

# 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.



Sepsis Screening  
Increased Surveillance  
Escalate Care

- 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)

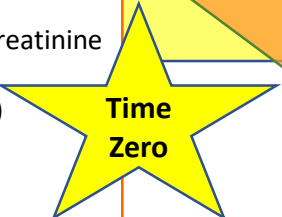
2 or more positive **OB SCREENING** Criteria **AND** **SUSCEPTED** source of infection\*  
= dx of **AT RISK FOR SEPSIS**

- INTERVENTIONS for 1<sup>st</sup> 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

- 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<sup>o</sup> 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**

- 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



- 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
  - Endometritis
  - Pneumonia
  - Intrauterine Fetal Demise
  - Pyelonephritis
  - UTI
  - Other

**\*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