INPATIENT MATERNAL SEPSIS TOOL

Worcestershire Acute Hospitals NHS Trust

To be applied to all women who are pregnant or up to six weeks postpartum (or after the end of pregnancy if pregnancy did not end in a birth) who have a suspected infection or have clinical observations outside normal limits

Staff member completing form:

Date ....

Name ....

Designation ....

Signature ....

1. Has WOWS triggered? ☐

OR does woman look sick? ☐

OR is baby tachycardic (≥160 bpm)? ☐

NO → Low risk of sepsis. Use standard protocols, consider discharge with safety netting. Consider obstetric needs.

YES ↓

2. Could this be an infection?

- Yes, but source unclear at present ☐
- Chorioamnionitis/ endometritis ☐
- Urinary Tract Infection ☐
- Infected caesarean or perineal wound ☐
- Influenza, severe sore throat, or pneumonia ☐
- Abdominal pain or distension ☐
- Breast abscess/ mastitis ☐
- Other (specify):.. ☐

NO → Low risk of sepsis. Use standard protocols, consider discharge with safety netting. Consider obstetric needs.

YES ↓

3. Is ONE maternal Red Flag present?

- Responds only to voice or pain/ unresponsive ☐
- Systolic B.P ≤ 90 mmHg (or drop >40 from normal) ☐
- Heart rate > 130 per minute ☐
- Respiratory rate ≥ 25 per minute ☐
- Needs oxygen to keep SpO2 ≥92% ☐
- Non-blanching rash, mottled/ ashen/ cyanotic ☐
- Not passed urine in last 18 hours ☐
- Urine output less than 0.5 ml/kg/hr ☐
- Lactate ≥2 mmol/l ☐

(note- lactate may be raised in & immediately after normal labour & delivery)

NO → 4.

YES ↓ Red Flag Sepsis

4. Any Maternal Amber Flag criteria?

- Relatives concerned about mental status ☐
- Acute deterioration in functional ability ☐
- Respiratory rate 21-24 OR breathing hard ☐
- Heart rate 100-130 OR new arrhythmia ☐
- Systolic B.P 91-100 mmHg ☐
- Not passed urine in last 12-18 hours ☐
- Temperature < 36°C or > 38°C ☐
- Immunosuppressed/ diabetes/ gestational diabetes ☐
- Has had invasive procedure in last 6 weeks (e.g. CS, forceps delivery, ERPC, cerclage, CVs, miscarriage, termination) ☐
- Prolonged rupture of membranes ☐
- Close contact with GAS ☐
- Bleeding/ wound infection/ vaginal discharge ☐
- Non-reassuring CTG/ fetal tachycardia >160 ☐

NO ↑ Low risk of sepsis. Use standard protocols, consider discharge with safety netting. Consider obstetric needs.

YES ↓

	Time Complete	Initials
Send bloods if 2 criteria present, consider if 1 Include lactate, FBC, U&Es, CRP, LFTs, clotting		
Immediate call to ST3+ doctor/ Shift Leader For review within 1hr		
Time clinician/ Midwife attended		

↓

Is AKI present? (tick) YES ☐ NO ☐

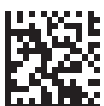
YES → Red Flag Sepsis

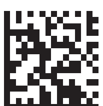
NO ↓

	Time Complete	Initials
Clinician to make antimicrobial prescribing decision within 3h		

Red Flag Sepsis - Start Sepsis 6 pathway NOW (see overleaf)

This is time critical, immediate action is required.





SEPSIS SIX
PATHWAY

To be applied to all women who are pregnant or up to six weeks postpartum (or after the end of pregnancy if pregnancy did not end in a birth) who have a suspected infection or have clinical observations outside normal limits

	TIME ZERO	CONSULTANT INFORMED?	INITIALS
Inform Consultant Obstetrician & Obstetric Anaesthetist; **OR** consider transfer to Obstetric Unit. State patient has Red Flag Sepsis			

Action (complete ALL within 1 hour)			
	TIME COMPLETE	INITIALS	REASON NOT DONE / VARIANCE
1. Administer oxygen Aim to keep saturations > 94%			
2. Take blood cultures At least a peripheral set. Consider e.g. urine, sputum, vaginal swabs, breast milk culture, throat swabs Think source control & timing of delivery of baby- start CTG			
3. Give IV antibiotics According to Trust protocol Consider allergies prior to administration			
4. Give IV fluids If hypotensive/lactate >2mmol/l, 500ml stat (can repeat up to 30ml/kg). Ask doctor regarding fluids if not hypotensive and lactate normal. Ask Anaesthetist regarding fluids if patient has pre-eclampsia			
5. Check serial lactates Corroborate high VBG lactate with arterial sample If lactate >4mmol/l, call Critical Care and recheck after each 10ml/kg challenge			Not applicable- initial lactate ☐
6. Measure urine output May require urinary catheter Ensure fluid balance chart commenced & completed hourly			

If after delivering the Sepsis Six, patient still has:

- systolic B.P <90 mmHg
- reduced level of consciousness despite resuscitation
- respiratory rate over 25 breaths per minute
- lactate not reducing

Or if patient is clearly critically ill at any time then call Critical Care Outreach immediately and Contact Obs Consultant Immediately

INITIAL ANTIBIOTICS (all IV)

Antenatal:Cefotaxine 2g QDS+Metronidazole 500mg TDS

Postnatal: Co-amoxiclav Dose 1.2g TDS

If severe infection ADD clindamycin 900mg QDS to above

SEVERE PENICILLIN ALLERGY (antenatal and postnatal)

Clindamycin 900mg QDS AND Gentamicin Dose 5mg/kg ideal body weight (3mg/kg if renal dysfunction) OD

IF FAILURE TO RESPOND CONTACT MICROBIOLOGIST