OBA NURSING ACADEMY · SEPSIS RECOGNITION AND MANAGEMENT · OBA-SEP-2026

Course Syllabus

Sepsis Recognition and Management · OBA-SEP-2026 · 8.5 CPD hours · fully self-directed online

DOCUMENT CONTROL

- Programme: Sepsis Recognition and Management (OBA-SEP-2026)
- Audience: Student and Facilitator
- Version 2.0 | Issued 20/09/2026 | Review due 20/09/2027
- Provider: OBA Nursing Academy

SCOPE OF PRACTICE AND CURRENCY

- This programme is professional development. It does not authorise any procedure, it credentials nobody, and it is not a substitute for assessed competence. It contains no antimicrobial agent, dose, route or duration, no fluid volume prescription and no vasopressor regimen - those come from the current Therapeutic Guidelines, your service's endorsed guidelines and antimicrobial formulary, and a prescriber. Your service's sepsis pathway, its escalation protocol and your own scope of practice override anything in this programme wherever they differ.
- Content verified 20/09/2026 against the ACSQHC Sepsis Clinical Care Standard (June 2022, seven quality statements), the NSQHS Recognising and Responding to Acute Deterioration Standard, the NSQHS Preventing and Controlling Infections and Comprehensive Care Standards, the Antimicrobial Stewardship Clinical Care Standard, and the Surviving Sepsis Campaign international guidelines. NOTE THE TWO LAYERS: the Australian clinical care standard of June 2022 is current and governs Australian practice; the Surviving Sepsis Campaign guidelines it draws on were updated in 2026, and that update extends rather than contradicts the standard. Where this programme cites one rather than the other, it says which.

1. Programme overview

Sepsis Recognition and Management is a fully self-directed, entirely online professional development programme delivered through the OBA Nursing Academy learning management system. There are no scheduled classes, no live sessions and no clinical placement. Learners complete eleven modules at their own pace, followed by a case study assessment and a single summative assessment.

THE LINE THIS PROGRAMME HOLDS

- COULD IT BE SEPSIS? QUALITY STATEMENT 1 OF THE AUSTRALIAN SEPSIS CLINICAL CARE STANDARD IS NOT A REQUIREMENT. IT IS A QUESTION - AND IT HAS TO BE ASKED OUT LOUD.
- It reads: a diagnosis of sepsis is CONSIDERED in any patient with an acute illness or clinical deterioration that MAY be due to infection. Not confirmed, not scored. Considered - a far lower bar than most clinicians set for themselves before they will say the word in front of a colleague.
- Every other statement in the standard - time-critical management, antimicrobials, coordination, telling the patient, handover, survivorship - depends on somebody having asked that one first. The

commonest failure in sepsis is not that somebody did not know what to do. It is that nobody said the word.

• AND THE PROGRAMME HOLDS BOTH HALVES OF THE ANTIMICROBIAL TIMING FRAMEWORK. In septic shock and in probable sepsis, immediately - ideally within one hour. In POSSIBLE sepsis without shock, rapid investigation with antimicrobials within three hours if concern persists. And where the likelihood of infection is low and there is no shock, defer. Which half applies is decided by certainty, not by the clock. It carries no antimicrobial agent, dose, route or duration, no fluid volume and no vasopressor.

TWO COURSES THIS ONE IS OFTEN CONFUSED WITH

TWO COURSES THIS ONE SITS BESIDE. OBA's Triage Principles course teaches the Australasian Triage Scale and the allocation of an acuity category at the front door; this course is about recognising a specific condition anywhere in a service, including hours after triage. And OBA's Infection Prevention and Control family is about stopping infection happening - this course starts after it has. Where they meet is antimicrobial stewardship, which appears in both and which this course treats as one half of a single recommendation rather than as a competing priority.

Who it is for

- Registered and enrolled nurses in every setting where an acutely unwell person presents - which is every setting, because sepsis arrives through emergency departments, wards, residential aged care, community nursing and general practice alike
- Emergency and acute ward nurses, who do most of the recognising and most of the escalating
- Aged care and residential nurses, where the presentation is least likely to look like the textbook and most likely to be delirium, hypothermia or a fall
- Community, primary care and remote area nurses, for whom the deliverable is recognition and referral rather than resuscitation - and for whom point-of-care lactate may be the only test available
- Midwives and maternity nurses, where no decision support tool may exist and early escalation is the priority
- Nurses caring for children, where hypotension is NOT required to diagnose septic shock and parental concern is a named trigger
- Nurse unit managers, educators and clinical leads, who own the sepsis pathway, the escalation protocol and the indicators
- Internationally qualified nurses, for whom the Australian standard, the escalation culture and the family-activated escalation systems are frequently new

How it is delivered

- Fully self-directed and entirely online, through the OBA learning management system. No scheduled classes, no live sessions, no clinical placement
- Eleven modules, each with a narrated video, a student learner guide, a reflective workbook activity and a formative knowledge check
- A case study assessment of five unfolding situations, and a single summative assessment
- Learners work at their own pace. Nothing is timed, and there is no completion deadline

How this programme treats the people taking it

Two things about how this programme is written. It contains no photographs and no reproduced real cases - every scenario is constructed, because sepsis education built out of coronial findings teaches clinicians to recognise somebody else's failure rather than their own patient. And it takes seriously that a large proportion of any cohort has been part of a case where sepsis was recognised late. That is almost always a system finding rather than an individual one, the course says so repeatedly, and the support lines are on every student-facing document.

SUPPORT - FOR YOU, NOT FOR A PATIENT

- Nurse & Midwife Support - 1800 667 877. 24 hours, seven days. Free and confidential, for nurses, midwives and students - including after a case where sepsis was recognised late, which is one of the commonest reasons people ring.
- Lifeline - 13 11 14. 24 hours, seven days. National crisis support.
- You may stop this programme at any point and come back. Nothing is timed and there is no penalty.

Programme outcomes

On completion, learners will be able to:

1. State the governing question - could it be sepsis? - and the patients it is asked about: anyone with acute illness or deterioration that MAY be due to infection
2. Define sepsis as life-threatening organ dysfunction caused by a dysregulated host response to infection, and septic shock as a subset
3. Explain why sepsis is a clinical diagnosis with no single diagnostic test, and state the threshold for antimicrobial treatment used in the standard
4. List the observations the standard names, including altered mentation and peripheral perfusion, and identify the red flags
5. State how sepsis presents in older people, in children, in pregnancy, and in people whose medicines have removed a physiological signal
6. Explain what blood lactate contributes and what it does not, and why a non-triggering screening tool does not exclude sepsis
7. State what a locally approved sepsis clinical pathway must contain and what escalation architecture a service must have in place
8. State both halves of the antimicrobial timing framework, and what decides which half applies to a given patient
9. Describe how a nurse contributes to antimicrobial stewardship without selecting an agent, dose, route or duration
10. Explain why family or carer concern is a named red flag, and what the evidence says about family-activated escalation
11. State when and how a patient and their family are informed that sepsis is suspected
12. State what a documented clinical handover must carry for a patient with suspected sepsis, and what must happen before a transfer
13. Describe what sepsis survivors live with, and what the discharge communication to the general practitioner must contain
14. Locate the programme inside the eleven indicators and the NSQHS actions, and identify the local questions this course deliberately leaves unanswered

2. Module structure

Module	Title	CPD hours	Knowledge check items
00	Orientation: The Question That Has to Be Asked Out Loud	0.50	4
01	What Sepsis Is: Organ Dysfunction, and Why There Is No Test	0.50	5
02	Could It Be Sepsis? The Full Set of Observations	0.50	6
03	The Patients Who Do Not Look Septic	0.50	6
04	Lactate, Tools and Clinical Judgement	0.50	5
05	Time-Critical Management: the Pathway and the Escalation	0.50	6
06	Antimicrobials: Both Halves of Quality Statement 3	0.50	7
07	Listening: Concern as a Clinical Finding	0.50	6
08	Coordination, Handover and Transitions of Care	0.50	5
09	After Sepsis: the Part Nobody Teaches	0.50	5
10	The System Around It: Indicators, Standards and Your Pathway	0.50	5
	Module subtotal	5.50	60
	Programme information documents	1.55	-
	Case study assessment (5 unfolding cases)	0.53	-
	Summative assessment	0.97	60
	CLAIMABLE CPD TOTAL	8.5	

Module hours are the measured time for that module's video, learner guide, knowledge check and workbook activity. The table below shows how every figure was measured.

Indicative workload, and how the CPD hours were arrived at

The CPD figure for this programme is not asserted. It is measured from the content: narration at 135 words per minute, reading at 130 words per minute for dense professional prose, knowledge checks timed to include reading every rationale, and the assessments timed as measured

reading plus a stated decision allowance. Individual learners vary, and a learner who claims a different figure should claim their actual time.

Component	Measured time	How it was measured
Module videos (11)	63 min	Narration word count at 135 wpm
Student learner guides (11)	123 min	Guide word count at 130 wpm
Module knowledge checks (11)	47 min	Stem, options and every rationale, read and answered
Reflective workbook activities (11)	88 min	Writing time for the five prompts in each module
Programme information documents	93 min	Rendered page word counts at 130 wpm
Case study assessment	32 min	19 minutes measured reading plus 30 seconds per decision across 25 steps
Summative assessment	58 min	28 minutes measured reading plus 30 seconds per item across 60 items
MEASURED TOTAL	504 min (8.40 h)	Sum of the above
CLAIMABLE CPD	8.5 hours	The measured total, to the nearest half hour

The measured total is 8.40 hours and the claimable figure is 8.5 - the measured total to the nearest half hour. The programme has not been padded to reach a rounder number, because the whole point of deriving the figure is that it is not chosen. A course that states its own CPD honestly is also the only kind whose other statements are worth trusting.

The five optional practice tools - could it be sepsis, what is the clock, what do you do next, listen or reassure, and the sepsis scope self-check - add approximately a further 85 minutes. They are deliberately excluded from the claimable figure, because they are optional. A learner who completes them may claim that time as additional self-directed CPD.

Module 00 - Orientation: The Question That Has to Be Asked Out Loud

What the programme covers and the sentence it is built on. Quality statement 1 of the Australian Sepsis Clinical Care Standard is not a requirement - it is a question: COULD IT BE SEPSIS? Every other statement in the standard depends on somebody having asked it out loud. Then the tension this course refuses to resolve in one direction: the same guidance that says antimicrobials immediately, ideally within one hour, also says that where the likelihood of infection is low and there is no shock, defer them. Both halves, or the course teaches either antimicrobial overuse or a preventable death. And what the programme deliberately withholds - every antimicrobial agent, dose, route and duration, every fluid volume and every vasopressor.

Learning outcomes

- State the question that quality statement 1 of the Sepsis Clinical Care Standard asks
- Explain why sepsis recognition fails at the point of asking rather than the point of knowing
- State both halves of the antimicrobial timing framework and what decides which applies
- Explain what this course does not carry, and why those things belong to a prescriber
- Identify the currency position: a current Australian standard on a guideline layer that moved

- Locate the ten local questions this course cannot answer for you

Key terms: sepsis; could it be sepsis; organ dysfunction; clinical care standard; antimicrobial stewardship; escalation; scope of practice

Module 01 - What Sepsis Is: Organ Dysfunction, and Why There Is No Test

Sepsis is life-threatening ORGAN DYSFUNCTION caused by a dysregulated host response to infection. Not a bad infection, not a bloodstream infection, and not defined by the organism. The module works through what each part of that sentence excludes, why Sepsis-3 deleted the term 'severe sepsis', what septic shock is as a subset, and the distinction between PROBABLE and POSSIBLE sepsis that decides the treatment clock in Module 06. Then the hard part: sepsis is a clinical diagnosis and there is no single diagnostic test - which is a statement about the biology, not a gap waiting for a better assay.

Learning outcomes

- State the Sepsis-3 definition of sepsis and what each element excludes
- Define septic shock as a subset of sepsis and state what distinguishes it
- Explain why the term 'severe sepsis' was eliminated and what it means when a document uses it
- Distinguish probable from possible sepsis and state why the distinction matters clinically
- Explain why sepsis is a clinical diagnosis with no single diagnostic test
- State the threshold for antimicrobial treatment used in the Australian standard

Key terms: Sepsis-3; organ dysfunction; dysregulated host response; septic shock; severe sepsis; probable sepsis; possible sepsis; clinical diagnosis

Module 02 - Could It Be Sepsis? The Full Set of Observations

The recognition module. Who the question gets asked about - which is anyone with an acute illness or deterioration that MAY be due to infection, a far wider net than most services cast. The observations the standard names, including the two that are not numbers: altered mentation, and peripheral perfusion. The at-risk groups and the red flags, with family or carer concern named first. What adults and children look like when this is happening. And the habit this module exists to build: asking out loud, and documenting that you asked.

Learning outcomes

- State who the question 'could it be sepsis?' should be asked about
- List the observations the standard names, including the non-numeric ones
- Identify the groups at higher risk of sepsis named in the standard
- Recognise the red flags, and state which one is named first
- Describe how sepsis presents in adults and in children
- Document a sepsis consideration in a way that survives to the next clinician

Key terms: could it be sepsis; altered mentation; peripheral perfusion; capillary refill; red flags; at-risk groups; escalation; delirium

Module 03 - The Patients Who Do Not Look Septic

The module that decides whether the rest of the course is useful. In older people the commonly recognised signs of sepsis are OFTEN ABSENT - fever, a raised white cell count and a raised CRP are all less likely, and hypothermia, delirium and falls are more likely. In children, hypotension is NOT necessary to diagnose septic shock. In pregnancy the normal physiology

flattens the very signals a tool is watching for, and for neonatal and maternity patients a decision support tool may not exist at all - in which case the standard says early assessment and escalation are the priority. And two common medicine groups - beta blockers and immunosuppressants - remove a signal each.

Learning outcomes

- State how sepsis presents differently in older people and why
- State that hypotension is not necessary to diagnose septic shock in children
- Explain why pregnancy masks the physiological signals of sepsis
- State what the standard directs when no decision support tool exists for a patient group
- Identify medicines that blunt the signs a screening tool depends on
- Explain why a screening tool performs worst in the group with the highest mortality

Key terms: older people; hypothermia; delirium; falls; paediatric septic shock; maternal sepsis; beta blocker; immunosuppression; compensation

Module 04 - Lactate, Tools and Clinical Judgement

Two instruments, and the same error available in both. Lactate is named in quality statement 1 and should be included routinely in decision-making for a deteriorating patient - and the standard says plainly that it is NOT SUFFICIENT for the purpose of diagnosis, and that a raised lactate may reflect a protective OR a maladaptive response. Screening tools are required by the standard, vary by age, cultural needs and setting, must be agreed locally, and DO NOT REPLACE CLINICAL JUDGEMENT. The single misuse this module exists to prevent: treating a normal lactate or a non-triggering tool as evidence that the patient does not have sepsis. Plus what point-of-care lactate changes in rural and remote settings.

Learning outcomes

- State what lactate contributes to sepsis recognition and what it does not
- Explain why a raised lactate may indicate a protective or a maladaptive response
- State the standard's qualifier on when to test lactate
- Explain what a clinical decision support tool is for and what it is not
- State why no single tool applies to every patient
- Describe what point-of-care lactate testing changes in rural and remote practice

Key terms: blood lactate; point-of-care testing; decision support tool; screening; clinical judgement; calling criteria; rural and remote

Module 05 - Time-Critical Management: the Pathway and the Escalation

Quality statement 2. Sepsis is a time-critical medical emergency: assessment and treatment are started urgently according to a LOCALLY APPROVED clinical pathway, the response to treatment is monitored and reviewed, and the patient is reviewed by a clinician experienced in recognising and managing sepsis, escalated to a higher level of care when required. The module works through the six elements the standard says a pathway must contain, the escalation architecture that has to exist 24 hours a day and seven days a week, what starts before transfer, and the sentence written for primary and community care: if diagnosing or managing sepsis is outside your scope, IMMEDIATE REFERRAL TO HOSPITAL may be the most appropriate action.

Learning outcomes

- State what quality statement 2 requires
- List the elements the standard says a sepsis clinical pathway must contain
- Describe the escalation architecture a service must have in place
- State what should start before a patient is transferred
- State the action available when managing sepsis is outside your scope
- Describe what a smaller or remote service should prioritise

Key terms: clinical pathway; escalation; rapid response; retrieval; source control; goals of care; transfer; time-critical

Module 06 - Antimicrobials: Both Halves of Quality Statement 3

The module the whole course is built around. Quality statement 3 has two halves and most teaching carries one. Blood cultures immediately - ENSURING THIS DOES NOT DELAY antimicrobial therapy. Antimicrobials within 60 minutes when signs of infection-related organ dysfunction are present. And the timing framework by certainty: immediately, ideally within one hour, for septic shock and for probable or definite sepsis; rapid investigation with antimicrobials within three hours for POSSIBLE sepsis without shock; and where the likelihood of infection is LOW and there is no shock, DEFER. Then the other half of the statement entirely - the Antimicrobial Stewardship Clinical Care Standard, and the review 24 to 48 hours after the first dose. No agent, no dose, no route, no duration anywhere in it.

Learning outcomes

- State quality statement 3 in full, including the clause about blood cultures
- State the antimicrobial time frame when infection-related organ dysfunction is present
- Describe the timing framework by certainty of diagnosis, including deferral
- Define what 'rapid assessment' means and what it involves
- State how antimicrobial therapy is reviewed after the first dose
- Describe how the nurse contributes to stewardship without choosing an agent

Key terms: quality statement 3; blood cultures; 60 minutes; rapid assessment; deferral; antimicrobial stewardship; de-escalation; 48-hour review

Module 07 - Listening: Concern as a Clinical Finding

The module about the finding that does not appear on any chart. Family or carer concern is named first among the standard's red flags, and it is evidence-cited: cases of sepsis have been missed because clinicians did not listen to patients, their families or carers, and a systematic review of patient- and family-activated escalation found ALL calls were deemed appropriate. In paediatrics parental concern is key to initiating escalation. It is also a governance requirement - Action 8.06 puts WORRY OR CONCERN in the escalation criteria and Action 8.07 requires a way for patients and families to escalate directly. Then quality statement 5: the patient and family are told sepsis is suspected FROM THE TIME IT IS SUSPECTED, verbally and in writing.

Learning outcomes

- Explain why family or carer concern is a red flag in the standard
- State what the evidence says about misuse of family-activated escalation
- State the NSQHS actions that make listening a governance requirement
- Describe what quality statement 5 requires and when
- Explain why 'verbally and in writing' is not a formality

- Respond to a concern you do not yet share, without dismissing it

Key terms: family concern; carer concern; patient-activated escalation; Action 8.06; Action 8.07; quality statement 5; information; REACH

Module 08 - Coordination, Handover and Transitions of Care

Two quality statements that answer the same question from opposite ends. Statement 4: sepsis is a complex, multisystem disease requiring a multidisciplinary approach, and treatment in hospital is COORDINATED BY A CLINICIAN WITH EXPERTISE in managing patients with sepsis - somebody owns it. Statement 6: a patient with known or suspected sepsis has a DOCUMENTED clinical handover at transitions of care, including the provisional sepsis diagnosis, comorbidities and the management plan for medicines and medical conditions - and that information goes to the patient, family and carer as appropriate. The failure mode both exist to prevent: a provisional diagnosis that evaporates between two clinicians, restarting the clock.

Learning outcomes

- State what quality statement 4 requires and why sepsis needs a coordinator
- State what quality statement 6 requires in a handover
- List what a sepsis handover must carry
- Describe what the standard requires when a patient is transferred between facilities
- Explain why the provisional diagnosis is the item most often lost
- Identify what the patient and family are entitled to at a transition of care

Key terms: quality statement 4; quality statement 6; clinical handover; coordination; transitions of care; transfer; Action 6.11; Action 5.05

Module 09 - After Sepsis: the Part Nobody Teaches

Quality statement 7 exists because surviving sepsis is not the end of it. Survivors have an increased risk of complications, face higher healthcare costs and longer treatment, and are at risk of rehospitalisation and recurrence. The standard requires INDIVIDUALISED follow-up to optimise functional outcomes, minimise recurrence, reduce rehospitalisation and manage the ongoing health effects - structured, holistic and coordinated post-discharge care involving the patient, family, carer and GP. The module covers what people actually report afterwards, why a person who was never told they had sepsis cannot participate in their own recovery, the requirement to address barriers to continuing antimicrobials INCLUDING COST, and bereavement support - which the Commission publishes as part of this standard.

Learning outcomes

- State what quality statement 7 requires and why it exists
- Describe what sepsis survivors commonly report after discharge
- Explain why being told the diagnosis is a clinical intervention, not a courtesy
- State what a discharge communication to the GP must contain
- Describe the requirement about continuing antimicrobials after discharge
- Identify what the standard provides for bereaved families

Key terms: survivorship; post-sepsis syndrome; rehospitalisation; recurrence; discharge; GP letter; bereavement; functional outcomes

Module 10 - The System Around It: Indicators, Standards and Your Pathway

The module that turns a course into a change. The eleven indicators the Commission publishes for local monitoring, and what each one actually measures. The NSQHS actions that sit underneath - 8.01, 8.04, 8.06 and 8.07 in the Acute Deterioration Standard, 3.18 and 3.19 for stewardship, 5.05 and 5.10 in Comprehensive Care, and 6.11 for handover. The scope matrix, in which asking the question and escalating is EVERY ROW. The NMBA decision-making framework applied to sepsis. And the ten local questions, which is where this course stops and your service begins.

Learning outcomes

- Identify the eleven indicators and what each measures
- State the NSQHS actions that underpin sepsis care
- Use the scope matrix to locate your own role's boundaries
- Apply the NMBA decision-making framework to a sepsis activity
- Identify what a service must have in place, as distinct from what a clinician must do
- Answer the ten local questions for your own workplace

Key terms: indicators; NSQHS; Action 8.06; Action 3.18; scope of practice; decision-making framework; governance; local pathway

3. Assessment

Component	Type	Weighting	Attempts
Module knowledge checks (11)	Formative, immediate feedback with rationales	Not graded	Unlimited
Reflective workbook	Formative, self-directed	Completion required	n/a
Case study assessment	Formative, branching decisions with feedback	Completion required	Unlimited
Summative assessment	60 single-best-answer items	100% - pass mark 80%	2

Summative assessment blueprint

Module	Items
00	4
01	5
02	6
03	6
04	5
05	6
06	7
07	6
08	5
09	5
10	5
TOTAL	60

Pass mark is 80 per cent (48 of 60). Learners have 2 attempts. The certificate of completion is issued automatically on a pass.

The assessment is bound by the same rules as the rest of the programme. No keyed answer names an antimicrobial agent, dose, route or duration, supplies a fluid volume as a prescription, or names a vasopressor - and bank.py enforces that with a drug-name and dose-unit check. No keyed answer states the one-hour rule as universal, and none applies deferral or investigation to a shocked patient: any keyed time frame carries the situation it attaches to. No screening tool or lactate is keyed as diagnostic or exclusionary, no normal observation set is keyed as excluding sepsis, and family or carer concern is never keyed as something to manage rather than act on. Nothing local is assessed as though it were national.

4. Standards and regulatory mapping

Framework	Elements addressed	Where
ACSQHC Sepsis Clinical Care Standard (June 2022)	All seven quality statements: could it be sepsis; time-critical management; management of antimicrobial therapy; multidisciplinary coordination; patient and carer education; transitions of care; and care after	Every module

	hospital and survivorship. Plus the eleven indicators	
Surviving Sepsis Campaign international guidelines	The antimicrobial timing framework by certainty of diagnosis, and the definition of rapid assessment. Updated 2026 - 129 statements, 46 of them new	Modules 01, 05 and 06
NSQHS Recognising and Responding to Acute Deterioration Standard	Actions 8.01 systems, 8.04 detecting physiological deterioration, 8.06 escalation criteria including worry or concern, 8.07 direct escalation by patients, carers and families	Modules 05, 07 and 10
NSQHS Preventing and Controlling Infections Standard	Actions 3.18 and 3.19, antimicrobial stewardship - named in the sepsis standard	Modules 06 and 10
Antimicrobial Stewardship Clinical Care Standard	Prescribing to guidelines and formulary; appropriate microbiology sampling and review; documenting the intended duration or review plan; and the 24 to 48 hour review	Module 06
NSQHS Comprehensive Care and Communicating for Safety Standards	Action 5.10 recognition and response, Action 5.05 multidisciplinary coordination, and Action 6.11 clinical handover	Modules 08 and 10
NMBA Registered nurse and Enrolled nurse standards for practice	Comprehensive assessment, thinking critically, escalating appropriately, and practising within scope	Modules 00 and 10, and the scope matrix

5. Scope of practice

This programme is written for registered and enrolled nurses, midwives, care workers, and the managers and educators who hold the other half of the subject. Every module identifies what each role may and may not do, and under what condition. The full activity-by-role matrix is published separately as the Scope of Practice Mapping document (facilitator) and the Student Scope of Practice Card.

THE RULE THAT GOVERNS THE PROGRAMME

- Completing this course authorises nothing. It is professional development: it does not authorise blood culture collection, point-of-care lactate testing, cannulation or the administration of anything, and it does not substitute for the employer's sepsis pathway, its antimicrobial formulary or its competency assessments.
- Blood culture collection and point-of-care lactate testing are credentialled activities assessed locally, and point-of-care testing also sits under device governance and quality control. This course explains what they contribute and when, and stops there.
- Two rows of the scope matrix read 'No' for every role including the most senior - delaying antimicrobials in septic shock to complete paperwork, and using a screening tool that did not trigger to rule sepsis out.
- One row reads 'Yes' for every role, including assistants in nursing and personal care workers: asking 'could it be sepsis?' out loud about any patient, and escalating.
- Where an organisation's policy is more restrictive than this course, the organisation's policy applies as well. Where the local sepsis pathway differs from anything here, the pathway applies.

6. Resources and further reading

A full directory of Australian and international sources, with live links, is published as the Further Reading and Organisation Directory. Four matter more than the rest, and all four are free. The ACSQHC SEPSIS CLINICAL CARE STANDARD (June 2022) is the operative Australian document: seven quality statements, each written three ways, plus eleven indicators. The ACSQHC SEPSIS CLINICAL TOPIC HUB carries the implementation resources - the self-assessment tool, the indicator monitoring tool, the lactate resource, the discharge planning guide and the GP letter template. The NSQHS RECOGNISING AND RESPONDING TO ACUTE DETERIORATION STANDARD carries actions 8.01, 8.04, 8.06 and 8.07. And the fourth is local: your sepsis pathway, your screening tool, your escalation protocol and your antimicrobial formulary. Support lines are on every module: Nurse & Midwife Support 1800 667 877, Lifeline 13 11 14.

7. Completion and CPD

15. Complete all eleven module knowledge checks.
16. Complete the case study assessment.
17. Achieve 80 per cent or above in the summative assessment within 2 attempts.
18. The certificate of completion is then issued automatically, carrying the learner's name, the completion date, 8.5 CPD hours and a unique certificate identifier.
19. Registered and enrolled nurses should retain the certificate together with their reflective workbook as CPD evidence, as required by the NMBA registration standard.