SEPSIS

Paediatric Sepsis screening and action tool

To be applied to all patients under 15 years of age

Patient Label

Name:

NHI:

DOB:

Address:

Staff member Completing Form:

Date(DD/MM/YY):

Name (Print):

Designation:

Signature:

1. Is child feverish or looking sick?

OR is parent/carer very worried?

OR any PEWs vital sign scoring 3?

NO → Low risk of sepsis Use standard protocols for treatment and consider reassessing for sepsis deterioration.

YES ↓

2. Could this be an infection?

- Yes, but source unclear at present
- Pneumonia / likely chest source
- Meningitis/ encephalitis
- Urinary Tract Infection
- Abdominal pain, drawing legs up, or distension
- Acquired bacteraemia (e.g. Group B Strep)
- Other (specify):

NO → Low risk of sepsis

YES ↓

3. Is ONE Red Flag Present?

- Looks seriously unwell to health professional
- Reduced GCS / Change in mental status (confusion, difficult to rouse, irritable)
- Perfusion changes (mottled/cold extremities/ capillary refill 3 seconds or more)
- Purpuric rash
- Unexplained raised respiratory rate (i.e. not crying or febrile)
- Persistant, severe or unexplained tachycardia (i.e. not crying or febrile)
- Fever >38°C AND child < 3 months

NO → 4. Any Amber Flag Criteria?

YES ↓

Red Flag Sepsis!

Start Sepsis Six pathway NOW and move child to resus.

4. Any Amber Flag Criteria?

- Relatives worried about mental status
- Māori and/or Pacific Ethnicity
- Reduced urine output
  - <1ml/kg/hr if catheterised
  - No wet nappies for 12 hours
- Rigors or temp >39°C
- Acute leg pain
- Moderate tachycardia / tachypnoea (see chart)
- Oxygen saturation <92% in air
- Immunocomprimised
- Central line, recent invasive surgery or trauma
- Significant cardia, respiratory, neuro-disability comorbidity

NO ↑ Low risk of sepsis

YES ↓

Discuss with Senior clinician, decide either:

	Time complete	Initials
Start Sepsis Six Pathway (see page 2)		
Take Bloods and review within 1 hour CBC, U+E's, blood gas / glucose, blood culture and coagulation		
Hold off bloods and review within 1hr		

YES ↓

Clinical deterioration AND/OR lactate >4

YES ☐ → Red Flag Sepsis!

NO ☐ ↓

No clinical change AND/OR lactate 2-4	Discuss with ED / Paediatric SMO or senior ED Registrar
Clinical improvement AND lactate <2	Discharge / prolonged observation

Age	Tachypnoea		Tachycardia	
	Severe	Moderate	Severe	Moderate
<1	≥60	50-59	≥160	150-159
1-2 y	≥50	40-49	≥150	140-149
3-4 y	≥40	35-39	≥140	130-139
5	≥29	27/28	≥130	120-129
6-7	≥27	24-26	≥120	110-119
8-11	≥25	22-24	≥115	105-114
>12 y	≥25	21-24	≥130	91-130

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Inform Senior Clinician and consider early discussion with ICU

Time complete	Tick	Initials

Action (complete ALL within 1 hour)

1. Give oxygen to achieve sats >94%

Unless contraindicated

(e.g. double outlet right ventricle and hypoplastic left heart)

Time complete

Initials

2. Obtain IV/IO access, take bloods

CBC, U+Es, blood glucose, lactate, coags, and urine microscopy.
Take blood cultures – at least a peripheral set.
Lumbar puncture and CXR if clinically indicated.
NB: Max 2 attempts at IV access or 90 seconds then proceed to IO

Time complete

Initials

3. Give IV/IO antibiotics

Consider allergies.

<3months give 50mg/kg Amoxicillin plus 100mg/kg Cefotaxime

>3months 100mg/kg Cefotaxime (MAX. 2g)

Time complete

Initials

4. Give Fluid bolus with 0.9% Saline

Neonate 10mls/kg
Infant or child 20ml/kg
Reassess and beware of fluid overload / cardiogenic shock (reassess for hepatomegaly)

Time complete

Initials

5. Regularly reassess

Ensure senior doctor attends

Repeat blood gas including lactate

Time complete

Initials

6. Consider inotropes

If normal physiology is not restored after 20ml/kg of IVF, consider inotropes.
Discuss with Senior Clinician
Prepare inotropes (see below) and start after 40mls/kg of IVF.
Further fluid may be required. Inform ICU.

Time complete

Initials

After delivering the Sepsis Six, child still has:

- reduced level of consciousness
- Severe tachycardia or tachypnoea
- Lactate remains over 2mmol/l after 1 hour

Or is clearly critically ill at any time.
Then call Senior Clinician immediately!

Intropes to be given in ED:

Intropes may be given while awaiting ICU admission and central access.
Intraosseous as first line, although ensure no delay to giving peripherally (ensure flushing well).
Commence Adrenaline–start at 0.1 micrograms/kg/min
Range (0.05–0.3 micrograms/kg/min)
If warm shock consider Noradrenaline 0.05–0.3 micrograms/kg/min
Use LOW concentration infusion from Waikato Paediatric Emergency Drug Calculator

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