Summary of changes: Maternal Sepsis Pathway (2024)

The Clinical Excellence Commission (CEC) have revised the adult, maternal, paediatric, and neonatal sepsis pathways to align with the national Sepsis Clinical Care Standard and current evidence-based guidelines. Improvements were also made in response to recommendations from NSW Health clinicians and expert working groups.

This document provides a summary of the changes to the CEC Maternal Sepsis Pathway. Further resources to support local implementation are available on CEC website.

Section	Change
OVERVIEW	The sepsis pathway is a clinical decision support tool for initial sepsis recognition and management. The sepsis management plan (previously Page 4) in response to feedback from NSW Health clinicians. The ongoing sepsis management plan should now be documented in the respective patients' health care record, be discussed with the Attending Medical Officer (AMO) and communicated with the clinical team. Management plans should include close observation and frequency of vital sign monitoring, any repeat investigations (e.g. lactate, cultures) and plans to review and revise antimicrobial treatment.
RECOGNISE (Page 1)	Revised wording to define use of the pathway, population group including any perinatal loss.
	Added "Could it be sepsis?" as a key prompt; aligns with sepsis NSW messaging and the Sepsis Clinical Care Standard
	Added definition of sepsis and time-critical medical emergency.
	Revised the signs and symptoms of infection to include "change in behaviour", "feeling cold", "oliguria", "breast redness, swelling and pain (including epidural block site")
	Revised risk factors to include "iron-deficiency anaemia", "unwell children", "household members".
	Added "Aboriginal and Torres Strait Islander people" as a high-risk and vulnerable population group for sepsis.
	Added "concern by women, family, clinician" as a risk factor.
	Added signs of organ dysfunction based off international guidance.
	Added "Commence A-G systematic assessment and document a full set of vital sign observations".
	Added lactate to Yellow Zone and Red Zone criteria.

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RESPOND & ESCALATE (Page 1)	Changed terminology to “probable” and “possible” sepsis to align with sepsis definition.
	Added “Escalate as per local CERS and Tiered Perinatal Network”.
	Changed wording from “Does the senior clinician consider the woman has sepsis?” to support ANY clinician can assess and consider sepsis.
	Added reminder to assess the fetal / baby wellbeing unless any perinatal loss.
RESUSCITATE (Page 2)	Removed triage data collection section.
	Updated formatting to include action list of interventions rather than A-G structure.
	Added visual clock cues to support timing of critical interventions.
	Added “Escalate and consult with Obstetrician / senior clinician”.
	Added “Call for assistance after 2 failed attempts at cannulation”.
	Added “Point of care test if available” to support sites to use point of care testing devices where available.
	Added reminder to “do not wait for test results: commence fluids and antibiotics” to prevent delays to commencing treatment.
	Changed volume of fluid resuscitation to be consistent across clinical areas with consideration of early referral for vasopressors and Intensive Care or retrieval services.
	Added link Therapeutic: Antibiotic Guidelines as recommended treatment guidance.
REASSESS & REFER (Page 2)	Removed parameters of vital signs observations to monitor and reassess.
	Added “re-examine for other sources of infection and refer for surgical control if required”.
	Updated advice on repeat lactate within two hours to assess for improvement or further deterioration.
	Added guidance on monitoring vital signs and fluid balance.