01 **START THIS CHART IF THE PATIENT LOOKS UNWELL OR MEOWS HAS TRIGGERED**

**RISK FACTORS FOR SEPSIS INCLUDE:**
- Impaired immunity (e.g. diabetes, steroids, chemotherapy)
- Recent trauma / surgery / invasive procedure
- Indwelling lines / IVDU / broken skin

02 **COULD THIS BE DUE TO AN INFECTION?**

**LIKELY SOURCE:**
- Respiratory
- Breast abscess
- Urine
- Abdominal pain / distension
- Infected caesarean / perineal wound
- Chorioamnionitis / endometritis

03 **ANY RED FLAG PRESENT?**

- Objective evidence of new or altered mental state
- Systolic BP ≤ 90 mmHg (or drop of >40 from normal)
- Heart rate ≥ 130 per minute
- Respiratory rate ≥ 25 per minute
- Needs O₂ to keep SpO₂ ≥ 92%
- Non-blanching rash / mottled / ashen / cyanotic
- Lactate ≥ 2 mmol/l*
- Not passed urine in 18 hours (<0.5ml/kg/hr if catheterised)

*may be raised in & immediately after normal delivery

04 **ANY AMBER FLAG PRESENT?**

- Acute deterioration in functional ability
- Respiratory rate 21-24
- Heart rate 100-129 or new dysrhythmia
- Systolic BP 91-100 mmHg
- Has had invasive procedure in last 6 weeks (e.g. CS, forceps delivery, ERPC, cerclage, CVS, miscarriage, termination)
- Temperature < 36°C
- Has diabetes or gestational diabetes
- Close contact with GAS
- Prolonged rupture of membranes
- Bleeding / wound infection
- Offensive vaginal discharge
- Non-reassuring CTG / fetal tachycardia >160

**FURTHER REVIEW REQUIRED:**

- Send bloods and review results
- Ensure senior clinical review within 1HR

**TIME OF REVIEW:**

**ANTI-TBIOTICS REQUIRED:**

- Yes
- No

**NO AMBER FLAGS = ROUTINE CARE / CONSIDER OTHER DIAGNOSIS**
PATIENT DETAILS:

DATE:      TIME:

NAME:      DESIGNATION:      SIGNATURE:

COMPLETE ALL ACTIONS WITHIN ONE HOUR

01 OXYGEN IF REQUIRED
AIM FOR O₂ SATURATIONS OF 94-98%

02 OBTAIN IV / IO ACCESS, TAKE BLOODS
BLOOD CULTURES, BLOOD GLUCOSE, LACTATE, FBC, U&Es
LUMBAR PUNCTURE IF INDICATED

03 GIVE IV ANTIBIOTICS
TO LOCAL POLICY, CONSIDER ALLERGY STATUS
ANTIVIRALS MAY ALSO BE REQUIRED

04 CONSIDER IV FLUIDS
IF LACTATE IS ABOVE 2 mmol/L GIVE FLUID BOLUS 20 ml/kg WITHOUT DELAY
IF LACTATE >4 mmol/L CALL CRITICAL CARE.

05 SERIAL LACTATE MEASUREMENT
NICE RECOMMENDS USING LACTATE TO GUIDE FURTHER FLUID THERAPY

06 MONITOR URINE OUTPUT +/- CTG

RED FLAGS AFTER ONE HOUR – ESCALATE TO CONSULTANT NOW

RECORD ADDITIONAL NOTES HERE:
e.g. allergy status, arrival of specialist teams, variance from Sepsis Six