MATERNITY PATIENTS

This form does not replace clinical judgement

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

Women'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 IMEWS ≥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:** ☐☐:☐☐

*When the patient 1st triggers for sepsis screen

Name _____ Grade_____

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 > 2mmols/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

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	Non Pregnancy Related
☐ Cerclage	☐ Age > 35 years
☐ Pre-term/prolonged rupture of membranes	☐ Minority ethnic group
☐ Retained products	☐ Vulnerable socio-economic background
☐ History pelvic infection	☐ Obesity
☐ Group A Strep. infection in close contact	☐ Diabetes, including gestational diabetes
☐ Recent amniocentesis	☐ Recent surgery
	☐ Symptoms of infection in the past week
	☐ Immunocompromised e.g. Systemic Lupus
	☐ Chronic renal failure
	☐ Chronic liver failure
	☐ Chronic heart failure

YES

NO

POSSIBLE SEPSIS

YES

NO

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

SITE OF INFECTION (IF KNOWN) _____

START SEPSIS 6+1 NOW

INFORM SENIOR DECISION MAKER

See overleaf

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) 1 HOUR	Amber Flags (POSSIBLE SEPSIS) 3 HOURS
IV Antimicrobials within **1 HOUR**	Review test results to identify infectious vs non-infectious causes of acute illness. If infection confirmed, administer IV antimicrobials within **3 HOURS**. **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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