SEPSIS SCREENING TOOL COMMUNITY NURSING

01 START THIS CHART IF THE PATIENT LOOKS UNWELL

RISK FACTORS FOR SEPSIS INCLUDE:

☐ Recent trauma / surgery / invasive procedure
☐ Impaired immunity (e.g. diabetes, steroids, chemotherapy)
☐ 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% (88% in COPD)
☐ Non-blanching rash / mottled / ashen / cyanotic
☐ Not passed urine in 18 hours (<0.5ml/kg/hr if catheterised)

04 ANY AMBER FLAG PRESENT?

☐ Behavioral / mental status change
☐ 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

NO AMBER FLAGS = ROUTINE CARE / CONSIDER OTHER DIAGNOSIS

COMMUNITY MIDWIFE RED FLAG BUNDLE:

THIS IS TIME-CRITICAL – IMMEDIATE ACTION REQUIRED:

DIAL 999 AND ARRANGE BLUE LIGHT TRANSFER

COMMUNICATION: Ensure communication of ‘Red Flag Sepsis’ to crew. Advise crew to pre-alert as ‘Red Flag Sepsis’. Where possible a written handover is recommended including observations and antibiotic allergies.

1 SAME DAY ASSESSMENT BY GP/TEAM LEADER
2 IS URGENT REFERRAL TO HOSPITAL REQUIRED?
3 AGREE AND DOCUMENT ONGOING MANAGEMENT PLAN (INCLUDING OBSERVATION FREQUENCY AND PLANNED SECOND REVIEW)

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