# 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.**

**SEPSIS RISK FACTORS**

- Māori or Pacific ethnicity
- 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?**

- ☐ Appears seriously unwell
- ☐ 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 normal labour and delivery)
- ☐ SBP ≤ 90 mmHg **OR** ≥ 40 mmHg below patient's normal
- ☐ HR ≥ 130
- ☐ Skin ashen/mottled **OR** non-blanching rash
- ☐ Responds to voice only **OR** pain/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
- ☐ Non-reassuring CTG / fetal tachycardia > 160
- ☐ 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

## RESUSCITATE

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

# Sepsis Six +2

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

***DO NOT DELAY*** for investigations or results

| | N/A | Time completed | Initials |
|---|---|---|---|
| **1. Give Oxygen if $SpO_2 \leq 92\%$**<br>Target saturation ≥ 94% | ☐ | 24 HOURS | |
| **2. Draw Blood Cultures**<br>Send at least TWO sets from a single site, even if patient is afebrile. Ensure all bottles are properly filled | ☐ | 24 HOURS | |
| **3. Obtain Lactate & Full Set of Bloods**<br>Including FBC, U&Es, CRP, LFTs, coags | ☐ | 24 HOURS | |
| **4. Give IV Fluids**<br>If hypotensive/lactate > 2 mmol/L, 500 ml stat<br>Repeat if clinically indicated up to 30 ml/kg IBW | ☐ | 24 HOURS | |
| **5. Give IV Antibiotics**<br>Refer to local antimicrobial guidance<br>Use sepsis-specific guideline if one is available | ☐ | 24 HOURS | |
| **6. Get Help**<br>Inform a senior clinician* that your patient has "red flag sepsis".<br>Prioritise investigation, referral and source control<br>*Obstetrician/SMO, anaesthetist, senior midwife, registrar, nurse practitioner | ☐ | 24 HOURS | |

## 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

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