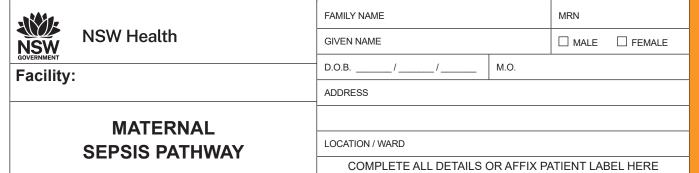
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Use for all pregnant women and up to six weeks post-pregnancy, including any perinatal loss, in any clinical setting to support recognition and management of sepsis

Use local febrile neutropenia guideline where relevant					
COULD IT BE SEPSIS? Sepsis is infection with organ dysfunction and is a medical emergency					
Does the woman have any signs or symptoms of INFECTION?					
 ☐ Myalgia, back pain, general malaise, headache ☐ Unexplained abdominal pain, distension ☐ Vomiting, diarrhoea ☐ New confusion, change in behaviour or altered level of consciousness 	 ☐ History of fevers, rigors or feeling cold ☐ Flu-like symptoms, cough, sputum, breathless ☐ Breast, wound or line redness, swelling, pain (including epidural block site) ☐ Dysuria, oliguria, frequency, odour 				
AND/OR any of the following risk factors?					
 □ Recent surgery, procedure, wound □ At risk of intrauterine infection (prolonged rupture of membranes, prolonged labour, retained products of conception, fetal tachycardia) □ Immunocompromised, chronic illness 	 ☐ Indwelling medical device or line ☐ Iron-deficiency anaemia ☐ Unwell children, household members ☐ Concern by woman, family, clinician ☐ Aboriginal and Torres Strait Islander people 				
Maternal sepsis often presents with vague non-specific symptoms					

Commence A-G systematic assessment and document a full set of vital sign observations

Does the woman have signs of ORGAN DYSFUNCTION? Including:

SBP < 90mmHg and/or respiratory rate ≥ 25 bpm and/or any non-alert mental status and/or raised lactate

ANY RED ZONE observation OR additional criteria (including lactate ≥ 4 mmol/L)	□ TWO or more YELLOW ZONE observations OR additional criteria (including lactate ≥ 2 mmol/L) Temperature instability is consistent with sepsis		
Call a RAPID RESPONSE (as per local CERS) and refer to any Resuscitation Plan	Call for a CLINICAL REVIEW within 30 minutes (as per local CERS) AND consult with the SENIOR CLINICIAN		

YES

This woman has NO **POSSIBLE SEPSIS**

Consider other causes of deterioration

Increase frequency of vital sign observations as indicated by the woman's condition

Reconsider sepsis if the woman deteriorates and escalate as per local CERS and Tiered Perinatal Network

Commence sepsis treatment (over page)

Discuss the management plan with the woman, family, carer including any Advance Care Plan Assess the fetal / baby wellbeing unless there has been a perinatal loss

Š RESPOND

This woman has

PROBABLE SEPSIS with a

high risk of deterioration

and SEPTIC SHOCK

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NSW Health		FAMILY NAME		MRN				
		GIVEN NAME	☐ MALE ☐ FEMALE					
Facilit	V'		D.O.B//	M.O.				
1 deine	у.		ADDRESS					
	MATERNAL							
	SEPSIS PATHWAY		LOCATION / WARD					
	SEPSIS PAI INVAT		COMPLETE ALL DETAILS	OR AFFIX F	ATIENT LA	BEL HERE		
Complete actions 1 to 5 within 60 minutes with ongoing A-G systematic assessment including fetal / baby wellbeing as relevant								
	1. Get help	 Escalate as per local CERS (if not already called) Consult with Obstetrician / senior clinician 						
	2. Commence monitoring	• Give oxygen as required to maintain SpO₂ ≥ 95%						
	Call for expert assistance after 2 failed attempts at cannulation Collect pathology Collect venous blood gas or point of care test if available							
	☐ Vascular access☐ Lactate (unless collected)	Vascular access • Collect 2 sets of blood cultures from 2 separate sites; 30						
ESUSCITATE	□ Pathology (FBC, EUC, LFTs, fibrinogen, coagulation screen, VBG + CRP if available)□ Blood cultures	Collect	microbiological samples according to suspected source (e.g. urine, swabs / lochia, breast milk, stool, wound, placental, viral swabs					
	☐ Other cultures / investigations☐ Blood glucose level	Do not wait for test results: commence fluids and antibiotics						
	Commence fluid resuscitation					WITHIN		
	Fluid bolus commenced		systolic blood pressure (SBP) > 90mmHg < 90mmHg after initial bolus call a RAPID RESPONSE					
	☐ IDC inserted		and document strict fluid input / output					
		hypotension, consider commencement of vasopressors and o Intensive Care or retrieval service						
	5. Commence antibiotics	Docum	Document source of infection if known					
	☐ First / new antibiotic	• Use <u>Th</u>	erapeutic Guidelines: Antibiotic_or local sepsis guideline					
	commenced	t expert advice if the woman is already on antibiotics and / or otic shock						
	6. Reassess		amine for other sources of infection					
Ш	Repeat lactate taken		e midwife in charge and Attending Medical Officer – use ISBAR					
		management plan documented by a medical officer						
		s the management plan with the woman and family						
Renea			t lactate within 2 hours					
SS	7. Refer	 Repeat lactate within 2 hours Refer for surgical source control if required 						
SE	☐ Intensive Care / retrieval service contacted	te via the Tiered Perinatal Network in line with service capability						
S	Selvice contacted	ievels	if no improvement or further deter	ioration				
Continue to monitor vital sign observations and fluid balance – minimum frequency every 30 minutes for 2 hours then hourly for 4 hours Actively seek microbiology and other investigation results and review treatment plan Escalate as per local CERS if any signs of deterioration								

Signature: _

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Designation: Date:_ Page 2 of 2 NO WRITING

Print Name: