Sepsis: Management of Maternal Sepsis Clinical Guideline

V2.3

June 2020
1. **Aim/Purpose of this Guideline**

1.1. To provide guidance for obstetricians, anaesthetists, midwives and nurses enabling prompt diagnosis and management of sepsis in pregnant and postnatal women.

1.2. This version supersedes any previous versions of this document.

1.3. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all healthcare professionals (NEW 2020).

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**Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We cannot rely on opt out, it must be opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

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2. **The Guidance**

2.1. **Introduction**

2.1.1. Sepsis during pregnancy and the puerperium (i.e. until 6 weeks postnatally) remains the leading direct cause of maternal death in the UK (UKOSS, 2015) Sepsis is a medical emergency and the first hour of diagnosis is crucial in achieving a successful outcome. Each hour of delay in administering broad spectrum intravenous antibiotic is associated with a measurable increase in maternal mortality.

2.1.2. Sepsis is the body’s overwhelming and life threatening response to infection that can lead to tissue damage, organ failure and death.

2.1.3. Signs of severe sepsis in peripartum women, particularly with group A streptococcal infection should be regarded as an obstetric emergency. Symptoms of sepsis may be less distinctive than in the non-pregnant population and are not necessarily present in all cases; therefore, a high index of suspicion is necessary. Bacteraemia can progress rapidly to severe sepsis.
2.1.4. All recently delivered women should be informed of the signs and symptoms of genital tract infection and how to prevent its transmission.

2.2. Risk factors for maternal sepsis in pregnancy and the puerperium

- Obesity
- Impaired glucose tolerance/diabetes
- Impaired immunity/immunosuppressant medication
- Anaemia
- Offensive Vaginal discharge
- History of pelvic infection
- History of group B streptococcal infection
- Amniocentesis and other invasive procedures
- Cervical cerclage
- Prolonged spontaneous rupture of membranes
- Vaginal trauma, caesarean section, wound hematoma
- Retained products of conception
- Group A streptococcus infection in close contacts/family members
- Black or other minority ethnic group origin

2.3. Clinical symptoms suggestive of sepsis

- Fever or rigors
- Diarrhoea or vomiting
- Rash, generalized rash
- Abdominal/pelvic pain and tenderness
- Offensive vaginal discharge
- Productive cough
- Urinary symptoms
- General – nonspecific signs such as lethargy, reduced appetite
- Breast engorgement/redness
- Wound infection,
- Delay in uterine involution, heavy lochia (postnatally)
- Impaired mental state

Genital tract sepsis may present with constant severe abdominal pain and tenderness unrelieved by simple oral analgesia. Severe infection may also be associated with pre term labour. Toxic shock syndrome caused by staphylococcal or streptococcal exotoxins can produce symptoms including diarrhoea, nausea and vomiting.

2.4. Clinical signs suggestive of sepsis

Includes one or more of the following:

- Pyrexia (temp >38°C)
- Hypothermia (temp <36°C)
- Tachycardia (>100 bpm)
- Tachypnoea, (>20 breaths per minute)
- Hypoxia/requiring O2 to maintain SATS
- Hypotension
- Oliguria
- New confusion
- Fetal tachycardia/abnormal CTG particularly in the presence of meconium
• Hyperglycemia, in absence of diabetes (Glucose >7mmol)

These signs, including pyrexia may not always be present and are not necessarily related to the severity of sepsis.

2.5. Recognition of sepsis

2.5.1. Recognition of Sepsis in the hospital setting

2.5.1.1. Maternity Early Obstetric Warning Scoring system (MEOWS) is an essential tool for assessing a woman’s clinical condition. If infection is suspected, the named midwife must commence a MEOWS chart and fluid balance chart.

2.5.1.2. If MEOWS score is 5 or more complete the Sepsis Screening Tool (Appendix 3) and transfer to Delivery Suite and manage as per sepsis 6 BUFALO bundle (See appendix 4).

2.5.1.3. Review the patient within 30 minutes of admission to delivery Suite. If the obstetric team are unavailable, it must be clearly documented in the notes why and when a review is expected. The co- ordinator should review the patient to assess the urgency. If a Dr is required urgently, immediate escalation to the Obstetric Consultant on call should take place. Until the review happens the co-ordinator should be kept up to date with any changes. (New 2019).

2.5.2. Midwives working from the community or Birth Centre’s

2.5.2.1. Community midwives request a category one ambulance, cannulate if competencies allow and administer IV fluids.

2.5.2.2. When ambulance arrives administer facial O₂ to maintain SATS >94% and if IV fluids administered by midwife document in notes.

2.5.2.3. It is important to remember that some physiological changes in labour such as raised heart rate are normal and may not be related to sepsis.

2.6. General Management of Sepsis

2.6.1. Complete and carry out BUFALO steps initiating broad spectrum antibiotics as per trust policy within the hour.

2.6.2. Consider paracetamol for women in labour with a fever, a temperature of 38°C or above (on a single reading) or 37.5°C or above on 2 consecutive readings (two hours apart). (NICE 2019)

2.6.3. Be aware that paracetamol is not a treatment for sepsis and should not delay investigation if sepsis is suspected.

2.6.4. Avoid Ibuprofen
2.7. Management of Sepsis in Labour / suspected Chorioamnionitis

2.7.1. The risk of neonatal encephalopathy and cerebral palsy is increased in the presence of intrauterine infection.

2.7.2. Undertake a multidisciplinary review by obstetrician, anaesthetist, senior midwife, labour ward coordinator, microbiologist.

2.7.3. Document a clear plan with regular review taking account of the clinical picture and response to treatment (NICE 2019).

2.7.4. Involve the woman in decision making regarding mode of delivery (NICE 2019).

2.7.5. When considering mode and timing of delivery consider
- Source and severity of sepsis
- Gestation
- Fetal wellbeing
- stage and progress of labour
- parity
- response to treatment

2.7.6. If the woman has a genital tract infection, the birth should be expedited taking account of the above considerations (NICE 2019).

2.8. Change to continuous intrapartum fetal monitoring;

2.8.1. Undertake continuous CTG with ST analysis if sepsis is suspected or if the temperature is >38°C once or 37.5°C on two occasions 2 hours apart.

2.8.2. The obstetric team must review the woman within 30 minutes of admission to delivery suite and documented in the notes. If the obstetric team are unavailable, it must be clearly documented in the notes why and when a review is expected. The co-ordinator should review the patient to assess the urgency. If an obstetric review is required urgently, immediate escalation to the Obstetric Consultant on call should take place. Until the review happens the co-ordinator should be kept up to date with any changes (NEW 2020).

2.8.3. All women who are assessed as high risk must be reviewed by an obstetrician a minimum of 6 hourly and this must be documented by them in the notes. If this timeframe cannot the reason why must be documented in the notes and the coordinator informed. (NEW 2020).

2.9. Aim for Vaginal delivery if;
- Normal CTG
- No significant ST events
- making adequate progress
- If using STAN then interpretation must be upgraded e.g if patient is being treated for sepsis and the CTG is classified as intermediary it would be upgraded to abnormal and ST events interpreted accordingly
- Be aware that FBS can be falsely reassuring in the presence of sepsis
2.10. Analgesia in labour for women with sepsis
2.10.1. For women in labour needing antibiotics start antibiotics before inserting needle for regional analgesia (NICE 2019).

2.10.2. Any concerns about providing a women’s choice of regional analgesia should be discussed with the anaesthetic consultant on call.

2.11. Post Natal
Ensure ongoing Multi-Disciplinary Team (MDT) review for first 24 hours.

2.12. Deteriorating Septic Patient
2.12.1. In severe or rapidly deteriorating cases including hypotension and/or a serum lactate >4mmol/l and where there is sign of end organ dysfunction.
   - Registrar needs to be in immediate attendance
   - On call Anaesthetic Registrar needs to be in immediate attendance
   - The on-call Consultant Obstetrician, Consultant Obstetric Anesthetist (ITU Consultant for out of hours) should be involved
   - Refer the woman to the HDU outreach team
   - Advice from the Consultant Microbiologist should be urgently sought.

2.12.2. Critical care outreach team and senior intensivist should be informed if has any sign of organ dysfunction
   - Altered consciousness
   - Hypotension
   - Decreased urine output
   - Reduced urine output – not responding to treatment
   - Need for 40% oxygen to maintain oxygen saturations to above 92%
   - Temperature less than 36 °C

2.12.3. Patient will be transferred to ITU/HDU if deemed appropriate and after MDT discussion.

2.12.4. Accurate record keeping is essential both in the written notes and on E3.

2.13. Sources of sepsis in the puerperium to be considered
All women who are unwell in the puerperium should be assessed clinically, and admission considered. Women may present with sepsis which is not deriving from the genital tract. Including:
   - Mastitis
   - UTI
   - Pneumonia
   - Gastroenteritis
   - Pharyngitis /sore throat- Group A strep
   - Infection related to regional anaesthetic
   - Infective endocarditis
   - Retained tissue
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Implementation of new Sepsis Screening Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The use of sepsis 6 BUFALO</td>
</tr>
<tr>
<td></td>
<td>Were IV ABX administered within 1 hour of identification</td>
</tr>
<tr>
<td>Lead</td>
<td>Audit Midwives</td>
</tr>
<tr>
<td>Tool</td>
<td>Sepsis audit at per trust ongoing audit undertaken by audit midwives</td>
</tr>
<tr>
<td>Frequency</td>
<td>As per trust sepsis audit</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Maternity Patient Safety Forum</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Any deficiencies identified will be discussed at patient safety meeting or maternity forum.</td>
</tr>
<tr>
<td></td>
<td>Action leads will be identified and a time frame set for the action to be completed.</td>
</tr>
<tr>
<td></td>
<td>The action plan will be monitored by the maternity Patient safety forum</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Sepsis: Management of Maternal Sepsis Clinical Guideline V2.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Sepsis: Management of Maternal Sepsis Clinical Guideline V2.2</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>May 2020</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>June 2020</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>May 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Sophie Haynes, Obstetric Consultant</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 250000</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Guidance for obstetricians, anaesthetists, midwives and nurses to enable prompt diagnosis and management of sepsis in antenatal and postnatal women.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Sepsis, infection, MEOWS</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT CFT KCCG</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Approval route for consultation and ratification:</td>
<td>Maternity Guidelines Group Obs and Gynae Directorate Meeting Divisional Board</td>
</tr>
<tr>
<td>General Manager confirming approval processes</td>
<td>Debra Shields, Care Group Manager</td>
</tr>
<tr>
<td>Name of Governance Lead confirming approval by specialty and care group management meetings</td>
<td>Caroline Amukusana</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>None required</td>
</tr>
</tbody>
</table>

## Related Documents:
- NICE Intrapartum care for women with existing medical conditions or obstetric complications and their babies NG121 (2019)
- Severe maternal Sepsis UKOSS (2015)
- The UK sepsis Trust professional resources
- RCOG Green Top Guideline No. 64A
- NICE recognition diagnosis and early management (2016)
- CMACE (2008) Saving Mothers’ Lives: Reviewing maternal deaths to make
<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd October 2014</td>
<td>V1.0</td>
<td>Initial Review</td>
<td>Louise Forster Obstetric Registrar</td>
</tr>
<tr>
<td>20th May 2016</td>
<td>V1.1</td>
<td>Bufalo sticker appendix added</td>
<td>Sarah-Jane Pedler Practice Development Midwife</td>
</tr>
<tr>
<td>4th August 2016</td>
<td>V1.2</td>
<td>Lactate amended to &gt;2 in line with RCHT sepsis guideline</td>
<td>Sarah-Jane Pedler Practice Development Midwife</td>
</tr>
<tr>
<td>2nd May 2019</td>
<td>V2.0</td>
<td>Reviewed, benchmarked and updated with up to date guidance and sepsis tool updated to reflect PROMPT training, the guideline and MEOWS trigger</td>
<td>Sophie Haynes Consultant Obstetrician Sarah-Jane Pedler Practice Development Midwife</td>
</tr>
<tr>
<td>12th June 2019</td>
<td>V2.1</td>
<td>Change to the watermark in Appendix 3</td>
<td>Sarah-Jane Pedler Practice Development Midwife</td>
</tr>
<tr>
<td>August 2019</td>
<td>V2.2</td>
<td>Additions to the guideline following Health Service Investigation Branch (HSIB) regarding escalation to the Obstetrician</td>
<td>Sarah-Jane Pedler Practice Development Midwife</td>
</tr>
<tr>
<td>May 2020</td>
<td>V2.3</td>
<td>Addition of 1.4. inclusion statements Addition of Obstetric review times (30 minutes and 6 hourly ongoing) 2.8.2. 2.8.3.</td>
<td>Julie Walton Audit Midwife</td>
</tr>
</tbody>
</table>
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This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing.

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### Appendix 2. Equality Impact Assessment

#### Section 1: Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Is this a new or existing Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis: Management of Maternal Sepsis Clinical Guideline V2.3</td>
<td>Existing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Name of individual/group completing EIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>Sophie Haynes, Obstetric Consultant</td>
</tr>
</tbody>
</table>

| Contact details: | 01872 250000 |

1. **Policy Aim**
   - Who is the strategy / policy / proposal / service function aimed at?
   - All staff who care for women in the obstetric setting

2. **Policy Objectives**
   - To support all staff and those in their care who develop sepsis.

3. **Policy Intended Outcomes**
   - To ensure that there is clear guidance to follow if a patient becomes septic.

4. **How will you measure the outcome?**
   - Using the monitoring compliance tool

5. **Who is intended to benefit from the policy?**
   - All pregnant women who become septic

6a). **Who did you consult with?**
   - Workforce

   - Patients

   - Local groups

   - External organisations

   - Other

   - X

b). **Please list any groups who have been consulted about this procedure.**

   - Maternity Guidelines Group

   - Obstetrics and Gynaecology Directorate

c). **What was the outcome of the consultation?**

   - Guideline agreed
### 7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

**Are there concerns that the policy could have a positive/negative impact on:**

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, non-binary, asexual etc.)</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender reassignment</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/ethnic communities/groups</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion/other beliefs</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation (bisexual, gay, heterosexual, lesbian)</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If all characteristics are ticked ‘no’, and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

**Name of person confirming result of initial impact assessment:** Sophie Haynes, Obstetric Consultant

If you have ticked ‘yes’ to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here: [Section 2. Full Equality Analysis](#).

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead debby.lewis@nhs.net.
## Appendix 3. Maternal Sepsis Screening Tool

### Maternal Sepsis Screening Tool

1. Has MOEWS been triggered?
2. Does the woman look sick?
3. Is the fetal heart rate ≥ 160 bpm?
4. Could this woman have an infection?

**Common infections include:**
- Chorioamnionitis/endometritis
- Urinary tract infection
- Wound infection
- Influenza/pneumonia
- Mastitis/breast abscess

### If YES to any of the above, complete the risk assessment

<table>
<thead>
<tr>
<th>High risk criteria</th>
<th>Moderate risk criteria</th>
<th>Low risk criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Respiratory rate ≥ 25</td>
<td>□ Respiratory rate 21-24</td>
<td>□ Respiratory rate ≤ 20</td>
</tr>
<tr>
<td>□ SpO2 &lt; 92% without O2</td>
<td>□ Heart rate 100-130</td>
<td>□ Heart rate &lt; 100</td>
</tr>
<tr>
<td>□ Heart rate &gt; 130</td>
<td>□ Systolic BP 91-100</td>
<td>□ Systolic BP &gt; 100</td>
</tr>
<tr>
<td>□ Systolic BP ≤ 90</td>
<td>□ 1x Temperature &lt;36 or &gt;38°C</td>
<td>□ Normal mental status</td>
</tr>
<tr>
<td>□ Altered mental status/ responds only to voice, pain or unresponsive</td>
<td>□ 2x temperatures &gt;37.5°C at least two hours apart</td>
<td>□ Temperature 36-37.4°C</td>
</tr>
<tr>
<td>□ Blood Lactate ≥ 2.0*</td>
<td>□ No urine output for 12-18 hours</td>
<td>□ Locks well</td>
</tr>
<tr>
<td>□ Non-blanching rash/mottled/cyanotic</td>
<td>□ Abnormal CTG or significant rise e.g. &gt; 20 bpm above baseline</td>
<td>□ Normal CTG</td>
</tr>
<tr>
<td>□ Urine &lt; 0.5 mL/kg/hr</td>
<td>□ Prolonged ruptured membranes</td>
<td>□ Normal urine output</td>
</tr>
<tr>
<td>□ No urine for 18 hours</td>
<td>□ Recent invasive procedure</td>
<td>If ALL criteria are present:</td>
</tr>
</tbody>
</table>

**If ONE criterion is present:**
- Commence ‘Sepsis Six’ NOW
- Immediate obstetric review (middle grade or above)
- Transfer to Obstetric Unit if in the community
- Inform Consultant Obstetrician & Consultant Anaesthetist
- Commence MEOWS chart
- Commence BUFALO sticker

**If TWO criteria are present:**
- Also consider if only ONE criterion
- Send bloods
  - FBC, lactate, CRP, U-Es, LFTs
  - Obstetric review (ST3 or higher) within one hour
- Consider ‘Sepsis Six’ or commencing antibiotics if infection but not septic

**Review bloods**
- If lactate ≥ 2, persistent raised temperature or CTG changes, or Acute Kidney Injury present
- Follow

**LOW RISK OF SEPSIS**
- Review and monitor for improvement or deterioration and continue MEOWS observations
- Consider obstetric need and full clinical picture

**HIGH RISK / BUFALO**

### Completed by:
- Name: [Name]
- Designation: [Designation]
- Time: [Time]
- Signature: [Signature]
- Date: [Date]
Appendix 4: ‘Sepsis 6 (BUFALO) Care Pathway
To be completed within 1 hour of admission if sepsis is suspected

Patient Label

Date:................ Time:................

Staff Name:...................... Designation:............... Ward:..............

B - Take blood cultures if not already taken
Consider sputum, MSU, HVS, MRSA & throat swab

U - Measure hourly Urine Output
Catheter if unconscious or retention, otherwise start strict fluid input chart.

F - Give a fluid challenge
Hypotensive: Syst BP< 90: STAT 20ml/kg Hartmann’s or 0.9% Saline, contact senior immediately.
Normotensive: At least 500ml Hartmann’s or 0.9% Saline

A - Give IV antibiotics
Take blood cultures first
According to Trust protocol (from intranet), 48 hour review at latest.

L - Measure lactate (blood gas: ED, ITU)
If > 2mmol/l: CONTACT Anaesthetist on call, give 20ml/kg Hartmann’s or 0.9% Saline
FBC, LFT, U& E, Coag, Glucose.

0 - Give high-flow oxygen
15l/minute via reservoir facemask initially. Monitor SATS. Seek expert help if used for > 4hr

Evaluation at 1 hour: MEOWS: Fluid volume given: Antibiotics:

SHO: Inform Registrar (SBAR): situation= ‘Confirm Sepsis’, Liaise with Microbiologist on call

BP Syst < 90 / Mean < 65 (after initial fluid challenge)

Urine output < 0.5 ml/kg/hr for 2 hrs
INR > 1.5
aPTT > 60 s
Billirubin > 34 μmol/l
O₂ Needed to keep SpO₂ > 90%
Platelets < 100 x 10⁹/l

NO

Continue MEOWS every 30 mins. Reassess for high-risk factors each time condition changes

YES

This is SEVERE SEPSIS
Call Registrar or Consultant to attend within 30 mins, document sepsis and action plan in notes.
Inform on call Anaesthetist, Critical Care Outreach Team to attend urgently

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