Policy Category	BC – BEST CARE		
Best Care Goals	☒ Safe ☐ Personal ☐ Connected ☐ Effective		
Applies To	NATIONAL		
Version	**Approval Authority**	**Effective From**	**Review By Date**
1		7/09/2021	7/09/2024

Contents

1. Rationale

The purpose of this Clinical Protocol is to provide a guiding framework for the in home management of mastitis.

2. Scope

The Clinical Protocol applies Nationally for HATH clients treated for mastitis.

3. Acceptance to HATH Criteria and Pathway

RED Unacceptable for community admission to HATH Refer to ED/ Inpatient management. (May become suitable for HATH after ED or inpatient stabilisation)	• Evidence of impending septic shock (fever >38.5°C, Systolic BP<90mmHg, HR>100/min) • Evidence of rapidly progressing infection or skin necrosis. • Co-existing medical condition requiring hospital admission or complex multiple co morbidities (eg diabetes, immunocompromised). • Laboratory confirmation or suspicion for multi resistant bacteria (eg MRSA). • Pregnancy beyond 22 weeks gestation.
ORANGE Requires discussion with Medical Governor and/or Haematologist prior to acceptance.	• Aged between 13 and 18 years, suitable for adult dosing who are not under the care of a paediatrician. • Suspected or confirmed immediate penicillin allergy or hypersensitivity (eg anaphylaxis, angioedema and/or urticaria) or cephalosporin hypersensitivity.

GREEN
Accepted for HATH Mastitis protocol
	All criteria must be met:
	• Client has a diagnosis of infective mastitis and the client's medical condition has been assessed as stable.
	• Intravenous antibiotics deemed as the only appropriate choice or patient unable to take oral medication.
	• Required pathology has been collected:
	  • Expressed breast milk MCS
	  • Blood Culture (if fever 38.50C or over)
	• Adults 18 years or over.

4. Pathology Work Up

- Blood tests are not normally indicated but may be ordered in collaboration with medical governance.
- Blood cultures should be ordered if fevers >38.5^{0}C
- Ensure breast milk sample has been sent for MCS
- Breast ultrasound should be organised if suspicion of breast abscess.

5. General Management

- Note the vast majority of cases of mastitis can be managed with oral antibiotics
- Access pathology results from referral source and, if necessary, organise expressed breast milk culture - hand-expressed midstream clean catch sample into sterile container (i.e. a small quantity of the initially expressed milk is discarded to avoid contamination with skin flora)
- FBE
- Collaborate with medical governance doctor regarding abnormal pathology results.
- Cross check if there are any known allergies/hypersensitivities to medications
- Initiate intravenous access and commence intravenous therapy as prescribed.
- Nursing care as per *Clinical Pathway – Mastitis BC-FRMC-0306*.
- Arrange review by medical governance doctor as soon as practicable.
- Advise client on the use of oral analgesia/antipyretic medication as directed.
- Advise client to continue breastfeeding the baby or to continue to drain the breasts with a breast pump. If client is breastfeeding, advise her to feed from the affected breast first and to ensure the baby drains the breast completely before offering the second side. There is no evidence of risk to the healthy, term infant of continuing breastfeeding.

6. Medical Management / Treatment Plan

Suggested antibiotic regimen if patient requires intravenous antibiotics and suitable for HATH:

- If significant cellulitis or has failed trial oral antibiotics use:
  - Cefazolin 2g IV 12 hourly for 48 hours, then if substantial clinical improvement, change to oral treatment regimen

  Note: 5 days of oral therapy may be sufficient if signs and symptoms ameliorate rapidly, otherwise continue all oral antibiotics for 7-10 days.
- Dicloxacillin 500mg orally 6 hourly

or

- Flucloxacillin 500mg orally, 6-hourly

or

- For patients hypersensitive to penicillins (excluding immediate hypersensitivity use Cefalexin 500mg orally, 6-hourly
- **or** for patients with immediate hypersensitivity: use Clindamycin 450mg 8 hourly

Organise follow up by local or referring Breastfeeding Centre if indicated.

7. Monitoring

- Daily for clinical improvement (resolution of fever, improvement in soft tissue induration, erythema and pain).
- When the symptoms and signs have eased– start oral therapy.
- Clinical deterioration (see below) – discuss with medical governor and consider hospital transfer.
- Indicators for urgent medical re-assessment or hospital admission:
  - Persistent fever > 37.80C after 72 hours of IV antibiotic therapy
  - Tachycardia, HR > 100/min
  - Hypotension (systolic BP < 90, and/or diastolic BP <60)

- Impression of a fluctuant mass suggestive of an abscess
- Extension of skin erythema or development of skin necrosis
- No improvement at all in symptoms and signs
- Increasing pain uncontrolled by prescribed analgesia.

8. Medical Governance

- The client must have access to medical governance support for 24 hours per day, 7 days per week.
- Primary medical governance can be by referring medical specialists, credentialed referring GPs or by Silver Chain medical staff.
- Care delivery is planned and provided in consultation with the client, medical officer/specialist holding medical governance and nursing staff.
- Where the primary medical governor is unavailable the Silver Chain medical officer can provide the medical governance.
- In the instance when a client's condition deteriorates the Silver Chain medical officer or nursing staff will confer with an emergency department medical officer.
- When governance is retained by a Silver Chain medical officer the client will have a medical review within 24 hours of admission and the medical officer will determine when the scheduled follow up and discharge will occur.
- A summary of the episode of care must be sent to the referrer or the client's GP at discharge.

9. Discharge Planning

- Ensure discharge summary highlights any significant clinical risks that should be followed up
- Ensure the client has an appointment arranged with own General Practitioner (GP) prior to discharge to ensure continuity of care.
- Referring Hospital appointment if required.

10. Supporting Documents

Silver Chain Group documents that directly relate to and inform this Clinical Protocol are available with this document in the Policy Document Management System (PDMS).

Other documents that directly relate to and inform this Clinical Protocol are as follows:

- Government of Western Australia North Metropolitan Health Service Women and Newborn Health Service. Mastitis: management of. Clinical Practice Guideline. Version 10/9/2020 https://www.kemh.health.wa.gov.au/~/media/Files/Hospitals/WNHS/For%20health%20professionals/Clinical%20guidelines/OG/WNHS.OG.BreastfeedingChallengesMastitis.pdf Accessed 13/8/2021
- Infant feeding and mastitis: Royal Women's Hospital, Melbourne Victoria 2020 https://thewomens.r.worldssl.net/images/uploads/downloadable-records/clinical-guidelines/infant-feeding-mastitis-and-breast-abscess_280720.pdf
- eTG Complete (March 2021 edition). Mastitis. Skin and soft tissue infections: bacterial; https://tgldcdp-tg-org-au.silverchain.idm.oclc.org/viewTopic?topicfile=lactational-mastitis&guidelineName=Antibiotic&topicNavigation=navigateTopic#toc_d1e47 Accessed July 2021

11. Document Details

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