Sepsis Trust NZ

Paediatric Sepsis screening and action tool

To be applied to all patients
under 15 years of age

Patient Label
Name: _____
NHI: _____ or patient details DOB: _____ dd/mm/yy
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 if deterioration.

YES ↓

2. Could this be an infection?

	Tick
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

YES ↓

3. Is ONE Red Flag present?

	Tick
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)	☐
Persistent, severe or unexplained tachycardia (i.e. not crying or febrile)	☐
Fever >38°C AND child < 3 months	☐

NO

YES ↓

Red Flag Sepsis!!

Start Sepsis Six pathway NOW and move child to resus.

NO ↑

4. Any two amber flag present?

	Tick
• Parent or carer concerned that child is behaving differently	☐
• 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	☐
• Immunocompromised	☐
• Central line, recent invasive surgery or trauma	☐
• Significant cardiac, respiratory, neuro-disability comorbidity	☐

YES ↓

Discuss with Senior Clinician, decide either:

	Time complete	Initials
Start sepsis six pathway (see page 2)		
Take bloods and review within 1hr CBC, U+E's, blood gas / glucose, blood culture and coagulation		
Hold off bloods and review within 1hr		

Clinical deterioration AND/OR lactate >4

Yes ☐ 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 zero | Consultant informed? ☐ (Tick) | Initials

Action (complete ALL within 1 hour) — Reason not done/variance

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.
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 Paediatric registrar attends
Repeat blood gas including lactate

Time complete | Initials

Not applicable – initial lactate ☐

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 2 mmol/l after 1 hour

Or is clearly critically ill at any time

Then call Senior Clinician immediately!!

Inotropes to be given in ED:

Inotropes 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 0.1micrograms/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.