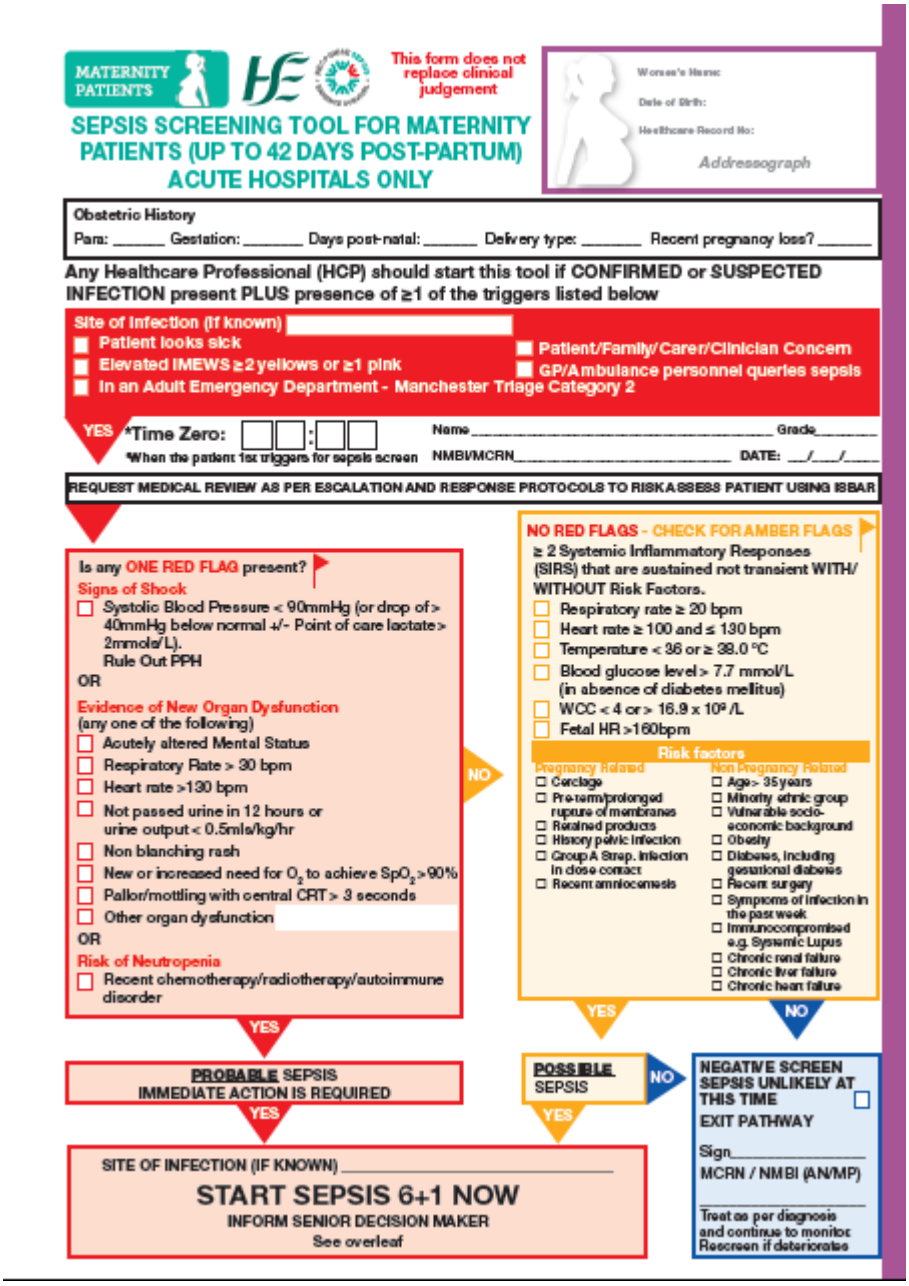

MATERNITY PATIENTS

This form does not replace clinical judgement

SEPSIS SCREENING TOOL FOR MATERNITY PATIENTS (UP TO 42 DAYS POST-PARTUM) ACUTE HOSPITALS ONLY

Woman's Name:
Date of Birth:
Healthcare Record No:
Addressograph

Obstetric History
Para: _____ Gestation: _____ Days post-natal: _____ Delivery type: _____ Recent pregnancy loss? _____

Any Healthcare Professional (HCP) should start this tool if CONFIRMED or SUSPECTED INFECTION present PLUS presence of ≥1 of the triggers listed below

Site of Infection (If known)
- Patient looks sick
- Elevated MEWS ≥2 yellows or ≥1 pink
- In an Adult Emergency Department - Manchester Triage Category 2
- Patient/Family/Carer/Clinician Concern
- GP/Ambulance personnel queries sepsis

YES *Time Zero: ☐☐:☐☐ Name _____ Grade _____
*When the patient 1st triggers for sepsis screen NMBI/MCRN _____ DATE: __/__/____

REQUEST MEDICAL REVIEW AS PER ESCALATION AND RESPONSE PROTOCOLS TO RISK ASSESS PATIENT USING ISBAR

Is any ONE RED FLAG present?

Signs of Shock
- Systolic Blood Pressure < 90mmHg (or drop of > 40mmHg below normal +/- Point of care lactate > 2mmole/L).
  Rule Out PPH

OR

Evidence of New Organ Dysfunction
(any one of the following)
- Acutely altered Mental Status
- Respiratory Rate > 30 bpm
- Heart rate >130 bpm
- Not passed urine in 12 hours or urine output < 0.5mls/kg/hr
- Non blanching rash
- New or increased need for O_2 to achieve SpO_2 >90%
- Pallor/mottling with central CRT > 3 seconds
- Other organ dysfunction

OR

Risk of Neutropenia
- Recent chemotherapy/radiotherapy/autoimmune disorder

YES

PROBABLE SEPSIS
IMMEDIATE ACTION IS REQUIRED

YES

SITE OF INFECTION (IF KNOWN) _____

START SEPSIS 6+1 NOW
INFORM SENIOR DECISION MAKER
See overleaf

NO

NO RED FLAGS - CHECK FOR AMBER FLAGS

≥ 2 Systemic Inflammatory Responses (SIRS) that are sustained not transient WITH/WITHOUT Risk Factors.
- Respiratory rate ≥ 20 bpm
- Heart rate ≥ 100 and ≤ 130 bpm
- Temperature < 36 or ≥ 38.0 °C
- Blood glucose level > 7.7 mmol/L (in absence of diabetes mellitus)
- WCC < 4 or > 16.9 x 10^9 /L
- Fetal HR >160bpm

Risk factors

Pregnancy Related
- Cerclage
- Pre-term/prolonged rupture of membranes
- Retained products
- History pelvic infection
- Group A Strep. infection in close contact
- 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

YES

POSSIBLE SEPSIS

NO

YES

NEGATIVE SCREEN SEPSIS UNLIKELY AT THIS TIME ☐
EXIT PATHWAY

Sign _____
MCRN / NMBI (AN/MP)

Treat as per diagnosis and continue to monitor
Rescreen if deteriorates

MATERNITY PATIENTS

SEPSIS TREATMENT PROTOCOL FOR MATERNITY PATIENTS (UP TO 42 DAYS POST-PARTUM)

SEPSIS 6+1 BUNDLE - COMPLETE WITHIN 1 HOUR

Addressograph

TAKE 3

1 TAKE BLOOD CULTURES
2 sets of peripheral blood cultures (aseptic technique) prior to giving antimicrobials unless this leads to a delay >45mins, and other cultures as per examination.
Time Taken: ☐☐:☐☐

2 TAKE BLOOD TESTS
FBC, Renal and Liver profile, point of care **lactate**, CRP +/- coagulation screen.
If initial lactate elevated > 2mmols/L, repeat lactate after sepsis 6 bundle to assess response.
Time Taken: ☐☐:☐☐

3 URINARY OUTPUT ASSESSMENT
Assess urinary output as part of volume/perfusion status assessment. For patients with sepsis/septic shock start fluid balance charts. Catheterisation and hourly measurements may be required.
Time: ☐☐:☐☐
Fluid balance chart commenced ☐

+1 IF PREGNANT ASSESS FETAL WELLBEING
Time Completed: ☐☐:☐☐
N/A ☐

GIVE 3

4 IV ANTIMICROBIALS (if appropriate), THINK SOURCE CONTROL. Consider Microbiology review

Red Flags (PROBABLE SEPSIS)	Amber Flags (POSSIBLE SEPSIS)
IV Antimicrobials within <u>1 HOUR</u>	Review test results to identify infectious vs non-infectious causes of acute illness. If infection confirmed, administer IV antimicrobials within <u>3 HOURS</u>. **Note:** If infection with new onset organ dysfunction present (e.g. AKI, thrombocytopenia or hyperlactatemia etc.) administer antimicrobials immediately.
TIME GIVEN ☐☐:☐☐	TIME GIVEN ☐☐:☐☐

☐ Patient already on appropriate antimicrobials
☐ This patient does not require antimicrobials at this time

5 GIVE IV FLUID BOLUS IF REQUIRED
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.
Refer to fluid resuscitation algorithm. Caution in pre-eclampsia.
Time Given: ☐☐:☐☐
or
N/A ☐

6 GIVE OXYGEN IF REQUIRED
Titrate supplementary oxygen to maintain oxygen saturations 94-98% (88-92% for patients with chronic lung disease).
Time Given: ☐☐:☐☐
or
N/A ☐

Reassess vital signs at least every 30 minutes.
IF CONDITION WORSENING / NOT IMPROVING, ESCALATE TO CONSULTANT.
Consider SEPTIC SHOCK if MAP less than 65mmHg DESPITE FLUID RESUSCITATION and escalate to critical care.

THIS IS LIKELY TO BE SEPSIS ☐ OR SEPTIC SHOCK ☐ AT THIS TIME
☐ **Senior Clinician Informed** **Time:** ☐☐:☐☐
☐ **Sepsis UNLIKELY at this time**

Signature _____ **MCRN / NMBI (AN/MP)** _____
Print Name _____ **Date:** _____ **Time:** ☐☐:☐☐

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