MATERNAL SEPSIS PATHWAY

For people who are pregnant or up to 6 weeks post-pregnancy

This pathway is to be filed in patient record and is intended for use by all clinicians

Family name

Given name | Gender

AFFIX PATIENT LABEL HERE

DOB | NHI

RAISE THE FLAG — Could it be Sepsis?

Sepsis is a life-threatening emergency and can happen to anyone.
Consider sepsis for any sick person with evidence of infection, especially when risk factors are present.

Māori and Pacific populations experience disproportionately higher rates of sepsis and sepsis-related harm

SEPSIS RISK FACTORS

- Socio-economic deprivation
- Previous sepsis event
- Chronic medical conditions
- Immunosuppressed
- Prolonged rupture of membranes
- Recent trauma, surgery/ procedure, or hospital admission

RECOGNISE

Date, time started, initial DD/MM/YY 00:00 24 HR AB

☐ Is the presentation consistent with **suspected** or **confirmed** infection?

NO → Exit sepsis pathway*

YES ↓

Does patient meet ANY of the following criteria?

- ☐ Concern for sepsis
- ☐ MEWS ≥ 1
- ☐ Fetal tachycardia > 160
- ☐ 2 or more temperatures > 37.5°C
- ☐ 1 or more temperature ≥ 38°C
- ☐ Pre-hospital treatment of sepsis

NO → Exit sepsis pathway*

YES ↓

RED FLAGS

- ☐ New oxygen requirement
- ☐ RR ≥ 25
- ☐ Lactate ≥ 2 mmol/L
  (Note – Lactate may be raised in and immediately after vaginal labour and birth)
- ☐ SBP ≤ 90 mmHg **OR** ≥ 40 mmHg below patient's normal
- ☐ HR ≥ 130
- ☐ Skin ashen/mottled **OR** non-blanching rash
- ☐ Responds only to voice, responds only to pain **OR** is unresponsive

ONE OR MORE RED FLAG

NO RED FLAG → AMBER FLAGS

AMBER FLAGS

- ☐ Persistent whānau concern
- ☐ RR 21 - 24 **OR** respiratory distress
- ☐ HR 100 - 129 **OR** new arrhythmia
- ☐ SBP 91 - 100 mmHg
- ☐ Temp < 36°C **OR** > 39°C
- ☐ Altered mental state
- ☐ Prolonged rupture of membranes (>24 hours)
- ☐ Close contact with Group A Strep
- ☐ Malodorous vaginal discharge
- ☐ Fetal tachycardia >160 **OR** abnormal CTG
- ☐ Invasive procedure or termination in last 6 weeks

≥2 flags ticked

- ☐ Send bloods including lactate + blood cultures (2 sets)

Review with results

- ☐ **New RED FLAG**
- ☐ Acute Kidney Injury

YES → Start Sepsis Six + 2 NOW

NO →

- ☐ Document treatment plan
- ☐ If antibiotic needed, administer within 3 hours
- ☐ Update patient and whānau

1 flag ticked → Update patient and whānau

No flag ticked → Exit pathway*

*In case of deterioration restart screening

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Sepsis Trust NZ

Health New Zealand Te Whatu Ora

Health Quality & Safety Commission Te Tāhū Hauora

Family name

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RESUSCITATE

Date, time started, initial DD/MM/YY 00:00 24 HR AB

Sepsis Six +2

These steps should be completed concurrently (steps are not sequential)

Complete **ALL** steps **WITHIN 1 HOUR**

DO NOT DELAY for investigations or results

1. Give Oxygen if $SpO_2 \leq 92\%$

Target saturation ≥ 94%

N/A ☐ | Time completed: 24 HOURS | Initials

2. Draw Blood Cultures

Send at least TWO sets from a single site, even if patient is afebrile. Ensure all bottles are properly filled

N/A ☐ | Time completed: 24 HOURS | Initials

3. Obtain Lactate & Full Set of Bloods

Including FBC, U&Es, LFTs, coags

N/A ☐ | Time completed: 24 HOURS | Initials

4. Give IV Fluids

If hypotensive/lactate > 2 mmol/L, 500 ml stat
Repeat if clinically indicated up to 30 ml/kg IBW

N/A ☐ | Time completed: 24 HOURS | Initials

5. Give IV Antibiotics

- Refer to Te Whata Kura – National Antibiotic Guideline for empiric antibiotic choice.
- Use sepsis-specific guideline if one is available

N/A ☐ | Time completed: 24 HOURS | Initials

6. Get Help

Inform a senior clinician* that your patient has “red flag sepsis”. Prioritise investigation, referral and source control

*Obstetrician/SMO, anaesthetist, senior midwife, registrar, nurse practitioner

N/A ☐ | Time completed: 24 HOURS | Initials

Who

REASSESS

Date, time started, initial DD/MM/YY 00:00 24 HR AB

PLUS 2

1. Assess fetal state and consider delivery or evacuation of retained products of conception
2. Prescribe thromboprophylaxis if appropriate

☐ Inform patient and whānau of sepsis diagnosis

- Observe vital signs every 30 minutes
- Prioritise investigation, referral, and source control
- Document hourly urine output

☐ **Assess treatment response WITHIN 3 HOURS; refer to hypoperfusion pathway if any of the following criteria are met:**

- systolic BP ≤ 90 mmHg
- reduced level of consciousness despite resuscitation
- RR ≥ 25
- lactate ≥2 mmol/L and not improving