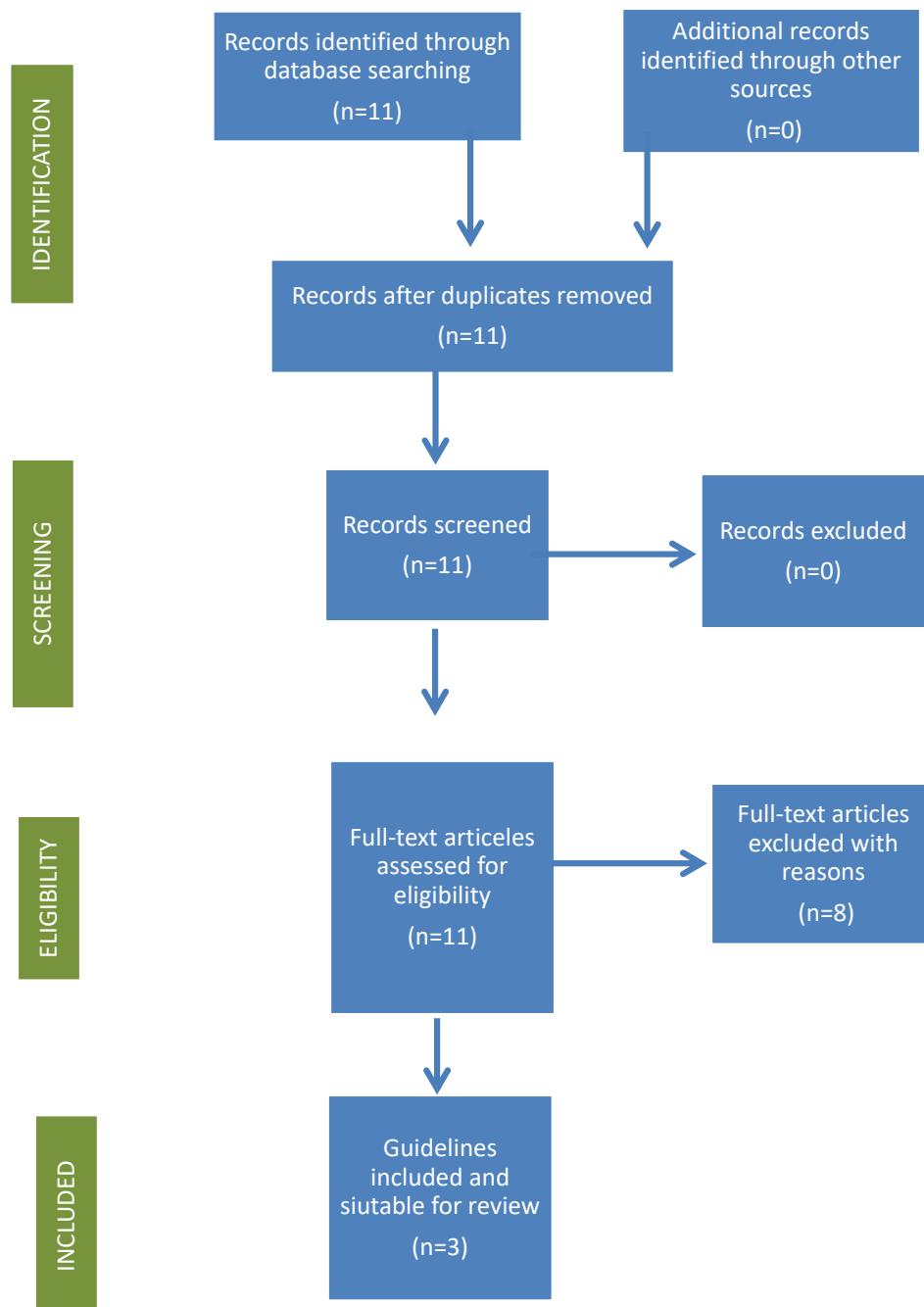


Figure 17. Prisma Flow Diagram - Sepsis Management Guideline Literature Review

The subsequent search in 2019 identified no additional guidelines in relation to Sepsis Management that had not been identified in 2014. The search identified 11 documents, 8 of which were excluded immediately as they related to pre-hospital care, non-acute care settings, paediatrics or were related to a specific type of sepsis, e.g. acute meningitis and meningococcal sepsis. When the exclusion criteria were applied only three guidelines were eligible for consideration:

- NICE Sepsis: recognition, assessment and early management (2016)
- Surviving Sepsis Campaign (SSC): International Guidelines for Management of Sepsis and Septic Shock (2016)
- The Japanese Clinical Practice Guidelines for the Management of Sepsis and Septic Shock (2018)

AGREE II Tool

In order to decide which guideline was relevant for the Irish Healthcare system and to appraise the quality of the guidelines, including the rigour and transparency in which the guidelines were developed a quality assessment was undertaken by two of the GDG Members using the Appraisal of Guidelines for Research and Evaluation II (AGREE II) tool, (Brouwers et al., 2010). The SSC Guideline ranked highest in all domains by both appraisers with overall domain percentages ranging 71-100%. Both appraisers agreed that based on the AGREE II process that the SSC Guideline should be adopted for use in the Irish Healthcare system.

Appendix 7: Consultation Stakeholders

Date	16th December 2019 - 7th January 2020. (Extended to 14th January)
Patient groups	Irish Patients Association HSE Patient 'Your service, Your say'
External review	Prof. Kevin Rooney, National Clinical Lead on Sepsis, Healthcare Improvement Scotland and Professor of Care Improvement, University of the West of Scotland Dr John Bates from the Joint Faculty of Intensive Care Medicine in Ireland
Clinical Programmes and healthcare divisions	Department of Health ONMSD CNO office DOH Divisions Patient Advocacy Unit Quality Improvement Division National Quality Assurance and Verification Division Quality and Patient Safety Acute Hospitals Division Office of the Nursing and Midwifery Services Hospital Group Clinical Directors Hospital Group CDONM's Hospital Directors of Nursing Acute Division Hospital Chief Executive Officers and General Managers Acute Division Hospital Clinical Directors, Acute Division National Director for Clinical Design and Innovation Nurse Leads, Clinical Design and Innovation Clinical Leads, Clinical Design and Innovation Programme Managers, Clinical Design and Innovation Directorate National Clinical Advisor and Group Lead for Acute Hospitals, Mental Health, Primary Care, Older Persons HSE National Director of Acute Hospitals Hospital Group Directors of Nursing Hospital Group Chief Executive Officers National Rehabilitation Hospital NWIHP NAS National Office of Clinical Audit PHECC HPSC (Health Protection Surveillance Centre) HSPC (Health and Social Care Professional Council) AMRIC – Antimicrobial Resistance Infection Prevention and Control
Academic Bodies	Royal College of Surgeons Royal College of Physicians in Ireland Irish College of General Practitioners Institute of Obstetrics and Gynaecology
Professional groups	CORU Surviving Sepsis Campaign Guideline Committee Intensive Care Society of Ireland Irish Association of Emergency Medicine Irish Association of Advanced Nurse Midwife Practitioners Irish Association of Directors of Nursing and Midwifery Irish Nurses and Midwifery Organisation Irish Private Hospitals Midwives association, Ireland SIPTU

Appendix 8: Implementation plan

These guidelines are divided into sections with each one pertaining to a different aspect of patient care. Implementation points are included to guide implementation of the SSCG recommendations in Ireland, particularly in the non-critical care environment.

While the implementation plan is specific to the individual recommendations in the guideline, some actions will assist with guideline implementation as a whole. These include the role of the Sepsis ADONS and engagement with hospital sepsis committees to ensure dissemination and communication of the updated guideline. The National Sepsis Programme will work with HSE communications both internally and externally to inform key stakeholders of the Sepsis Management – National Clinical Guideline No. 26 update and to provide support as appropriate. The Annual Sepsis Summit will also be used as a platform to disseminate the updated guideline. The sepsis e-learning module update further supports the updated National Clinical Guideline and will continue to be available through HSeLaND.

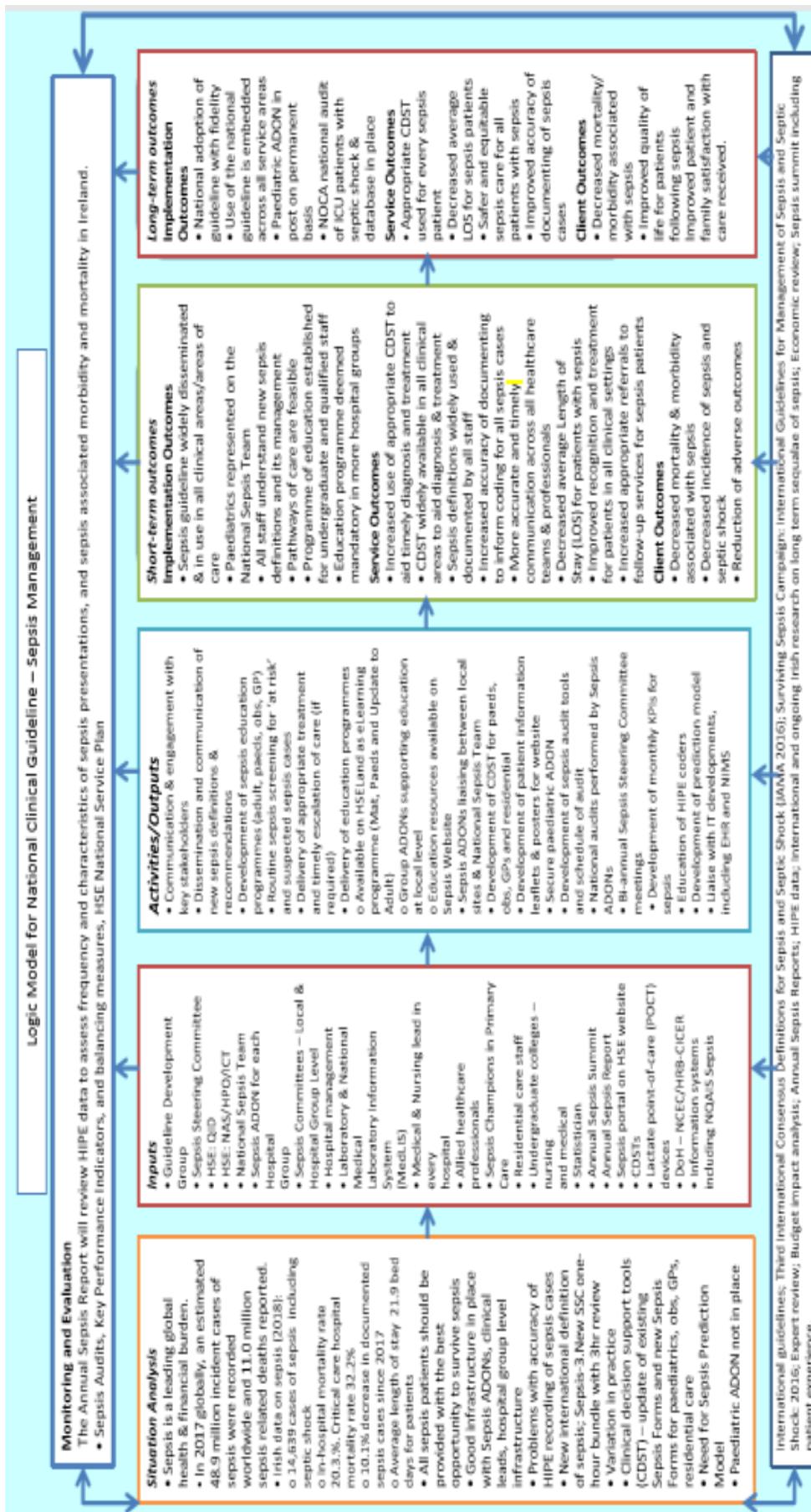
The implementation of the Sepsis Management National Clinical Guideline No. 26 (2021) is dependent on various factors. Table 26 identifies the enablers and barriers to implementing the recommendations along with the responsibilities and timelines. See also the Logic model illustrated in Table 27.

Table 26. Implementation plan for National Clinical Guideline (NCG) on sepsis management

Guideline recommendation or number(s)	Implementation barriers/enablers/gaps	Action/intervention/task to implement recommendation	Lead responsibility for delivery of the action	Timeframe for completion			Expected outcome and verification			
				Year 1	Year 2	Year 3	Outcome	Year 1	Year 2	Year 3
General	Enablers <ul style="list-style-type: none"> Current good compliance with many of the recommendations from the Sepsis Summit Lack of knowledge Barrier	Develop communication, dissemination and stakeholder engagement plan, including annual Sepsis Summit.	<ul style="list-style-type: none"> Sepsis National Clinical Programme 	X			<ul style="list-style-type: none"> Improved awareness and knowledge of sepsis guideline 	Verification <ul style="list-style-type: none"> Acknowledgement from hospital leads upon receipt of guideline Monitoring and Audit feedback 		
Screening for sepsis and performance improvement Recommendation 1	Enablers <ul style="list-style-type: none"> Audit and feedback Medical and nursing sepsis leads in hospitals Support from Hospital Senior Management Local Sepsis Committees Sepsis ADONS NQAIIS Sepsis currently being tested Barrier <ul style="list-style-type: none"> Lack of hospital senior management engagement Lack of medical/nursing sepsis leads in hospitals 	<p>Development of network of medical and nursing sepsis leads in hospitals</p> <p>Develop and use audit tools and audit schedules</p> <p>Dissemination of audit findings with hospital management</p> <p>Link with NQAIIS Sepsis team re: building of mortality prediction model for sepsis. When operational, this tool will facilitate the development of Key Performance Indicators (KPI's) for sepsis.</p>	<ul style="list-style-type: none"> Sepsis ADONS <ul style="list-style-type: none"> Hospital Sepsis Committees 	X	X	X	<ul style="list-style-type: none"> Greater clarity for role of Clinical Leads More champions Improved focus on sepsis by management Improved compliance with guideline, leading to improved outcomes for patients Improved support from hospital management Improved access to sepsis data and hospital comparisons of mortality data 	Verification <ul style="list-style-type: none"> Audit and annual reports Reporting from Sepsis ADONS Feedback from Hospital Sepsis Committees 		

Initial resuscitation	Enabler <ul style="list-style-type: none">CDST (Sepsis Forms and Algorithms) for early recognition & treatment Barriers: <ul style="list-style-type: none">Reluctance to use CDSTSLack of knowledge	Ongoing review and update of CDSTS <ul style="list-style-type: none">Promote value and importance of CDSTS (use medical/nursing sepsis leads in hospitals) Targeted education on use of clinical decision-making tools – develop scenarios and video/animation	<ul style="list-style-type: none">National Sepsis TeamHospital Nursing and Clinical LeadsNational Sepsis Team	X X X	Outcome <ul style="list-style-type: none">Improved knowledge of recognising sepsis Verification <ul style="list-style-type: none">Audit and Annual report	
Recommendations (2 – 14)	Enablers <ul style="list-style-type: none">Sepsis e-learning programmeMandatory training Barriers <ul style="list-style-type: none">Lack of knowledgeChallenges in recognising sepsis early – complex and evolving	Update e-learning sepsis education programme to include the new sepsis definitions and review every three years Advocate for making sepsis e-learning mandatory in all hospital groups Delivery of local education, as required (by ADONS, ANPs, Clinical leads, National Clinical Lead)	<ul style="list-style-type: none">Sepsis National Clinical ProgrammeSepsis ADONsLocal Sepsis Committees	X X X	Outcome <ul style="list-style-type: none">Easy access to online Sepsis Education via HSE Iland which will improve the recognition and management of sepsis in adult and maternity settings Verification <ul style="list-style-type: none">HSelD e-learning reports	
	Barriers <ul style="list-style-type: none">Lack of IT systems to capture informationLack of integration across IT systems	Addressing the lack of a National IT system is beyond the scope of this National Clinical Guideline however the GDG advocate for liaising with national groups overseeing the development of IT systems to ensure sepsis requirements are appropriately included.	<ul style="list-style-type: none">National Sepsis TeamNational Sepsis Team	X X	Outcome <ul style="list-style-type: none">IT systems more fit for purpose – earlier recognition, supporting more effective treatment and monitoring Verification <ul style="list-style-type: none">IT systems in place	

Antimicrobial therapy Recommendations (15-33)	Enabler	Although the requirement for POC Lactate measurement has not changed with the update of the guideline, hospitals should be aware of the requirement for POC Lactate availability and should support, where appropriate, applications for additional equipment.	<ul style="list-style-type: none"> • Sepsis ADONs • Hospital Sepsis Committees 	<ul style="list-style-type: none"> • Improved access to equipment • Improved adherence to local antimicrobial guidelines
	Barriers	All hospital induction programmes should incorporate training on local antimicrobial guidelines. All hospital induction programmes should incorporate training on local antimicrobial guidelines.		
	Source control	<p>Recommendation (34-35) Vasoactive medication Recommendations (36-41) Corticosteroids (Recommendation 42) Blood products (Recommendation 43) Immunoglobulins (Recommendation 44) Blood purification (Recommendation 45) Anticoagulants (Recommendation 46-47) Mechanical ventilation (Recommendation 48-62) Sedation and analgesia (Recommendation 63) Glucose control (Recommendation 64-67) Renal Replacement Therapy (Recommendation 68-70) Bicarbonate Therapy (Recommendation 71) Venous Thromboembolism Prophylaxis (Recommendation 72-75) Stress Ulcer Prophylaxis (Recommendation 76-78) Nutrition (Recommendation 79-90) Setting Goals of Care (Recommendation 91-93)</p>	The GDG have provided implementation points after each recommendation or group of recommendations, to guide implementation of the SSGC recommendations in Ireland.	

Table 27. Logic model for National Clinical Guideline - Sepsis Management

Appendix 9: Sepsis Forms

The Sepsis Screening Tool for Adults, and the Sepsis Screening Tool for Maternity Patients are living forms and are periodically updated by the HSE National Clinical Programme for Sepsis. To ensure you are using the most current forms please click on the following link:

<https://www.gov.ie/en/department-of-health/publications/sepsis-management-for-adults-including-maternity/>

If you cannot access the forms through this link, please email ncec@health.gov.ie.

Appendix 10: Supporting tools

National Sepsis Programme: <https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/>

HSeLanD: <https://www.hseland.ie/>

Global Sepsis Alliance: <https://www.global-sepsis-alliance.org/>

Surviving Sepsis Campaign: <https://www.sccm.org/SurvivingSepsisCampaign/Home>

UK Sepsis Trust: <https://sepsistrust.org/>

Deteriorating Patient Improvement Programme: <https://www.hse.ie/eng/about/who/cspd/ncps/deteriorating-patient-improvement-programme/>

National Acute Medicine Programme: <https://www.hse.ie/eng/about/who/cspd/ncps/acute-medicine/>

National Clinical Programmes: <https://www.rcpi.ie/national-clinical-programmes/>

NCG No 1 INEWS: <https://www.gov.ie/en/collection/cc5faa-national-early-warning-score-news/>

NCG No. 4 IMEWS: <https://www.gov.ie/en/collection/517f60-irish-maternity-early-warning-system-imews-version-2/>

NCG No. 5 Communication (Clinical Handover) in Maternity Services: <https://www.gov.ie/en/collection/d3b3bd-clinical-handover-in-maternity-services/>

NCG No. 11 Clinical Handover in Acute and Children's Hospital Services: <https://www.gov.ie/en/collection/006e63-clinical-handover-in-acute-and-childrens-hospital-services/>

NCG No. 12 PEWS: <https://www.rcpi.ie/paediatric-early-warning-system/>

NCG No. 18 EMEWS: <https://www.gov.ie/en/collection/bd79b1-emergency-medicine-early-warning-system-emeaws/>

Conversion websites:

<http://www.conversion-website.com/pressure/centimeter-of-water-to-millimeter-of-mercury.html>

<https://www.sensorsone.com/mmhg-to-kpa-conversion-table/>

Glucose measurement conversion chart: https://www.google.com/search?q=convert+mg/dl+to+mmol/l&rlz=1C1GCEU_enIE857IE857&source=lnms&tbo=isch&sa=X&ved=2ahUKEwiS3ISb_PfqAhX5SxUIHW-LALgQAUoAXoECA0QAw&biw=1024&bih=488#imgrc=W4Q7ngSpX6Q6FM

Appendix 11: Sepsis Predisposition and Recognition in the Community

(This has been developed with PHN Services Community Healthcare West and will be piloted with various PHN services).

Sepsis Predisposition & Recognition in the Community



Maternal Sepsis is a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion or postpartum period (WHO 2017).

Clinical suspicion of infection?

Yes

Are you concerned that the woman could have infection

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> History of fevers or rigors
<input type="checkbox"/> Cough/sputum/breathlessness
<input type="checkbox"/> Flu like symptoms
<input type="checkbox"/> Unexplained abdominal pain/distension
<input type="checkbox"/> Pelvic pain
<input type="checkbox"/> Vomiting and/or diarrhoea
<input type="checkbox"/> Skin Breakage/IV Cannulation/Epidural puncture site any infection/redness/swelling/pain | <input type="checkbox"/> Possible intrauterine infection
<input type="checkbox"/> Myalgia/back pain/general malaise/headache
<input type="checkbox"/> New onset of confusion
<input type="checkbox"/> Cellulitis/wound infection/perineal infection
<input type="checkbox"/> Possible breast infection
<input type="checkbox"/> Multiple presentation with non-specific malaise
<input type="checkbox"/> Others |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Have a lower index of suspicion for infection or sepsis in the unwell women with risk factors.

THINK SEPSIS

Risk Factors

Pregnancy Related

- Pre-term/prolonged rupture of membranes
- Retained products
- History pelvic infection
- Group A Strep. – young children unwell at home
- Recent amniocentesis

Non Pregnancy Related

- Age > 35 years
- Minority ethnic group
- Vulnerable socio-economic background
- Obesity
- Diabetes, including gestational diabetes
- Recent surgery
- Symptoms of infection in the past week
- Immunocompromised e.g. Systemic Lupus
- Chronic renal failure
- Chronic liver failure
- Chronic heart failure



Feidhmeannachta Seirbhise Sláinte
Health Service Executive

Obstetric History

Gestation at birth (re neonate): _____
 Pregnancy related complaints:

Days post-natal: _____

Delivery:
 Spontaneous vaginal delivery (SVD)
 Vacuum assisted delivery
 Forceps assisted delivery
 Caesarean section

Assessment

Heart rate: _____ Resp rate: _____ Temperature: _____ BP: _____
 Post natal blood loss: _____ (? Foul smelling)

Infection Plus any one of the following:**Any 1 of the following signs of acute organ dysfunction:**

- Altered Mental State
- RR > 30 rpm
- HR >130 bpm
- SBP < 90mmHg
- Oligo or anuria
- Pallor/Mottled or ashen appearance with prolonged capillary refill
- Non-blanching rash
- Other organ dysfunction

Sustained SIRS Response, i.e. ≥ 2 modified SIRS criteria listed below.

- Respiratory rate ≥ 20 bpm
- Heart rate ≥100 bpm
- Temperature <36°C or ≥38°C
- Acutely altered mental status

At risk of neutropenia

(bone marrow failure, autoimmune disorder or treatment including but not limited to, **chemotherapy and radiotherapy** and unwell

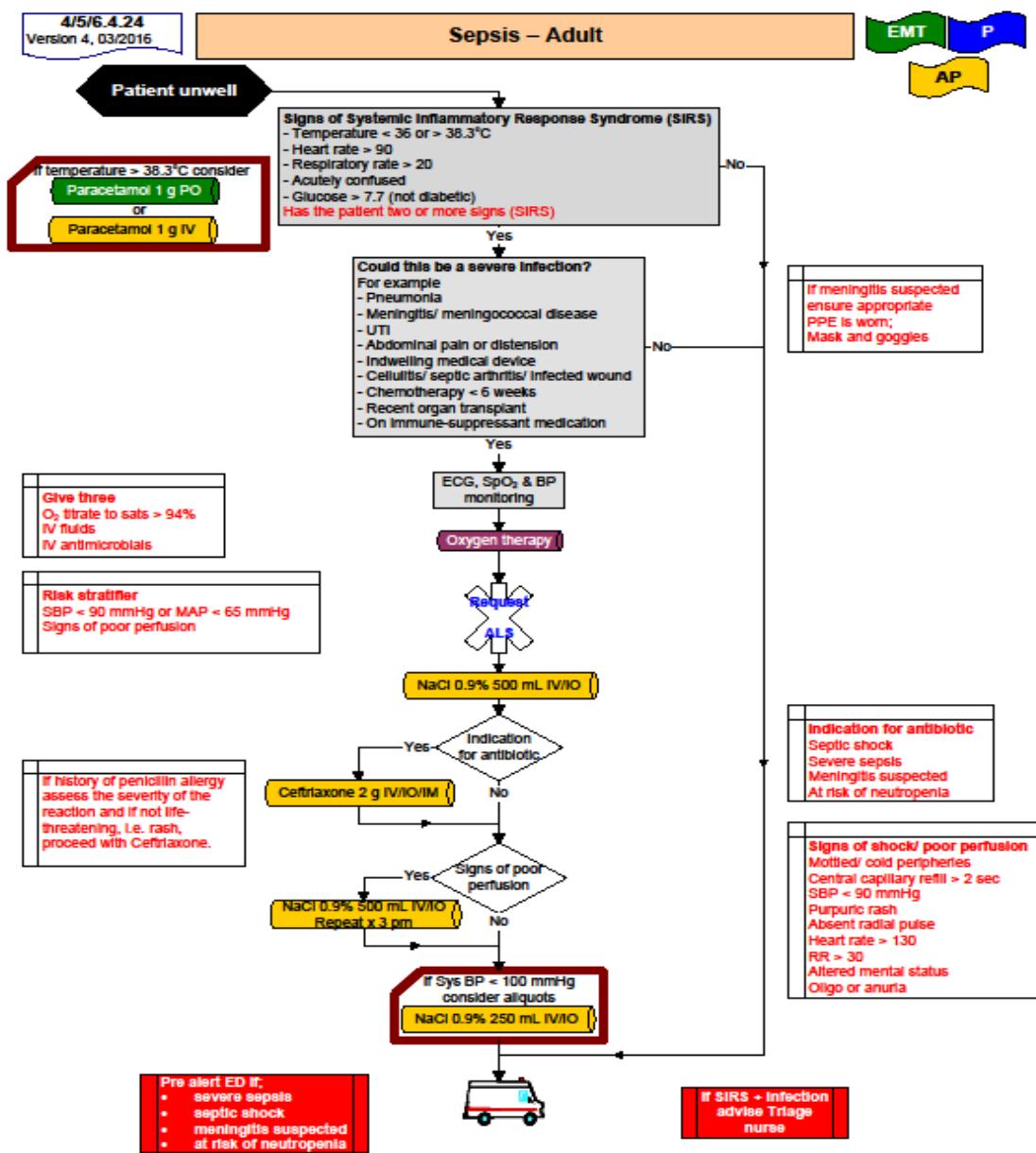
Yes**Requires hospital medical review****No**

Follow usual pathway for uncomplicated infection.

Give safety net advice and the Sepsis Information leaflet. If condition deteriorates advise to contact PHN or GP.

Appendix 12: PHECC practitioner screening and treatment CPG for Sepsis

This algorithm applies to patients with clinical signs of tissue hypoperfusion where infection is suspected to be the cause. The focus of care is to 'give three'; oxygen, IV fluids and antimicrobials, however the latter two are within the scope of practice of advanced paramedics only. The EMT and paramedic therefore will request advanced paramedic back-up to maximise the care of patients presenting with suspected sepsis.



Reference: National Clinical Guideline No. 6: Sepsis Management, National Clinical Effectiveness Committee, Department of Health, November, 2014

Appendix 13: Fluid resuscitation algorithm for adults with sepsis

FLUID RESUSCITATION ALGORITHM FOR ADULTS (INCLUDING MATERNITY) WITH SEPSIS



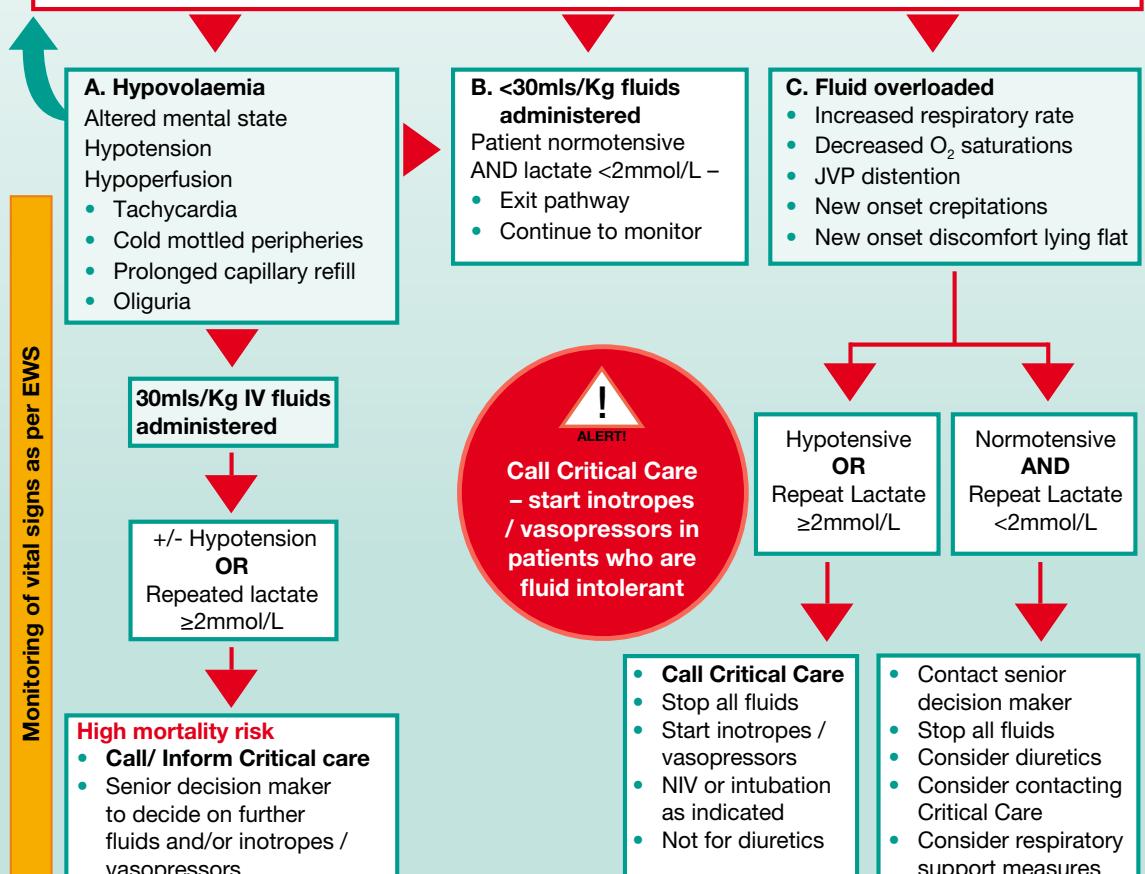
- Hypotension:**
- SBP <90mmHg or >40mmHg drop from baseline
 - OR
 - MAP <65mmHg

OR

- Hypoperfusion:**
- Tachycardia
 - Vasoconstriction
 - Oliguria
 - Lactate ≥2mmol/L

For hypotension or hypoperfusion give a 250 - 500mls IV bolus of balanced crystalloid * **

Select the patient response from one of the boxes A, B or C below



*A total volume of fluid resuscitation up to 30ml/kg (ideal body weight) within the first 3 hours unless fluid intolerant or the patients clinical condition requires earlier referral to critical care for consideration of inotropes / vasopressors. Caution in pre-eclampsia.

**Strict monitoring and documentation of urine output assessment and measurement in mls on a fluid balance chart.

SBP: Systolic blood pressure, **MAP:** Mean arterial pressure, **JVP:** Jugular venous pressure, **NIV:** Non-invasive ventilation
For more information on National Clinical Guideline No. 26 Sepsis Management go to: www.hse.ie/sepsis

Appendix 14: ISBAR Communication Tool

ISBAR Communication Tool	
I	IDENTIFY Yourself Recipient of handover information Patient
S	SITUATION Why are you calling? (identify your concerns)
B	BACKGROUND What is the relevant background?
A	ASSESSMENT What do you think is the problem?
R	RECOMMENDATION What do you want them to do?

Appendix 15: Start Smart and Then Focus approach for antimicrobial therapy

Start Smart, Then Focus An Antibiotic Care Bundle for Hospitals



Day 1: Start Smart...

1. Start antibiotics only if there is clinical evidence of bacterial infection
 - If there is evidence of bacterial infection, prescribe in accordance with your local antibiotic guidelines and appropriately for the individual patient (see notes below)
2. Obtain appropriate cultures before starting antibiotics
3. Document in both the drug chart and medical notes:
 - Treatment indication
 - Drug name, dose, frequency and route
 - Treatment duration (or review date)
4. Ensure antibiotics are given within four hours of prescription
 - Within 1 hour for severe sepsis or neutropenic sepsis

When deciding on the most appropriate antibiotic(s) to prescribe, consider the following factors:

- History of drug allergy (document allergy type: minor (rash only) or major (anaphylaxis, angioedema))
- Recent culture results (e.g. Is patient colonised with a multiple-resistant bacteria?)
- Recent antibiotic treatment
- Potential drug interactions
- Potential adverse effects (e.g. *C. difficile* infection is more likely with broad spectrum antibiotics)
- Some antibiotics are considered unsafe in pregnancy or young children
- Dose adjustment may be required for renal or hepatic failure

Consider removal of any foreign body/indwelling device, drainage of pus, or other surgical intervention

For advice on appropriate investigation and management of infections, consult your local Infection specialist(s) (microbiologist, infectious disease physician and/or antimicrobial pharmacist)

...then Focus (Day 2 onwards)

- At 24-48 hours after starting antibiotics, make an Antimicrobial Prescribing Decision
- Review the clinical diagnosis
 - Review laboratory/radiology results
 - Choose one of the five options below
 - Document this decision

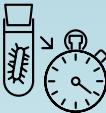
- Options**
1. Stop antibiotic(s)
 - no evidence of bacterial infection, or infection resolved
 2. Switch from intravenous to oral antibiotic(s)
 - if patient meets criteria for oral switch
 3. Change antibiotic(s)
 - narrower spectrum, if possible;
 - broader spectrum, if indicated
 4. Continue current antibiotic(s)
 - review again after further 24 hours
 5. Outpatient parenteral antibiotic therapy
 - consult with local OPAT team

Developed by the RCPI Hospital Antimicrobial Stewardship Working Group (2012)
Adapted, with permission, from the UK Department of Health "Start Smart, Then Focus" hospital antimicrobial stewardship programme

Appendix 16: Recommendations on Timing of Antibiotic Administration

Surviving Sepsis Campaign®

Antibiotic Timing

	 Shock is present	 Shock is absent
Sepsis is definite or probable	<p> Administer antimicrobials immediately, ideally within 1 hour of recognition.</p>	<p> Administer antimicrobials immediately, ideally within 1 hour of recognition.</p>
Sepsis is possible	<p> Administer antimicrobials immediately, ideally within 1 hour of recognition.</p>	<p> Rapid assessment* of infectious vs. noninfectious causes of acute illness.</p> <p> Administer antimicrobials within 3 hours if concern for infection persists.</p>

*Rapid assessment includes history and clinical examination, tests for both infectious and noninfectious causes of acute illness, and immediate treatment of acute conditions that can mimic sepsis. Whenever possible, this should be completed within 3 hours of presentation so that a decision can be made as to the likelihood of an infectious cause of the patient's presentation and timely antimicrobial therapy provided if the likelihood is thought to be high.

Appendix 17. Summary of vasoactive agent recommendations

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Campaign®

Vasoactive Agent Management

	<p> Use norepinephrine as first-line vasopressor.</p>
<i>For patients with septic shock on vasopressors</i>	<p> Target a MAP of 65 mm Hg.</p> <p> Consider invasive monitoring of arterial blood pressure.</p>
<i>If central access is not yet available</i>	<p> Consider initiating vasopressors peripherally.*</p>
<i>If MAP is inadequate despite low-to-moderate norepinephrine</i>	<p> Consider adding vasopressin.</p>
<i>If cardiac dysfunction with persistent hypoperfusion is present despite adequate volume status and blood pressure</i>	<p> Consider adding dobutamine or switching to epinephrine.</p>
<p> Strong recommendations are displayed in green</p> <p> Weak recommendations are displayed in yellow.</p>	
<p>*When vasopressors are used peripherally, they should be administered only for a short period of time and in a vein proximal to the antecubital fossa.</p>	

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