CHILD AND ADOLESCENT HEALTH SERVICE

PAEDIATRIC SEPSIS PATHWAY

Med Rec. No: .....

Surname: .....

Forename: .....

Gender: ..... D.O.B. .....

AFFIX LABEL HERE

Results / Investigations

Document key results; handover outstanding results and investigations to be followed up

Additional clinical notes

Disposition

☐ **Ward** ☐ **PCH ED** ☐ **PCH Critical Care** ☐ **Other:**

Date Time: Signed: Clinician:

Post Resuscitation Care Guide

Patients with presumed sepsis are at a high risk of deterioration despite initial resuscitation, IV antibiotics and fluids.
Ongoing management plans are to be documented in the health care record.

Ongoing monitoring	• Monitor closely for deterioration • Document required frequency of observations • Document plan for timing of repeat blood tests e.g. blood gas / lactate, renal function, LFTs, FBC and coagulation profile
Medical review	• Document time for next medical review (within 4 hours of pathway commencement)
Source of sepsis	• Reassess and re-examine patient for source of infection, including invasive devices • Consider urine sample, bacterial and viral swabs of skin lesion, EDTA blood for meningococcal, pneumococcal and Group A streptococcal PCR, CSF collection and imaging
Antimicrobial review	• Follow-up all cultures and PCR results and notify (when required) public health • Review antimicrobial regimen within 24 – 72 hours • Seek advice from Infectious Diseases physician and/or Microbiologist
Sepsis diagnosis	• Confirm and document **sepsis** diagnosis in health care record
Family	• Discuss sepsis diagnosis and management plan with patient and carers, and document discussion • Antibiotic prophylaxis for household contacts (meningococcal, Group A streptococcal sepsis) • Referral to Allied Health and support services as required • Consider cultural needs, and use an interpreter for families with limited English proficiency • Consider and discuss pre-existing goals of care and advanced care plans

Discharge Guide

- Discharge Summary completed with **sepsis** as a diagnosis
- Follow-up appointments, referrals and surveillance e.g. audiology, developmental etc.
- PCH Patient and visitor sepsis resources provided to patient and carers (Scan QR code)

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For use in infants, children and adolescents (< 16 years) with suspected or confirmed sepsis
(excluding those admitted to the Neonatal Intensive Care Unit)
Clinical pathways / guidelines never replace expert clinical judgement.

SEPSIS is infection with organ dysfunction and is a MEDICAL EMERGENCY

Could this be sepsis?
If sepsis is considered, perform full set of observations then follow the Paediatric Sepsis Pathway

SCREEN

High-risk patients - consider a lower threshold for requesting Senior Clinician Review in the following groups
one tick box constitutes high risk

- ☐ Infants less than 3 months
- ☐ Immunosuppression, chemotherapy, long-term steroids or asplenia
- ☐ Central venous access devices (CVAD), indwelling medical devices
- ☐ Unimmunised or incomplete immunisation
- ☐ Remote, delayed access to health care or patient transfer
- ☐ Recent surgery, burn or wound
- ☐ Complex / chronic medical condition
- ☐ Culturally and or linguistically diverse
- ☐ Re-presentation (including GP)
- ☐ Family and/or clinician concern

Screening initiated:

Date: Time: Signed: Clinician:

ESCALATE

Suspected infection and/or abnormal temperature and ANY of the following:

- ☐ EWS 6 - 7
- ☐ Mottled, CRT ≥ 3 or cold peripheries
- ☐ Non-blanching rash
- ☐ Drowsy or confused
- ☐ Unexplained pain
- ☐ Lactate 2 - 4 mmol/L
- ☐ Family and/or clinician concern is continuing or increasing

☐ Request Treating Doctor or STARS review within 15 mins
☐ State 'sepsis review required'
☐ Treating doctor to notify Senior Clinician / Consultant responsible for the patient

Suspected infection and/or abnormal temperature and ANY of the following:

- ☐ EWS ≥ 8
- ☐ Any observation in red zone
- ☐ AVPU score P (if unresponsive, call a CODE BLUE)
- ☐ Lactate > 4 mmol/L
- ☐ BGL < 3 mmol/L

☐ Request Senior Clinician Review within 5 mins
ED: Consultant (Registrar overnight)
Ward: Request MET review
☐ State 'sepsis review required'
☐ No response within 5 mins or clinically indicated call a CODE BLUE
☐ Treating doctor to notify Senior Clinician / Consultant responsible for the patient

Outcome of Senior Clinician review

☐ **NO - Unlikely sepsis**	☐ **YES - Suspected sepsis WITHOUT shock**	☐ **YES - Suspected sepsis WITH shock**
Patient unlikely to have sepsis **now**. Consider differential diagnosis. Re-evaluate & escalate as indicated	☐ **ED - consider moving to RESUS** ☐ **WARD - consider calling a MET** ☐ **ED & WARD - call Consultant**	☐ **ED - move to RESUS** ☐ **WARD - call a MET / CODE BLUE** ☐ **ED & WARD - call Consultant**
☐ Patient and carers directed to appropriate consumer resources	**Urgently commence resuscitation and sepsis management as per page 3**	**Urgently commence resuscitation and sepsis management as per page 3**

Date: Time: Signed: Clinician:

HCHPCFMR301H

PC785
11/24

PAEDIATRIC SEPSIS PATHWAY

MR301.08 / MR872.00

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Initial Medical Assessment

Allergies

Medications

ASSESS

Primary Assessment

Comments

Airway	☐ Patent ☐ Compromised	
Breathing	RR: SpO2: Effort: Auscultation:	
Circulation	HR: BP: Central CRT: Heart sounds: Pulse Volume: ☐ Normal ☐ Reduced ☐ Bounding Femoral pulses (in neonates) Skin: Pale, mottling, cool peripheries, flushed?	
Disability	A V P U BGL: Photophobia: ☐ Yes ☐ No Pupils: Neck Stiffness: ☐ Yes ☐ No Anterior fontanelle: ☐ Normal ☐ Bulging ☐ Sunken Seizures: ☐ Yes ☐ No Tone: Irritable or unexplained pain?	
Exposure	Temperature: Rash? Consider source, document other key examination findings (e.g. abdominal exam)	

Impression – include likely source of infection

Senior Clinician to select appropriate box on page 1 and sign

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Sepsis Management

Refer to PCH Sepsis Recognition and Management Guideline for further details

RESUSCITATE

Airway	Assess and maintain airway **If airway compromised consider calling a CODE BLUE,** intubation in sepsis / septic shock is high risk.		
Breathing	Assess and apply oxygen as required to keep SpO2 ≥ 93%	☐ **Supplemental oxygen** Type:	
Circulation	**Vascular Access, Bloods, Antibiotics, Fluids +/- Inotropes**		
	Vascular access: In septic shock aim for access within 5 minutes. Consider intraosseous access after 2 failed attempts at cannulation.	☐ **Vascular access** Time:	
	Blood sample: Don't delay resuscitation and antibiotics if blood collection is not possible. Aim for the following (in order of priority): • Glucose - if < 3 mmol/L treat with 2 mL/kg glucose 10% • VBG including lactate • Blood Cultures • FBC, UEC, LFTS, CRP, coagulation studies *Normal blood test results do not exclude sepsis; Cultures are still useful post antibiotics.*	☐ **Glucose checked** Result: _____ mmol/L ☐ **Lactate checked** Result: _____ mmol/L ☐ **Blood cultures taken** Time:	**WITHIN 15 MINS**
	Antibiotics: Prescribe as per the PCH Sepsis and Bacteraemia ChAMP Guideline • Check allergy status • **Give first dose by IM injection if no access within 15 minutes** • All IVABs in the ChAMP Guidelines are suitable for IM route **except vancomycin and aciclovir**	☐ **Antibiotics commenced** Time:	
	Fluid Resuscitation • 10 - 20 mL/kg sodium chloride 0.9% bolus pushed via vascular access for patients with septic shock or circulatory compromise • Review after each bolus for reversal of shock e.g. CRT, HR, BP, clinical condition • Repeat boluses, as required, total volume up to 40 mL/kg (may exceed on Consultant / PCH Critical Care advice) • Consider balanced fluids (e.g. Plasma-Lyte 148 or Hartmann's) if patient is acidotic or hyperchloraemic	☐ **1st fluid bolus** Time: mL/kg: ☐ **Additional boluses** Time: mL/kg: Time: mL/kg: Time: mL/kg:	**WITHIN 60 MINS**
	Inotropes considered (PCH Critical Care consultation recommended 08 6456 2222): • If circulatory failure / shock persists after 40 mL/kg fluids **or** if deemed appropriate by Consultant • Peripheral adrenaline infusion is appropriate first line choice in most circumstances	☐ **Inotropes commenced** Time: ☐ **Discuss with PCH Critical Care**	
Disability	**Assess level of consciousness** • Repeat BGL as appropriate • Consider need for airway support if low GCS / level of consciousness	☐ **Glucose rechecked** Result: _____ mmol/L	
Exposure	**Targeted history and re-examine the patient for sources of sepsis**		
Fluids	**Commence Fluid Balance Chart and monitor strict fluid input / output** • Consider indwelling urinary catheter • Monitor for signs of fluid overload (e.g. worsening breathlessness, new onset wheeze, hepatomegaly)		
Steroids	• Children on long-term steroid therapy or with adrenal insufficiency should receive stress steroids • IV hydrocortisone should be considered for catecholamine resistant shock		
Refer	• Refer to local policy regarding intra-hospital and inter-hospital transfer		

Date: Time: Signed: Clinician: