The shortcut to the Surviving Sepsis Campaign database tool will be placed automatically on your desktop after you download the software. You can open the database using this shortcut on your desk top.

Enter Site Information

Step 1

The Menu tab is the home screen for the database. Select the Site info box to enter your site information. The site information is required prior to entering patient information.
Site Information

Step 2

Enter complete data for site, contact information, ICU description and units for reporting. Be sure to include country in the appropriate field.
Entering a new patient

Step 3

Step 3
Entering a new patient (drop down box)
Select add a new chart

Move through screens using the “Next” button or tabs at the top of the screen
Screen 1 – Evaluation for Severe Sepsis Screening Tool

Step 4

1. Select at least one (1) new infection. If the patient presents with more than one new infection, check all that apply.

2. Select at least two (2) new signs and symptoms of infection. If the patient presents with more than two, check all that apply.

Change from previous version of the database.

- Note: Removal of chills and rigors
- Note: Change in hyperglycemia from 120 to 140 mg/dL
Screen 2 – Evaluation for Severe Sepsis Screening Tool

Step 5

Select at least one (1) organ dysfunction. If more than one organ dysfunction is present, check all that apply.

Change from previous version of the database.

- Note: Added acute lung injury criteria in the absence or in the presence of pneumonia.

Step 6 – Example

Chart is eligible when screen 1 and 2 are completed and applicable.
After data completion of the screening tool for questions 1, 2 and 3 (screen 1 and screen 2), the chart is considered to have met the severe sepsis criteria. A database identification (ID) is created and automatically populated for the subject.

Step 7 – Complete Presentation Data

1. Select if patient **met criteria** for severe sepsis or septic shock at time of presentation.
   
   - **Severe sepsis** includes patients with sepsis plus organ dysfunction NOT including sepsis-induced hypotension not responsive to 30 ml/kg fluids (MAP < 65 mm Hg after 30 ml/kg) requiring vasopressors to maintain a MAP ≥65 mmHg.
   
   - **Septic shock** includes patients with sepsis-induced hypotension requiring vasopressors to maintain a MAP ≥65 mmHg.

2. Enter a **Unique Patient ID**, for example, the medical record number (not transferred to SCCM with file upload). The unique ID may be accessed via the drop down box chart, located on the menu page. The unique ID allows ease in selecting subjects for data completion or chart review. The unique patient ID is exported on the Chart_Identified.txt file for site use.

3. Enter a **Secondary Patient ID**, for example, the patient name (not transferred to SCCM with file upload). Although not required, the secondary patient ID may be useful for internal quality improvement case review. The secondary patient ID may be located on the exported Chart_Identified.txt file only.
4. Enter **DOB** mm/dd/yy. The DOB is required to calculate age. The age is automatically populated on the APACHE calculation worksheet.

5. Enter **Gender** using drop down box.

6. Select an **Admission category** using one of 3 selections, applying the definitions on the presentation screen to the appropriate category.
   - *In the event a severely septic patient was not admitted to the critical care unit (eg, to step-down or telemetry), the selection is based on the patient’s location as if the intention had been admission to the critical care unit. In this case, please choose from one of the 3 admission category criteria on the presentation screen.*

7. Enter **Time of last sepsis screen** for non-ED admissions. If an admission category other than ED is selected, time of last sepsis screen on the unit/floor data field will be available to enter date and time. This data field has been made available for sites with a screening process in place, allowing for entry of the last negative sepsis screen.
   - *If ED admission category is selected, Time of last sepsis screen date and time will be unavailable for date and time entry.*

8. Enter date and time of severe sepsis **Presentation**. Please follow criteria listed under Time of presentation-(eg, ED = triage time). Presentation time is Time Zero (T₀)

9. Enter the **Hospital Admission** date and time.

10. Enter the **Critical Care Unit Admission** date and time. The system defaults to include the check, indicating the patient is admitted to a critical care unit.
    - *If the patient is not admitted to a critical care unit, remove default check. Removal of the check will allow the date and time to be null. No date and time will be required in this circumstance.*
Lactate
Step 8

Enter the **Lactate data**. If the initial lactate is elevated (> 2 mmol/L), then 4a will open for data entry. **Was lactate re-measured?** If the lactate was re-measured within 6 hours of time of presentation, the lowest lactate obtained after the time of presentation is recorded.

**Example: where lactate was initially elevated and re-measured within 6 hours.**
Example: if the initial lactate was elevated and the re-measured lactate was not completed within 6 hours. The elapsed time to measure the lactate is calculated but indicator compliance will not be met if measured outside the 6-hour window.

Example: if initial lactate was elevated and the lactate was not re-measured.
Blood Cultures and Antibiotics

Step 9

Enter the date and time **Blood Cultures** were obtained.

**Example:** blood culture date and time.
If blood cultures were obtained before the patient was started on antibiotics for a suspected infection other than severe sepsis (eg, cultures obtained in the ED for pneumonia and patient transferred to the floor yesterday), select the first box. If obtained related to the current infection, the date and time will not be required. Compliance with this indicator will be issued.

Antibiotics
Step 10

Enter the antibiotic data. If “yes” is selected, a drop down menu for antibiotic selection is available. If multiple antibiotics are administered, enter the antibiotics in the order of administration. Indicator compliance is based on the first antibiotic administered. If an antibiotic is not listed, select “other” and enter the drug name in the text field.
Example: antibiotic data entry.

- If a broad spectrum antibiotic was initiated for a suspected infection other than severe sepsis (e.g., antibiotic started in the ED for pneumonia and patient transferred to the floor yesterday), and continued until time of presentation with severe sepsis, select the first box. If an antibiotic was initiated and continued until the time of presentation with severe sepsis, the date and time will not be required. Compliance with this indicator will be issued.
  - Eg, patient presents to the ED with pneumonia, blood cultures obtained, broad spectrum antibiotic administered and patient is admitted to the general medical floor. Ten hours after admission to the floor, the patient becomes hypotensive and has acute respiratory distress requiring intubation. The blood cultures and antibiotic were continued through the time of presentation with severe sepsis. The indicator compliance will score as obtained for blood cultures and antibiotics for this patient when a check is placed in the top box for 5 and 6.
BP-Fluid Resuscitation

Step 11

Enter hypotension data at time of presentation. Consider review of organ dysfunction criteria (Step 5) to ensure consistent data entry. If 7b is checked “yes,” 7c and 7d will open. Check all that apply in 7b. The MAP calculator is available to assist in determining MAP (sample below).
Enter a selection for 7c. Entering “yes, within the first 24 hours”’s allows data entry for date and time when 30 ml/kg fluid challenge has been completed.

If 7d is yes, the patient meets the criteria for severe sepsis and 7e will not open.

If 7d is no, the patient meets the criteria for septic shock and 7e will open.

If yes to 7e, 7f will open.

If no to 7e, 7f will not open.

Section 7c applies to patients with a lactate ≥ 4 mmol/L with or without hypotension.

*Screen shot examples for a patient with lactate ≥ 4 mmol/L without hypotension can be found on page 23 of this document.*
Central line and CVP

Step 12

Enter information related to central line insertion. Date entered for #8 central line is not calculated for indicator compliance, but can help sites determine treatment delays and variation among sites.

**Example:** central line yes date/time.
Example: CVP yes date/time.

Entering CVP measured is applicable to patients with hypotension not responsive to 30 ml/kg (MAP remains <65 mm Hg and or lactate ≥ 4 mmol/L). Further data entry requirements are based on the selection made (“yes” or “no”).

If #9 is yes, “was CVP achieved” is made available for data entry.

If #9 is no, “was CVP achieved” is not available for data entry.

- If CVP is measured outside the 6-hour window, elapsed time (ET) is calculated, but indicator compliance is not granted. Similarly, if CVP ≥ 8 mm Hg is achieved outside the 6-hour window, elapsed time (ET) is calculated but indicator compliance is not granted.

Example: if CVP was not measured.
ScvO₂/SvO₂

Step 13

Enter ScvO₂/SvO₂ measured data based on the available selections (#10).

If #10 is “yes,” 10a and 10b are made available for data entry.
If #10 is “no,” 10a and 10b are not available for data entry.

- If ScvO₂/SvO₂ is measured outside the 6-hour window, elapsed time (ET) is calculated, but indicator compliance is not granted. Similarly, if ScvO₂/SvO₂ is achieved outside the 6-hour window, elapsed time (ET) is calculated, but indicator compliance is not granted (example below).
Discharge-Status-Remarks

Step 14

Enter critical care unit and hospital discharge date and time.
Enter status at time of hospital discharge.

Example: discharge/status/remarks.
APACHE score calculation is optional and is not required to complete chart data entry. Understanding the APACHE methodology is required to obtain accurate APACHE scores for your patient. APACHE II scores offer value in providing severity scores for your patients.

APACHE II score = acute physiology score + age points + chronic health points. Minimum score = 0; maximum score = 71. Increasing score is associated with increasing risk of hospital death. Physiologic variables are based on the worst value in the past 24 hours.

Glasgow Coma score = 15 minus actual GCS. Example 15 - 7 = 8

Drop down menu: refer to definitions for chronic health status criteria.

Optional variable: Use only if no ABGs.
Example: APACHE II completed form below for reference.

Scoring
Step 16
Click Check Data button to ensure all required data are complete, allowing for chart scoring.
Click on “Score Chart” to review indicator compliance, status and points for the individual patient chart. Review the findings to ensure data entry is complete and accurate.
6-hour Bundle 1 - Measured Indicators

Review time to meet the indicator to ensure accurate compliance points

6-hour Bundle 2 - Achieved Indicators

Review time to meet the indicator to ensure accurate compliance points
Supplemental Example Patient with a lactate ≥ 4 mmol/L without hypotension

Lactate value entered with corresponding date and time. The lactate was re-measured with corresponding date, time and repeat value within the 6 hours. If multiple lactates are drawn during the 6-hour period, enter the lowest measured lactate.

The patient was not hypotensive (7a, no). However, 7c applies as the patient has a lactate ≥ 4 mmol/L and requires fluid resuscitation (30 ml/kg).

Activation of 7c will prompt 7d to open. Check “yes” as this subject was not hypotensive and did not have a MAP < 65 mmHg.
The patient meets criteria for CVP (example below).

The patient meets criteria for ScvO2/SvO2 (example below).
3-hour Bundle

Fluids administered for lactate ≥ 4 mmol/L, but not within 3 hours of time of presentation.

6-hr Bundle 1 - Measured bundle – Status points

Not applicable as patient was not hypotensive requiring vasopressors

ScvO2 measured outside the 6-hour window. No points granted.
### 6-hour Bundle 2 - Achieved Bundle

<table>
<thead>
<tr>
<th>6-Hour Achieved Indicators</th>
<th>Applies To</th>
<th>Status</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Apply vasopressors for hypotension to maintain HAP &gt; 85 mmHg</td>
<td>hypotension not responsive to fluids</td>
<td>Not applicable—hypoventilatory</td>
<td>0</td>
</tr>
<tr>
<td>2) Central venous pressure ( \geq 8 ) mm Hg achieved within 6 hours of presentation</td>
<td>septic shock or lactate ( \geq 20 ) mmol/L, (26 mg/dL)</td>
<td>CVP ( \geq 8 ) mm Hg achieved in 7 hr 51 min</td>
<td>0</td>
</tr>
<tr>
<td>3) SaO2 &gt; 90% (or SaO2 65%) achieved within 6 hours of presentation</td>
<td>septic shock or lactate ( \geq 20 ) mmol/L, (26 mg/dL)</td>
<td>SaO2 &gt; 90% (or SaO2 65%) achieved as 8 hr 26 min</td>
<td>0</td>
</tr>
<tr>
<td>4) Retrace lactate</td>
<td>initial lactate ( \geq 2 ) mmol/L, (16 mg/dL)</td>
<td>Repeat lactate measured in 5 hr 8 min</td>
<td>1</td>
</tr>
<tr>
<td>5) Compliance with all applicable elements of the ACHIEVED 6-hour bundle</td>
<td>septic shock or lactate ( \geq 20 ) mmol/L, (26 mg/dL)</td>
<td>Did not complete all applicable elements within 6 hours</td>
<td>0</td>
</tr>
<tr>
<td>6) Compliance with all applicable elements of the ACHIEVED 6-hour bundle</td>
<td>septic shock or lactate ( \geq 20 ) mmol/L, (26 mg/dL)</td>
<td>Did not complete all applicable elements within 6 hours</td>
<td>0</td>
</tr>
<tr>
<td>7) Mortality due to severe sepsis or septic shock</td>
<td>severe sepsis or septic shock</td>
<td>Survived</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total 5-Hour Achieved Quality Score:**

<table>
<thead>
<tr>
<th>Total Quality Score</th>
<th>Number of unique (unduplicated) indicators applicable to this chart</th>
<th>Total unique points earned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>