

Sepsis Pathway < 18 years

Clinical Assessment / Management tool for Children and Young People



Assessment and Management – Out of Hospital Setting

Child presents with signs and/or symptoms of infection

- **Think sepsis**, even if they do not have a high temperature
- Be aware that children with sepsis may have non-specific, non-localising presentations
- **Pay particular attention to concerns expressed by the child and family/carer**
- Take particular care in the assessment of children, who might have sepsis, who are unable, or their parent/carer is unable, to give a good history

Consider additional vulnerability to sepsis:

- The very young (<1yr)
- Non-immunised
- Recent (<6 weeks) trauma or surgery or invasive procedure
- Impaired immunity due to illness or drugs
- Indwelling lines/catheters, any breach of skin integrity e.g. any cuts, burns, blisters or skin infections

If at risk of neutropenic sepsis - refer to secondary care

Perform assessment to identify likely source of infection, risk factors and clinical indicators of concern (see below)

Sepsis not suspected

Suspected sepsis

Stratify risk of severe illness and death from sepsis using risk criteria

Table 1

Moderate to High Risk					RISK CRITERIA	High Risk					
Look for 2 of:											
<1	1-2	3-5	6-11	12-17	AGE (yr)	<1	1-2	3-5	6-11	12-17	Any CYP
50-59	40-49	30-39	22-29	21-24	Resp Rate (brpm)	>60	>50	>40	>30	>25	
<91% in air or increased oxygen requirement				<92% in air or increased oxygen requirement		<90% in air or increased oxygen requirement					
150-159	140-149	130-139	120-129	90-100	O ₂ sat	>160	>150	>140	>120	>100	<60
3-6 months >39°C					Heart Rate (bpm)	Less than 3 months (or oncology patient) >38°C					
					Temperature	<36°C					
Plus 1 of:											
<ul style="list-style-type: none"> • Not responding normally to social cues e.g. no smile • Wakes only with prolonged stimulation • Decreased activity • Poor feeding in infants • Parent or carer concern that the child is behaving differently than usual • Limb pain 					Activity/ Behaviour	<ul style="list-style-type: none"> • Altered behaviour or mental state: <ul style="list-style-type: none"> - No response to social cues - Does not wake or if roused does not stay awake • Weak, high pitched or continuous cry • Appears ill to a healthcare professional 					
• Nasal flaring					Respiratory	<ul style="list-style-type: none"> • Grunting • Apnoea 					
<ul style="list-style-type: none"> • CRT > =3 seconds or flash fill • Pale or flushed • Pallor of skin, lips or tongue • Cold hands or feet • Dry mucous membranes • Reduced urine output 					Circulation/ Hydration	<ul style="list-style-type: none"> • Appearance of skin: mottled, ashen or cyanotic • Cyanosis of lips or tongue 					
					Skin	• Non-blanching rash of skin					

RECORD ALL CLINICAL FINDINGS

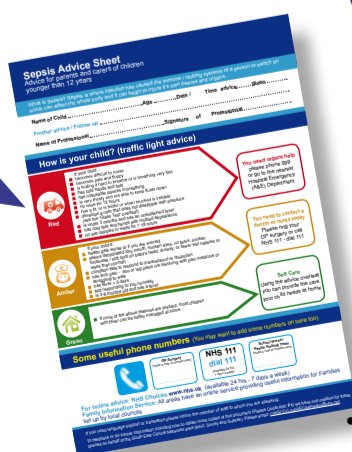
No Moderate or High Risk Criteria met

Clinical Action

Where a definitive condition affecting the child can be identified, use clinical judgment to treat using NICE guidance relevant to their diagnosis when available. **If clinical concern of possible sepsis remains, seek advice even if trigger criteria not met.**

Safety-Netting

- Arrange follow up and re-assessment as clinically appropriate
- Provide information about symptoms to monitor and how to access medical care
- Consider if there are any issues relating to safeguarding that require action



• Fever Safety netting sheet

Are 2 + 1 Criteria for High Risk met?

YES

Immediate Action

- Request 999 ambulance and say "Red Flag Sepsis" for fastest response time from Ambulance Service. Send patient urgently to emergency paediatric care service (to a setting that has resuscitation facilities)
- Where possible, alert hospital and provide clinical data
- Antibiotic administration should not be required in a primary care setting because transfer time will be <1 hour

Are 2 + 1 Criteria for moderate to High Risk/High risk met?

YES

Seek urgent advice from primary care colleague or Paediatrician.
Can a definitive diagnosis be made and treated in an out of hospital setting?

NO

Urgent Action

- Refer immediately for urgent review according to local pathway (hospital ED or paediatric unit) - consider 999
- Alert Paediatrician
- Commence relevant treatment to stabilise child for transfer
- Send relevant documentation

NO

YES