2021 Surviving Sepsis Campaign Adult Sepsis Guidelines – Gap Analysis Tool

This tool was developed by THA to aide hospitals in assessing compliance with current treatment guidelines for sepsis in adults. For complete details, refer to the Guidelines which are available here. **Please note important guideline criteria (if for sepsis or septic shock, if suggested-vs-recommended) in the columns to the left of each guideline.** Contact Leslie Hayes at lhayes@tha.com with any questions.

Surviving Sepsis Campaign						**Hospital**				
Guideline Number	For Sepsis	For Septic Shock	Suggested	Recommended	Guidelines	Not in place	Planned	Implemented	Standard Practice	Comments
1	X	X		X	Screen all acutely ill, high-risk patients for sepsis.					
	X	X		X	Have standard operating procedures for treating sepsis.					
	X	X		X	Have a sepsis performance improvement program that monitors sepsis metrics and acts on identified opportunities.					
2	X	X		X	Do NOT use qSOFA as a single screening tool for sepsis.					
3	X	X	X		Measure blood lactate.					
4	X	X		X	Treat sepsis as a medical emergency and begin treatment and resuscitation immediately.					
5		X	X		For sepsis-induced hypoperfusion or shock, give 30 mL/kg of IV crystalloid fluid within the first three hours of resuscitation.					
6	X	X	X		Use dynamic measures to guide fluid resuscitation over physical examination or static parameters alone.					
7	X	X			Guide resuscitation to decrease serum lactate in patients with elevated lactate.					
8		X	X		Use capillary refill time to guide resuscitation as an adjunct to other measures of perfusion.					
9		X		X	For patients on vasopressors, use an initial MAP target of 65 mm Hg over higher MAP targets.					
10	X	X	X		For patients requiring ICU admission, admit to ICU within 6 hours.					

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11	X	X		X	When infection is unconfirmed, continuously re-evaluate and search for an alternative diagnosis and discontinue empiric antimicrobials if an alternative cause of illness is demonstrated or strongly suspected.					
	X	X		X	Obtain a full screen for infectious agents prior to starting antimicrobials wherever it is possible to do so in a timely manner.					
12	X	X		X	For patients with *possible septic shock* or *high likelihood of sepsis,* administer antimicrobials immediately, ideally within 1 hour of recognition.					
13	X			X	For *possible* sepsis *without* shock, rapidly (ideally, within 3 hours) assess the likelihood of infectious-vs-non-infectious causes of acute illness, including history, exam, tests for infectious and non-infectious causes, and immediate treatment of acute conditions that can mimic sepsis.					
14	X		X		For *possible* sepsis *without* shock, conduct a time-limited course of rapid investigation, and if concern for infection persists, administer antimicrobials within 3 hours from the time sepsis was first recognized.					
15	X		X		When there is *low* likelihood of infection and *no shock*, defer antimicrobials while continuing to closely monitor the patient.					
16	X	X	X		Do NOT use procalcitonin to decide when to start antimicrobials.					
17	X	X		X	For patients at *high* risk of MRSA, use empiric antimicrobials with MRSA coverage.					
18	X	X	X		For patients with *low* risk of MRSA, do NOT use empiric antimicrobials with MRSA coverage.					
19	X	X	X		For patients with *high* risk of MDRO, use two antimicrobials with gram-negative coverage for empiric treatment rather than one.					
20	X	X	X		For patients with *low* risk of MDRO, do NOT use two antimicrobials with gram-negative coverage for empiric treatment over using one.					
21	X	X	X		Do NOT use double gram-negative coverage once the causative pathogen and susceptibilities are known.					
22	X	X	X		For *high* risk of fungal infection, use empiric antifungal therapy.					

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23	X	X	X		For *low* risk of fungal infection, do NOT use empiric antifungal therapy.					
25	X	X	X		Use prolonged infusion of beta-lactams for maintenance (after an initial bolus dose).					
26	X	X		X	Optimize dosing strategies of antimicrobials based on accepted pharmacokinetic/pharmacodynamic principles and specific drug properties.					
27	X	X		X	Rapidly identify or exclude specific anatomical diagnosis of infection that requires emergent source control.					
	X	X		X	Implement source control intervention as soon as medically and logistically possible (within 6-12 hours); pursue source control over prolonged efforts at stabilization in severely ill patients.					
28	X	X		X	Promptly remove intravascular access devices that are a possible source of sepsis/septic shock after other vascular access has been established. (*In the absence of shock or fungemia*, some tunneled catheter infections may be treated with prolonged antimicrobial therapy if catheter removal is not practical.)					
29	X	X	X		Assess daily for antimicrobial de-escalation.					
30	X	X	X		With an initial diagnosis of sepsis/septic shock and adequate source control, use a shorter duration of antimicrobial therapy.					
31	X	X	X		When there is adequate source control and the optimal duration of therapy is unclear, use procalcitonin together with clinical evaluation to decide when to discontinue antimicrobials.					
32	X	X		X	Use crystalloid as the first-line fluid for resuscitation.					
33	X	X	X		Use balanced crystalloid instead of normal saline for resuscitation.					
34	X	X	X		Use albumin in patients who received large volumes of crystalloid over using crystalloid alone.					
35	X	X		X	Do NOT use starches for resuscitation.					
36	X	X	X		Do NOT use gelatin for resuscitation.					

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37		X		X	Use norepinephrine as the first-line vasoactive agent. When norepinephrine is not available, use epinephrine or dopamine and closely monitor for arrhythmias.					
38		X	X		For patients on norepinephrine with inadequate MAP, add vasopressin instead of escalating the dose of norepinephrine. Vasopressin is usually started when the dose of norepinephrine is in the range of 0.25-0.5 µg/kg/minute.					
39		X	X		For patients on norepinephrine *and* vasopressin with inadequate MAP, add epinephrine.					
40		X	X		Do NOT use terlipressin.					
41		X	X		For patients with septic shock and cardiac dysfunction with persistent hypoperfusion despite adequate volume status and arterial blood pressure, add dobutamine to norepinephrine OR use epinephrine alone.					
42		X	X		For patients with septic shock and cardiac dysfunction with persistent hypoperfusion despite adequate volume status and arterial blood pressure, do NOT use levosimenden.					
43		X	X		Use invasive monitoring of arterial blood pressure as soon as practical and if resources are available.					
44		X	X		Start vasopressors peripherally to restore MAP rather than delay initiation until central venous access is secured; administer only for a short time and in a vein that is in or proximal to the antecubital fossa.					
47	X	X	X		For sepsis-induced hypoxemic respiratory failure, use high-flow nasal oxygen over non-invasive ventilation.					
49	X	X		X	For sepsis-induced ARDS, use a low tidal volume ventilation strategy (6 mL/kg) over a high tidal volume strategy (>10 mL/kg).					
50	X	X		X	For sepsis-induced severe ARDS, use an upper limit goal for plateau pressures of 30 cm H_2O over higher plateau pressures.					
51	X	X	X		For moderate-to-severe sepsis-induced ARDS, use higher PEEP over lower PEEP.					

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52	X	X	X		For sepsis-induced respiratory failure without ARDS, use low tidal volume as compared to high tidal volume ventilation.					
53	X	X	X		For sepsis-induced moderate-severe ARDS, use traditional recruitment maneuvers.					
54	X	X		X	When using recruitment maneuvers, do NOT use incremental PEEP titration/strategy					
55	X	X		X	For sepsis-induced moderate-severe ARDS, use prone ventilation for greater than 12 hours daily, particularly within the first 36 hours of intubation.					
56	X	X	X		For sepsis-induced moderate-severe ARDS, use intermittent neuromuscular blockade agent boluses over continuous infusion.					
57	X	X	X		For adults with sepsis-induced severe ARDS, use veno-venous ECMO when conventional mechanical ventilation fails (in experienced centers with the infrastructure in place to support its use).					
58		X	X		For ongoing vasopressor requirement, use IV corticosteroids (hydrocortisone 200 mg/day given as 50 mg IV every 6 hours or as a continuous infusion). Commence at a dose of norepinephrine or epinephrine ≥0.25μg/kg/minute at least 4 hours after initiation.					
59	X	X	X		Do NOT use polymyxin B hemoperfusion for blood purification.					
61	X	X		X	Use a restrictive transfusion strategy over a liberal strategy guided by assessment of the patient's overall clinical status rather than Hgb concentration alone, considering extenuating circumstances such as acute MI, severe hypoxemia, or acute hemorrhage.					
62	X	X	X		Do NOT use IV immunoglobulins.					
63	X	X	X		Use stress ulcer prophylaxis in patients at risk for GI bleeding.					
64	X	X		X	Use pharmacologic VTE prophylaxis *unless* a contraindication to such therapy exists.					
65	X	X		X	Use low molecular weight heparin over unfractionated heparin for VTE prophylaxis.					
66	X	X	X		Do NOT use mechanical prophylaxis in addition to pharmacologic prophylaxis.					

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67	X	X	X		For patients with acute kidney injury who *require* renal replacement therapy, use either continuous or intermittent renal replacement therapy.					
68	X	X	X		For patients with acute kidney injury with *no definitive indication* for renal replacement therapy, do NOT use renal replacement therapy.					
69	X	X		X	Initiate insulin therapy at a glucose level of ≥ 180 mg/dL.					
70	X	X	X		Do NOT use IV vitamin C.					
71		X	X		For septic shock and hypoperfusion-induced lactic acidemia, do NOT use sodium bicarbonate therapy to improve hemodynamics or reduce vasopressor requirements.					
72		X	X		For septic shock, severe metabolic acidemia (pH ≤ 7.2) and acute kidney injury (AKIN score 2 or 3), use sodium bicarbonate therapy.					
73	X	X	X		For patients who can be fed enterally, begin enteral nutrition early (within 72 hours).					
74	X	X		X	Discuss goals of care and prognosis with patients and families.					
75	X	X	X		Address goals of care early (within 72 hours).					
77	X	X		X	Integrate principles of palliative care (which may include palliative care consultation based on clinician judgement) into the treatment plan, when appropriate, to address patient and family symptoms and suffering.					
78	X	X	X		Do NOT routinely consult palliative care for all patients.					
79	X	X	X		Refer sepsis survivors and their families to peer support groups, if available.					
80	X	X	X		Use a handoff process of critically important information at transitions of care.					
82	X	X		X	Screen for economic and social support (including housing, nutritional, financial, and social support) and make referrals where available to meet these needs.					
83	X	X	X		Offer written and verbal sepsis education (diagnosis, treatment, and post-ICU/sepsis syndrome) prior to hospital discharge and in the follow-up setting.					

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84	X	X		X	Provide opportunity for patients/families to participate in shared decision-making in post-ICU and hospital discharge planning to ensure discharge plans are acceptable and feasible.					
85	X	X	X		Use a critical care transition program (ICU clinicians follow patients on wards for a few days or until clinically stable).					
86	X	X		X	Reconcile medications at both ICU and hospital discharge,					
87	X	X		X	For sepsis survivors and their families, include information about the ICU stay, sepsis and related diagnoses, treatments, and common impairments after sepsis in the written and verbal hospital discharge summary.					
88	X	X		X	For patients that developed new impairments, include follow-up with clinicians able to support and manage the new and long-term sequelae in hospital discharge plans.					
91	X	X		X	Provide for assessment and follow-up of physical, cognitive, and emotional problems after hospitalization.					
92	X	X	X		Refer to a post-critical illness follow-up program, if available.					
93	X	X	X		For survivors who received mechanical ventilation for >48 hours or an ICU stay of >72 hours, refer to a post-hospital rehabilitation program.					