



HEALTH HOLDING

HAFER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology		
Document:	Multidisciplinary Policy and Procedure		
Title:	Adult Sepsis Screening & Management		
Applies To:	All Physicians & Nurses in Obstetric Gynecology Department, Internal Medicine.		
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1. PURPOSE:

- 1.1 Screening and early recognition of sepsis in adult females with Obstetric / Gynecology problem, and prompt goal-directed therapy improves outcome.
- 1.2 A key goal is for screening to detect as many obstetric gynecology patients as possible at risk for sepsis and trigger early treatment without increasing unnecessary broad-spectrum antibiotics and preventable hospitalizations.
- 1.3 Systematic screening is associated with improved outcomes and, therefore, enhance timely recognition of septic shock and other sepsis-associated organ dysfunction in children who present as acutely unwell
- 1.4 To outline management of sepsis and septic shock.

2. DEFINITONS:

- 2.1 **Sepsis:** sepsis is better defined as life-threatening organ dysfunction caused by a dysregulated host response to infection, Sepsis pathophysiology involves both pro and anti inflammatory mediators superimposed on genomic, proteomic, and metabolomic reprogramming of the immunoinflammatory response.
- 2.2 **Septic Shock:** Septic shock is a serious medical condition that can occur when an infection in the body causes extremely low blood pressure and organ failure due to sepsis. Septic shock is life-threatening and requires immediate medical treatment. It's the most severe stage of sepsis. life-threatening cardiovascular dysfunction in patients with suspected or confirmed infection and confers a high risk for mortality in Pregnant and postpartum women compared to those with uncomplicated infections or sepsis without shock. If this process is not corrected, numerous adverse vascular, inflammatory, metabolic, cellular, and endocrine responses contribute to a state of multiple organ dysfunction syndrome (MODS), cardiovascular collapse, and death

3. POLICY:

- 3.1 The Surviving Sepsis Campaign recommends 6 key initial management steps for obstetric gynecology patient with suspected sepsis or septic shock:
 - 3.1.1 Obtain intravenous/intraosseous access
 - 3.1.2 Collect a blood culture (and other diagnostic tests for most likely sites of infection), in the first hour i.e septic workup(Urine, Stool, Sputum cultures, CSF as needed according to the presentation).
 - 3.1.3 Measure blood lactate (Initial measure in first hour)
 - 3.1.4 Start empiric broad-spectrum antibiotics
 - 3.1.5 Administer fluid bolus(es) if shock is present
 - 3.1.6 Start vasoactive agents if shock persists.

4. PROCEDURE:

- 4.1 For Patient in Ob-Gyn Emergency Department: Screening (By Triage staff nurse)

- 4.1.1 Assess whether FEVER at home or a High Risk patient. Document in patient ED Card.
 - 4.1.1.1 Patient has 2 or more of the following:
 - 4.1.1.1.1 Fever, High Risk, Abnormal HR or RR, Abnormal WBC
 - 4.1.1.1.1.1 Fever (temperature)
 - 4.1.1.1.1.1.1 ED Temp > 38 C or < 36 C, or History of home fever.
 - 4.1.1.1.1.2 High risk: DM, PROM, PROLONGED LABOR
 - 4.1.1.1.1.2.1 Central Line/ Port.Cath.
 - 4.1.1.1.1.2.2 Malignancy
 - 4.1.1.1.1.2.3 Chronic oral steroid dependence (asthma, autoimmune disease)
 - 4.1.1.1.1.2.4 Asplenia including Sickle Cell Disease
 - 4.1.1.1.1.2.5 Bone Marrow or Solid Organ Transplant
 - 4.1.1.1.1.2.6 Complex urogenital anatomy/repair
 - 4.1.1.1.1.2.7 Severe neurologic impairment
 - 4.1.1.1.1.3 Abnormal Heart Rate (HR) or Respiratory Rate(RR) :
 - 4.1.1.1.1.3.1 HR > 90 Beats per minutes. Respiratory Rate > 20 breaths per minutes
 - 4.1.1.1.1.4 WBC count 12,000 or < 4000 per UL
- 4.2 SEPSIS SCREEN POSITIVE
 - 4.2.1 Notify attending physician or resident for immediate assessment and documentation.
 - 4.2.2 Assessment by physician (Attending / Resident) for Sepsis Huddle (which includes but not limited to):
 - 4.2.2.1 Confirm Sepsis Screen Vital Signs
 - 4.2.2.2 Obtain Brief History
 - 4.2.2.3 Assess for :
 - 4.2.2.3.1 Altered MENTAL STATUS
 - 4.2.2.3.2 Mottled, cool SKIN
 - 4.2.2.3.3 Weak, thready or Bounding PULSES
 - 4.2.2.3.4 > 3 SEC Cap Refill
 - 4.2.2.3.5 Hypotension : SBP<100 mmgh or less
 - 4.2.2.3.6 Other physician concerns
 - 4.2.3 Attending Physician/Resident Assessment Confirms Sepsis
 - 4.2.3.1 Initiate full Modified Early Obstetrics Warning System Chart
 - 4.2.3.2 Establish IV or IO
 - 4.2.3.3 Obtain CBC with diff, loaded blood gas and blood culture, Serum Lactate & RBS, Serum Chemistry & Electrolytes, CRP, PT,PTT,INR)
 - 4.2.3.4 Administer ANTIBIOTICS after blood culture obtained; DO NOT DELAY if culture cannot be drawn.
 - 4.2.3.5 Implement SEPTIC SHOCK ALGORITHM if septic shock suspected
 - 4.2.3.6 Push fluids – 30 ml/kg boluses (x3 if indicated) via iv cannula within the 1 st 3 hours . (For justification of Intravenous Fluid Resuscitation refere to point 4.3.2 in this policy).
 - 4.2.3.7 Contact ICU for consultation and possible admission to ICU for fluid given or physician concern.
 - 4.2.3.8 Early involvement of microbiologist/infectious disease expert and pharmacist in the MDT.
- 4.3 Initial Management:
 - 4.3.1 Empirical broad-spectrum antibiotics
 - 4.3.1.1 For adults with septic shock, antimicrobial therapy should be administered as soon as possible, ideally within 1 hour of recognition.
 - 4.3.1.2 For adults with suspected sepsis without shock, an expedited diagnostic examination to confirm sepsis should be completed, with antibiotics for those most likely to benefit given as soon as possible but not later than 3 hours.

- 4.3.1.3 early antibiotics are administered along with other therapies provides maximal benefit
- 4.3.1.4 Choice of antibiotics: should be broad and started empirically based on the suspected infection site, likely pathogen, clinical context (community vs hospital acquired) and local resistance pattern
- 4.3.2 Fluid resuscitation
 - 4.3.2.1 Fluid bolus therapy in 30 mL/kg aliquots administered is recommended for adults with septic shock treated in healthcare systems with availability of intensive care (either locally or via transport) over the first hour of resuscitation and titrated to clinical markers of cardiac output.
 - 4.3.2.2 Crystalloids, possibly balanced/buffered solutions, are preferred as first-line option for fluid bolus therapy.
 - 4.3.2.3 Frequent reassessment of fluid balance beyond initial resuscitation is recommended to avoid over or under hydration
 - 4.3.2.4 Assessment by dynamic blood pressure response, tissue perfusion and urine output
- 4.3.3 Vasoactive medications
 - 4.3.3.1 Norepinephrine is the 1st line vasopressor agent for hypotension that not responsive to fluid resuscitation and prevent mortality.
 - 4.3.3.2 Epinephrine or vasopressin are the 2nd line agents
- 4.4 For Inpatient: Screening by assigned nurse staff.
 - 4.4.1 Screening by Modified Early Obstetrics Warning System Chart
 - 4.4.1.1 Complete full set of vitals.
 - 4.4.1.2 Notify attending physician or resident for immediate assessment and documentation.
 - 4.4.1.3 Assessment by physician (Attending / Resident) for Sepsis Huddle (refer to point 4.2.2 in this policy), then follow the same sequence.
 - 4.4.1.4 Assess for VTE risk and administer prophylaxis as required.
 - 4.4.1.5 Assess need for imaging and involve radiologists if required.

5. MATERIALS AND EQUIPMENT:

5.1 Forms and Records:

- 5.1.1 Triage Form
- 5.1.2 Clinical Notes Form
- 5.1.3 Nurses Notes Form
- 5.1.4 Laboratory Request Forms
- 5.1.5 Order Sheet
- 5.1.6 Nursing Task Form

6. RESPONSIBILITIES:

- 6.1 Adult ED Doctors & Nurses
- 6.2 Adult Ward Doctors & Nurses
- 6.3 Adult ICU Doctors & Nurses

7. APPENDICES:

- 7.1 Modified Early Obstetrics Warning System Chart (MEOWS)
- 7.2 MCH ADULT Antimicrobial Guideline 2025


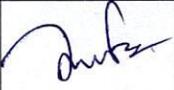







8. REFERENCES:

- 8.1 Current Medical Diagnosis And Treatment 2025

8.2 Pocket Medicine 2022

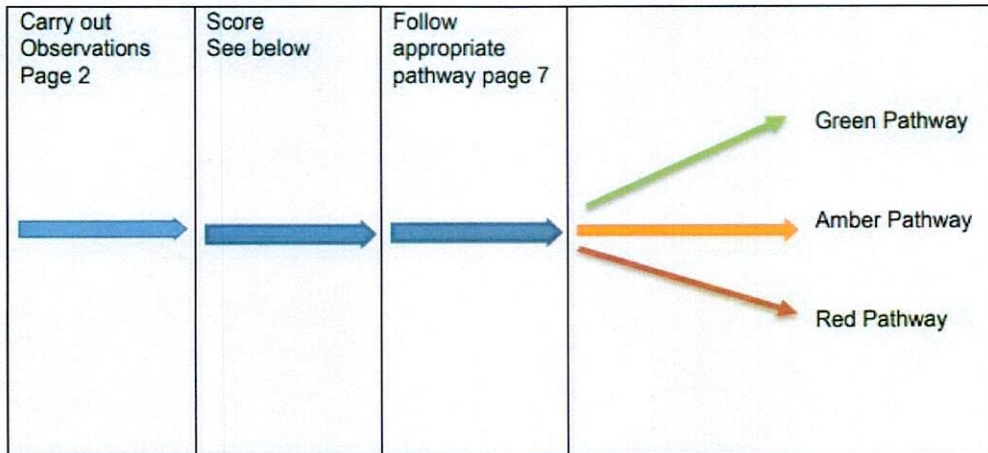
8.3 The ICU Book 2024

9. APPROVALS:

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APPENDIX 7.1 Modified Early Obstetrics Warning System Chart (MEOWS)

The form should be used for the recording of physiological Observation and MEOWS Score. All action communications in relation to a deteriorating obstetric patient must be documented in the maternal notes.



ALWAYS CONSIDERED SEPSIS (PAGE 6)

Physiological Parameters	3	2	1	0	1	2	3
Respiratory Rate	<12			12-20		21-25	>25
Oxygen Saturation	<92	92-96		>95			
Any supplemental Oxygen		Yes		No			
Temperature	<36			36.1-37.2		37.3 - 37.7	>37.7
Systolic	<90			90-140	141-150	151-160	>160
Diastolic				60-90	91-100	101-110	>110
Heart Rate	<50	50-60		61-100	101-110	111-120	>120
Level of consciousness				A			V, P or U
Pain (Excluding Labour)				Normal			Abnormal
Discharges/Lochia				Normal			Abnormal
Proteinuria						+	++>

GREEN PATHWAY

Total MEOWS = 0

Continue routine 4 hourly observation

Repeat observation if patient condition changes

Total MEOWS = 1 - 4

Inform Midwife/Nurse in charge who must assess the patient immediately

Midwife/Nurse to decide if increased frequency of monitoring and/or escalation of clinical care are required

If concerned about patient contact SHO

If symptom of pre-eclampsia (Headache, visual disturbance, Abdominal pain) Lower threshold for escalation

CONSIDERED SEPSIS (See Page 6)

Document all action

AMBER PATHWAY

Total MEOWS = 5-6
OR

If any individual parameters = 3
Inform Midwife/Nurse in charge
(consider critical care outreach)

Midwife/Nurse to immediately review the patient

Contact middle grade doctor obstetric (ST/REG./Trust Grade and consider early consultant involvement

Inform obstetric anaesthetist care to be provided in appropriately monitored environment.

Increased the frequency of observation to 1 hourly.

If symptom of pre-eclampsia (Head, visual disturbance, Abdominal pain) Lower threshold for escalation

Considered sepsis

(see Page 6)

Document all action

RED PATHWAY

MEOWS ≥ 7

Acutely concerned regarding sudden deterioration

Contact middle grade doctor obstetric (ST/Reg./Trust Grade) and Obstetrics Anaesthetist immediately

Consider 2222 for Obstetric emergency team

Commence continuous monitoring of vital signs

Consider immediate referral to ICU or HDU obstetric

Considered Critical Care Outreach (Bleep 654)

CONSIDERED SEPSIS (See Page 6)

Document all action