NOTE: A MAP < 65 mm Hg (persistent after 30 ml/kg fluid load) in setting of infection directly defines SEPTIC SHOCK

**Suspected Infection**

### Step 1: Initial Sepsis Screen
- Oral temp < 36°C (96.8°F) or > 38°C (100.4°F)
- Heart rate > 110 beats per minute
- Respiratory rate > 24 breaths per min
- WBCs > 15,000/mm³ or < 4,000/mm³ or > 10% bands

**Positive if any 2 of 4 criteria met**

**Action**: If suspected infection, start source-directed antibiotics and 1-2 L of IV fluids; increase monitoring and surveillance. Move to confirmation evaluation.

### Step 2: Confirmation of Sepsis Evaluation
- Respiratory: New need for mechanical ventilation or PaO2/FiO2 < 300
- Coagulation: Platelets < 100 x 10⁹/L or INR > 1.5 or PTT > 60 secs
- Liver: Bilirubin > 2 mg/dL
- Cardiovascular: SBP < 85 mm Hg or MAP < 65 mm Hg or > 40 mm Hg decrease in SBP (after fluids)
- Renal: Creatinine ≥ 1.2 mg/dL or doubling of creatinine or urine output < 0.5 ml/kg/hr x 2 hrs
- Mental Status: Agitated, confused, or unresponsive
- Lactic Acid: > 2 mmol/L in absence of labor

**Confirmed if 1 or more criteria met**

#### ≥ 1 Criterion
- **POSITIVE** defines SEPSIS

#### All Criteria
- **NEGATIVE**

**Action**: Start source-directed antibiotics, broad spectrum antibiotics if source unclear; increase fluids to 30 ml/kg within 3 hours; collect blood cultures if not already obtained, maintain close surveillance, e.g. RRT, and repeat lactate. Escalate care as needed.

**Action**: As above for Sepsis, admit to ICU. If hypotension persists after 30 ml/kg fluid load, assess hemodynamic status and consider vasopressor use.

**Action**: This group remains at high risk for sepsis and requires close supervision and reevaluation.

**Action**: At a minimum, maintain close surveillance; consider additional fluids to reduce lactic acid level; repeat lactate. (See Discussion of the Role of Lactic Acid in the Peripartum Period In the toolkit for more detail.)

Elevated lactate ONLY in Labor

MAP < 65 mm Hg (with confirmation) defines SEPTIC SHOCK

**Action**: Start source-directed antibiotics, broad spectrum antibiotics if source unclear; increase fluids to 30 ml/kg within 3 hours; collect blood cultures if not already obtained, maintain close surveillance, e.g. RRT, and repeat lactate. Escalate care as needed.

### Suspected Infection

#### Routine Vital Signs / WBC Screening

- **Oral temp < 36°C (96.8°F) or > 38°C (100.4°F)**
- **Heart rate > 110 beats per minute**
- **Respiratory rate > 24 breaths per min**
- **WBCs > 15,000/mm³ or < 4,000/mm³ or > 10% bands**

**Positive if any 2 of 4 criteria met**

**Action**: If suspected infection, start source-directed antibiotics and 1-2 L of IV fluids; increase monitoring and surveillance. Move to confirmation evaluation.