Maternal Sepsis is a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion or postpartum period (WHO 2016).

**Section 1:**
- Midwife Name: 
- Midwife Signature: 
- NMBI PIN: 
- IMEWS: 
- Date: 
- Time:  

**Section 2:**  Are you concerned that the woman could have infection

<table>
<thead>
<tr>
<th>History of fevers or rigors</th>
<th>Possible intrauterine infection</th>
</tr>
</thead>
<tbody>
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<td>Myalgia/back pain/general malaise/headache</td>
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<td>Flu like symptoms</td>
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<td>Pelvic pain</td>
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<td>Multiple presentation with non-specific malaise</td>
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<td>Line associated infection/redness/swelling/pain</td>
<td>Others</td>
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**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

**Section 3:** Obstetric History

<table>
<thead>
<tr>
<th>Para:</th>
</tr>
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<tbody>
<tr>
<td>Gestation:</td>
</tr>
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</table>

**Pregnancy related complaints:**

<table>
<thead>
<tr>
<th>Days post-natal:</th>
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<th>Delivery:</th>
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<tr>
<td>Spontaneous vaginal delivery (SVD)</td>
</tr>
<tr>
<td>Vacuum assisted delivery</td>
</tr>
<tr>
<td>Forceps assisted delivery</td>
</tr>
<tr>
<td>Cesarean section</td>
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</table>

**Section 4:**

1. IMEWS trigger for immediate review, i.e. ≥2 YELLOWS or >1 PINK

2. SIRS Response, i.e. ≥2 SIRS criteria listed below.

   **SIRS criteria:** Note - physiological changes must be sustained not transient.
   - Respiratory rate ≥ 20 breaths/min
   - Heart rate ≥ 100bpm
   - Fetal heart rate >160bpm
   - WCC < 4 or > 16.9 x 10^9/L
   - Temperature <36° or ≥ 38.3°C
   - Bedside glucose > 7.7mmol/L

3. At risk of neutropenia, due to bone marrow failure, autoimmune disorder or treatment including but not limited to, chemotherapy and radiotherapy, who present unwell.

**Section 5:** If sepsis is suspected following screening, escalate to Medical review. Use ISBAR as outlined.

**Section 6:**

**Record observations on the Irish Maternity Early Warning (IMEWS) chart.**

**Request immediate medical review**

if you are concerned the woman has INFECTION plus ANY 1 of the following:

**Doctor’s Name:** 

**Time Doctor Contacted:** 

**Midwife’s Signature:**
Sepsis Form - Maternity

( ALWAYS USE CLINICAL JUDGEMENT )

If infection suspected following History and Examination, Doctor to complete and sign sepsis screening form

Section 6: Clinical Suspicion of Infection

Document site:
☐ Genital Tract
☐ Urinary Tract
☐ Skin
☐ Respiratory Tract
☐ Intra-abdominal
☐ Catheter/Device Related
☐ Central Nervous System
☐ Intra-articular/Bone
☐ Unknown
☐ Other suspected site:

☐ No clinical suspicion of INFECTION: proceed to section 9.

Section 7: Who needs to get the “Sepsis 6” – infection plus any one of the following:

1. ☐ SIRS Response, i.e. ≥2 SIRS criteria listed on page 1.
2. ☐ Clinically or biochemically apparent new onset organ dysfunction, i.e. any one of the following:
   - Acutely altered mental state
   - RR > 30
   - O₂ sat < 90%
   - O₂ check point of care lactate & full blood count, U&E +/- LFTs +/- Coag. Other test and investigations as indicated by history and examination.
   - Pallor/mottling with prolonged capillary refill
   - Non-blanching rash
   - Other organ dysfunction
3. ☐ Patients at risk of neutropenia, due to bone marrow failure, autoimmune disorder or treatment including but not limited to, chemotherapy and radiotherapy, who present unwell.

☐ YES. Start Maternal Sepsis 6 + 1 Time Zero:

☐ NO.

Section 8

TAKE 3

SEPSIS 6 + 1* – complete within 1 hour

☐ BLOOD CULTURES: Take blood cultures before giving antimicrobials (if no significant delay i.e. >45 minutes) and other cultures as per examination.

☐ BLOODS: Check point of care lactate & full blood count, U&E +/- LFTs +/- Coag. Other test and investigations as indicated by history and examination.

☐ URINE OUTPUT: assess urinary output as part of volume/perfusion status assessment. For patients with sepsis or septic shock start hourly urinary output measurement.

*+1 If Pregnant, Assess Fetal Wellbeing

GIVE 3

☐ OXYGEN: Titrate O₂ to saturations of 94 -98%
☐ or 88-92% in chronic lung disease.

☐ FLUIDS: Start IV fluid resuscitation if evidence of hypovolaemia. 500ml bolus of isotonic crystalloid over 15mins & give up to 2 litres, reassessing frequently. Call Anaesthesia/Critical Care if hypotensive or not fluid responsive. Caution in pre-eclampsia.

☐ ANTIMICROBIALS: Give IV antimicrobials according to the site of infection and following local antimicrobial guidelines.

Laboratory tests should be requested as EMERGENCY aiming to have results available and reviewed within 1 hour

Section 9

Following history and examination, and in the absence of clinical criteria or signs. Sepsis 6+1 is not commenced. If infection is diagnosed, proceed with usual treatment pathway for that infection.

☐ NO.

Section 10

Look for signs of new organ dysfunction after the Sepsis 6+1 bundle or from blood tests - any one is sufficient:

☐ Lactate ≥ 4 after 30mls/kg Intravenous therapy
☐ Cardiovascular - Systolic BP < 90 or Mean Arterial Pressure (MAP) < 65 or Systolic BP more than 40 below patient’s normal
☐ Respiratory - New or increased need for oxygen to achieve saturation > 90% (note: this is a definition, not the target)

One or more new organ dysfunction due to infection:

☐ This is SEPSIS. inform Registrar, Consultant and Anaesthetics immediately. Reassess frequently in 1st hour. Consider other investigations and management +/- source control if patient does not respond to initial therapy as evidenced by haemodynamic stabilisation then improvement.

No new organ dysfunction due to infection:

☐ This is NOT SEPSIS. If infection is diagnosed proceed with usual treatment pathway for that infection.

Section 11

Look for signs of septic shock (following adequate initial fluid resuscitation, typically 2 litres in the first hour unless fluid intolerant)

☐ Requiring inotropes/pressors to maintain MAP ≥ 65

☐ This is SEPTIC SHOCK

☐ Inform Consultant
☐ Contact CRITICAL CARE/Anaesthesia

Pathway Modification

All Pathway modifications need to be agreed by the Hospital’s Sepsis Steering Committee and be in line with the National Clinical Guideline No 6 Sepsis Management.

Clinical Handover. Use ISBAR, Communication Tool

This section only applies when handover occurs before the form is completed and is then signed off by the receiving doctor.

Section 12

Clinical Handover. Use ISBAR, Communication Tool

Doctor’s Name (PRINT):
Doctor’s Signature: 
Date: 
Time: 

Patient care handed over to:
Time: 
Sections completed:

File this document in patient notes - Document management plan.

Doctor’s Name: 
Doctor’s Signature: 
MCRN: 
Date: 
Time: