FAST-M TREATMENT BUNDLE

Case #9

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| **Patient name** | **Chisomo Malawira** | | | **Staff name** |  | | |
| **DOB / Age** | **26 years** | | | **Role / Cadre** |  | | |
| **Patient ID** |  | | | **Signature** |  | | |
| **Date and time of red flag observation** | **06 /06 / 2023** | **Date & time FAST-M Treatment Bundle started** | / / : | | | **Date & time of review by nurse / midwife / clinician** | / / : |

REMEMBER TO COMPLETE THESE ACTIONS WITHIN ONE HOUR



**1HR**



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| **IDENTIFY THE SOURCE** | | |
| **Consider:** | | |
| * Clinical history * Clinical examination * Blood tests (if available)   (FBC, U&Es, LFTs, CRP, clotting) | * Blood cultures * HIV and malaria tests * Urine sample * Swabs (wound, vagina, throat) | * Sputum sample * Imaging (abdominal / chest) * Lumbar puncture |

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| **F** | **FLUIDS (caution in pre-eclampsia, severe anaemia and heart failure)** | | | | | | | |
| Date | / / | | Time started | : | Initials |  | **Give 500 ml crystalloid immediately. Repeat 500 ml boluses to a maximum of 30 ml/kg if hypotension persists** |
| Details / reason not completed | | To be Given. | | | | |

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| **A** | **ANTIBIOTICS** | | | | | | | |
| Date | / / | | Time started | : | Initials |  | **Give antibiotics.**  **See below for guidance** |
| Details / reason not completed | | To be given. | | | | |

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| **S** | **SOURCE control (identify and treat the source of infection)** | | | | | | | |
| Date | / / | | Time considered | : | Initials |  | **Identify and control the source. See below for guidance** |
| Details / reason not completed | | Source identification Required ( smelly vaginal discharge, abdominal pains) | | | | |

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| **T** | **TRANSFER if required (to a different hospital or location that can provide a higher level of care)** | | | | | | |
| Date & time considered | | / / : | Initials |  | Transport required | YES NO |
| Date & time requested | | / / : | Initials |  | N/A | |
| Date & time patient left facility | | / / : | Initials |  | N/A | |
| Destination | “YES” IF LOW LEVEL. Transfer to upper level of care | | | | | |
| Reason for any delay |  | | | | | |

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| **M** | **MONITORING (start MEOWS Chart if not already started and repeat observations every 30 minutes, until otherwise decided by the nurse / midwife / clinician performing the review)** | | | |
| Date and time monitoring commenced: | / / : | | Details / reason not completed |
| Maternal / fetal monitoring should include: | Respiratory rate Temperature Heart rate Blood pressure | Urine output Mental state Fetal heart rate | Monitoring required. |
| Neonatal monitoring and review commenced: | YES NO X N/A | |





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| **ANTIBIOTIC RECOMMENDATION** |
| **Consider:** |
| **Immediate treatment for maternal sepsis of unknown origin:**   * Ceftriaxone 2g IV OD plus metronidazole 500mg IV TDS * Add a one-off dose of gentamicin 5mg/kg IV if the patient is haemodynamically unstable   **If the above regimen is not available or the patient is not improving after 48 hours:**   * Seek urgent advice from a senior decision-maker (nurse / midwife / clinician)   **If maternal infection source is known, or as soon as it is identified:**   * Adapt the antibiotic choice to cover that source specifically, according to local guidelines |

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| **REMOVE / TREAT THE SOURCE** | |
| **Consider:** | |
| * Malaria treatment * Delivery of the baby / babies * Removal of retained products of conception * Debridement of wound / drainage of collection | * Removal of infected cannula / line * Hysterectomy * Targeted antibiotics once source known |