

Complete Screening when entering the facility (thru ED, triage or admitted), once per shift and upon transitioning into different phases of birthing process (ante, intra postpartum), within 2 hours of DISCHARGE, and with any worsening in condition.	Date Time						
	Initials						

**SECTION I & II: SUSPECTED OR CONFIRMED INFECTION AND GENERAL VARIABLES**

**Is there suspected or confirmed infection? →**  
**Possible sources of infection** could include but **NOT** limited to: Chorioamnionitis, Endomyometritis/Endometritis, Peri-Incisional infections, Ruptured Membranes, Labor, Hemorrhage, Pneumonia, UTI/Pyelo, Acute abdomen, Empyema, Bloodstream /Catheter Infection, Meningitis, and Skin Infection .

<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

**ANSWER ABOVE AND IMMEDIATELY CONTINUE TO GENERAL VARIABLES ↓**

**General Variables: Two (2) or more positive general variables plus (+) infection = Sepsis**

		Check all that apply in the table below ↓					
1. Temperature	Greater than or equal to 38 C/100.4 F OR Less than or equal to 36 C/96.9 F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Fetal Heart Rate	Greater than 160 bpm (*baseline, gestational age greater than or equal to 20 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Maternal Heart Rate >110 *exclude during pushing	Greater than 110 bpm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Respiratory Rate	Greater than 24/min	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. WBC Count	Greater than 15,000 or less than 4,000 or greater than 10% Bands (without ↑ WBC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Altered Mental Status – (confusion, agitation, combativeness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Hyperglycemia -- (Blood glucose greater than 140mg/dL in the absence of DM)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section II: Are any two (2) of the above present?</b> If YES to section I & II proceed to Section III. Contact provider & consider drawing lactic acid and creatinine. If "NO" to Sections I and II - STOP HERE! 🖐️		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION III: SIGNS OF ACUTE END ORGAN DYSFUNCTION: SEPSIS + AT LEAST (1) ACUTE END ORGAN DYSFUNCTION = SEVERE SEPSIS**

Check all below that may apply (**ACUTE CHANGE ONLY**): Is at least ONE (1) of the following present?

<input type="checkbox"/> Decreased Cap refill/mottling skin	<input type="checkbox"/> INR greater than 1.5 or PTT greater than 60 without medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lactic acid above normal values	<input type="checkbox"/> Systolic Blood Pressure decrease greater than 40 mmHg from baseline	Initials	Initials	Initials	Initials	Initials	Initials
<input type="checkbox"/> Bilirubin greater than 2mg/dL	<input type="checkbox"/> MAP less than or equal 65 mmHg						
<input type="checkbox"/> Urinary output less than 0.5ml/kg/hr for 2 hours or creatinine increase by greater than 0.5mg/dL or Serum creatinine greater than 1.5mg/dL	<input type="checkbox"/> Acute Lung Injury with PaO2/FiO2 ratio less than 250 (RT can calculate)						
<input type="checkbox"/> Increased O <sub>2</sub> to maintain sats >92%	<input type="checkbox"/> Platelet count less than 100,000						

**RESUSCITATION BUNDLE RECOMMENDATIONS/GUIDELINES (First 3 hours of treatment)**

- ◆ **NOTIFY RAPID RESPONSE TEAM AND PHYSICIAN**
  - ◆ Lactic Acid level within 3 hours of identification, ◆ Blood Cultures drawn PRIOR to antibiotics
  - ◆ Start Antibiotics within 1 hour from floor (inpatient) or 3 hours from the time the patient presents to your facility (ED, OB)
  - ◆ Start Crystalloids 30ml/kg over 30 minutes for SBP less than 90/ MAP less than or equal to 65 or Lactate greater than or equal to 4
- \*\*Transfer to higher level of care to continue resuscitation efforts and initiate hemodynamic monitoring

Signature: \_\_\_\_\_ Initials: \_\_\_\_\_ Signature: \_\_\_\_\_ Initials: \_\_\_\_\_ Signature: \_\_\_\_\_ Initials: \_\_\_\_\_

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