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

ADD BARCODE

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 24HR 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 → Exit pathway*

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 $SpO_2 \leq 92\%$ Target saturation ≥ 94%	☐	24 HOURS	
2. Draw Blood Cultures 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 Including FBC, U&Es, CRP, LFTs, coags	☐	24 HOURS	
4. Give IV Fluids If hypotensive/lactate > 2 mmol/L, 500 ml stat Repeat if clinically indicated up to 30 ml/kg IBW	☐	24 HOURS	
5. Give IV Antibiotics Refer to local antimicrobial guidance Use sepsis-specific guideline if one is available	☐	24 HOURS	
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	☐	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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