NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

MATERNAL SEPSIS PATHWAY

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

RECOGNISE

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

RESPOND & ESCALATE

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)

→ Call a **RAPID RESPONSE** (as per local CERS) and refer to any Resuscitation Plan

→ This woman has **PROBABLE SEPSIS** with a high risk of deterioration and **SEPTIC SHOCK**

☐ **TWO or more YELLOW ZONE observations OR additional criteria** (including lactate ≥ 2 mmol/L)
Temperature instability is consistent with sepsis

→ Call for a **CLINICAL REVIEW** within 30 minutes (as per local CERS) **AND** consult with the **SENIOR CLINICIAN**

→ This woman has **POSSIBLE SEPSIS**

NO → 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

YES

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

SMR060402

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

NH700107 050224

MATERNAL SEPSIS PATHWAY

SMR060.402

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MATERNAL SEPSIS PATHWAY

RESUSCITATE

Complete actions 1 to 5 within 60 minutes with ongoing A-G systematic assessment including fetal / baby wellbeing as relevant

1. Get help

2. Commence monitoring

- Escalate as per local CERS (if not already called)
- Consult with Obstetrician / senior clinician
- Give oxygen as required to maintain $SpO_2 \geq 95\%$

WITHIN 5 min

3. Obtain access and collect pathology

- ☐ Vascular access
- ☐ Lactate (unless collected)
- ☐ Pathology (FBC, EUC, LFTs, fibrinogen, coagulation screen, VBG + CRP if available)
- ☐ Blood cultures
- ☐ Other cultures / investigations
- ☐ Blood glucose level

- Call for expert assistance after 2 failed attempts at cannulation
- Collect venous blood gas or point of care test if available
- Collect 2 sets of blood cultures from 2 separate sites; if difficult to obtain do not delay antibiotics
- Collect microbiological samples according to suspected source (e.g. urine, vaginal swabs / lochia, breast milk, stool, wound, placental, viral swabs and throat)

Do not wait for test results: commence fluids and antibiotics

WITHIN 30 min

4. Commence fluid resuscitation

- ☐ Fluid bolus commenced
- ☐ IDC inserted

- Give initial 1000mL sodium chloride 0.9% bolus STAT
- Aim for systolic blood pressure (SBP) > 90mmHg
- If SBP < 90mmHg after initial bolus call a RAPID RESPONSE
- Monitor and document strict fluid input / output

If ongoing hypotension, consider commencement of vasopressors and escalate to Intensive Care or retrieval service

WITHIN 60 min

5. Commence antibiotics

- ☐ First / new antibiotic commenced

- Document source of infection if known
- Use Therapeutic Guidelines: Antibiotic or local sepsis guideline
- Consult expert advice if the woman is already on antibiotics and / or has septic shock

REASSESS & REFER

6. Reassess

- ☐ Repeat lactate taken

- Re-examine for other sources of infection
- Update midwife in charge and Attending Medical Officer – use ISBAR
- Sepsis management plan documented by a medical officer
- Discuss the management plan with the woman and family
- Update the baby's care team on the woman's condition (if applicable)
- Repeat lactate within 2 hours

7. Refer

- ☐ Intensive Care / retrieval service contacted

- Refer for surgical source control if required
- Escalate via the Tiered Perinatal Network in line with service capability levels if no improvement or further deterioration

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

Print Name: _____ **Signature:** _____

Designation: _____ **Date:** _____ / _____ / _____

NO WRITING

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