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Pharmacist's Letter
Hospital

Use Updated Guidelines to Help Improve Sepsis Outcomes

Top Takeaways

- *Aim to give antibiotics within 1 hour for septic shock, or with confirmed or high suspicion of sepsis without shock. Three hours may be reasonable when an alternative diagnosis is likely without shock.*
- *If using beta-lactam antibiotics, recommend continuous or extended infusions after a loading dose.*
- *You may see topical oropharyngeal antibiotics for GI decontamination in select ventilated patients to decrease pneumonia and mortality risk.*

Hospitals will be revising their adult sepsis protocols...due to updated Surviving Sepsis Guidelines.

Help implement guidance highlights to improve infection outcomes.

"Code sepsis" teams. Expect creation or expansion of sepsis teams to treat patients ASAP...similar to code blues for cardiac arrest.

Ideally advocate that your team includes a pharmacist to help guide antibiotic choices, coordinate timely med administration, etc.

Antibiotic timing. Still anticipate antibiotics to be given within 1 hour for septic shock (hypotension needing pressors, etc)...and patients who have a confirmed or high suspicion for sepsis withOUT shock.

On the other hand, start antibiotics within 3 hours for possible sepsis without shock...where an alternative diagnosis is likely.

Watch order start times closely. And work with your ID, emergency department, and IT colleagues to clearly communicate antibiotic priorities in sepsis order sets based on shock status, sepsis suspicion, etc.

Prolonged-infusion antibiotics. Recommend giving certain beta-lactams (cefepime, piperacillin/tazobactam, meropenem, etc) via extended or continuous infusions to optimize their ability to kill bacteria.

Ensure these courses start with a short loading dose first, such as cefepime 2 g IV over 30 min once, then 2 g IV over 4 hours Q8H.

Work with IT to include these regimens in sepsis order sets. And clearly differentiate short vs prolonged infusion entries in your EHR and pump libraries to avoid confusion.

Be ready for compatibility questions...these infusions will occupy IV lines longer. Ideally have 2 or more IV sites for more flexibility.

Elderly blood pressure goals. Consider a lower initial mean arterial pressure (MAP) goal of 60 to 65 mm Hg for patients 65 years and up, since evidence links lower MAP goals to decreased sepsis mortality.

Double-check MAP goals against the patient's age on titrated pressor orders...and verify with the prescriber if the goal seems high.

Selective GI decontamination. Point out that topical oropharyngeal antibiotics (polymyxin, tobramycin, amphotericin B, etc) may decrease ventilator-associated pneumonia and mortality in ventilated patients without increasing antibiotic adverse effects.

But check with your ID team first before routinely suggesting this strategy...it's typically reserved for ICUs with low resistance rates.

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Antibiotic de-escalation. Frequently reassess culture data (at least every shift, etc) to see if you can narrow or stop antibiotics.

Combine procalcitonin labs with clinical assessment to help determine when to stop antibiotics if there's infection source control. Data show this can shorten antibiotics by about 2 days in the ICU.

Review these tips along with other cornerstones of sepsis treatment (fluids, pressors, etc) using our *Sepsis Management in Adults* chart.

Key References:

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