Maternal Sepsis Pathway

Screen in triage, upon admission, every shift (within first 2 hours of shift) and PRN suspected infection
Document in OB Sepsis Summary Flowsheet.

Start Here

Sepsis Screening

OB Screening Criteria

- ☐ Temp > 100.4°F (38°C) **OR** Temp < 96.8°F (36°C)
- ☐ HR > 110
- ☐ RR > 24
- ☐ WBC > 15,000
- ☐ WBC < 4,000 OR > 10% bands (CBC differential)

2 or more positive **OB SCREENING Criteria AND SUSCEPTED** source of infection*
= dx of **AT RISK FOR SEPSIS**

INTERVENTIONS for 1st HOUR

- ☐ Notify RRT and OB provider
- ☐ Draw Lactate, CBC, CMP, PT, PTT**
- ☐ Blood Cultures X2 (before ABX)**
- ☐ MD eval/bedside assessment
- ☐ Give broad spectrum antibiotic**
- ☐ Implement pulse oximetry, strict I/O
- ☐ Chest XRAY (if suspected lung infection)
- ☐ Collect UA if suspect urinary source of infection
- ☐ Vital Signs Q30 x2, Q1Hx2, Q2 x2, then Q4H
- ☐ Give 1 liter of NS/LR
- ☐ Mental status assessment

Increased Surveillance

ACUTE ORGAN DYSFUNCTION EVALUATION

Evaluate for 1 or more ACUTE ORGAN DYSFUNCTION Criteria due to infection

- ☐ Lactate ≥ 2 mmol/L
- ☐ Oxygen Sat < 92%
- ☐ SBP < 90 mmHG◊ or MAP < 65
- ☐ SBP decrease < 40mmHG from baseline
- ☐ Urine output ≤ 30 ml/hr for 2 hours
- ☐ Creatinine ≥ 1.2 mg/dL OR doubling of creatinine
- ☐ Platelet count < 100,000
- ☐ Coagulopathy (INR > 1.5 or PTT > 60 sec)
- ☐ Agitation, confusion, unresponsiveness
- ☐ Bilirubin > 2mg/dL

SEPSIS + 1 or more positive acute organ dysfunction
= dx of **SEPSIS**

Time Zero

SEPSIS INTERVENTIONS

- ☐ Consider IV Fluids N/S or LR 30 mL/kg; each liter over 60 min (Lactate 2-3.9)
- ☐ Blood Cultures (if not previously drawn)
- ☐ Repeat lactate every 3 hours until lactate < 2 mmol/L
- ☐ SpO2 per protocol, titrate oxygen to ≥ 92%
- ☐ Consult with RRT
- ☐ MD eval/bedside assessment
- ☐ Vital signs Q30 x2, Q1H x2, Q2x2, then Q4h

Escalate Care

SEPTIC SHOCK CRITERIA

Evaluate for SEPTIC SHOCK Criteria

- ☐ Lactate ≥4 mmol/L OR
- ☐ BP Systolic < 90, MAP < 65 despite fluid resuscitation
- ☐ Clinical features are the same as **SEPSIS**

SEPTIC SHOCK INTERVENTIONS

- ☐ MD eval/bedside assessment/**escalation of care**
- ☐ RN- Call RRT
- ☐ Broad spectrum antibiotic
- ☐ RRT/ICU MD determine if ICU admission required
- ☐ IV fluids NS or LR bolus 30ml/kg NOW for lactate ≥ 4 mmol/L or hypotensive (if not previously done) Use pressure bag
- ☐ Vital signs q 30 min

***Consider source of infection**
- Chorio
- Pyelonephritis
- Endometritis
- UTI
- Pneumonia
- Other
- Intrauterine Fetal Demise

***Notes for OB provider:**
- Add "Sepsis" to problem list.

Lactate in labor
- Not used in diagnosis of SEPSIS
- Used to trend, give fluids, & closely monitor

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