NSW GOVERNMENT

NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

PAEDIATRIC SEPSIS PATHWAY

Use for patients from 28 days corrected age to 16 years in any clinical setting to support recognition and management of sepsis

Babies up to 28 days corrected age use CEC Neonatal Sepsis Pathway

Use febrile neutropenia guideline where relevant

RECOGNISE

COULD IT BE SEPSIS?

Sepsis is **infection** with **organ dysfunction** and is a **medical emergency**

Does the patient have any **signs of INFECTION** or history / evidence of **fever** or **hypothermia, PLUS ANY** of the following:

- ☐ Looks sick or toxic – grunting, rigors, pallor, poor feeding
- ☐ Change in behaviour or decreased level of consciousness
- ☐ Persistent tachycardia
- ☐ Severe unexplained pain
- ☐ Non-blanching rash
- ☐ Parental, carer or clinician concern
- ☐ Immunocompromised or complex medical history
- ☐ Re-presentation or worsening with same illness
- ☐ Under 3 months of age
- ☐ Central line or invasive device
- ☐ Recent surgery, burn, wound
- ☐ Aboriginal and Torres Strait Islander people

Commence A-G systematic assessment and document a full set of vital sign observations including blood pressure

Does the patient have ANY features of SEVERE ILLNESS?

*Laboratory features of **severe illness / organ dysfunction** include acidosis, low platelets, elevated creatinine, elevated CRP or coagulopathy*

Any of the following RED ZONE criteria:

- ☐ Respiratory rate OR distress
- ☐ Heart rate
- ☐ Blood pressure (or drop in diastolic pressure or widening pulse pressure)
- ☐ Lactate ≥ 4 mmol/L
- ☐ Level of consciousness ACV**PU**

Call a **RAPID RESPONSE** (as per local CERS)

Any of the following YELLOW ZONE criteria:

- ☐ Respiratory rate OR distress
- ☐ Heart rate
- ☐ Blood pressure
- ☐ Central capillary refill ≥ 3 seconds
- ☐ Lactate 2.0 to 3.9 mmol/L
- ☐ Change in behaviour

Call for a **CLINICAL REVIEW** within 30 minutes (as per local CERS) **AND** consult with the **SENIOR CLINICIAN**

RESPOND & ESCALATE

Does the senior clinician consider the patient has sepsis?

PROBABLE SEPSIS
(with or without signs of shock)
- Resuscitate (over page)
- Treat within 60 minutes

POSSIBLE SEPSIS
(no signs of shock)
- Investigate
- Treat within 3 hours

SEPSIS UNLIKELY
- Consider other causes of deterioration
- Reconsider sepsis if the patient deteriorates

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RESUSCITATE

Complete actions 1 to 5 within 60 minutes with ongoing A-G systematic assessment

1. Get help

- Consult with Paediatrician / Emergency Physician / ICU / NETS

2. Commence monitoring

- Give oxygen as required to maintain $SpO_2 \geq 95\%$

WITHIN 5 min

3. Obtain access and collect pathology

- ☐ Vascular access
- ☐ Blood culture
- ☐ Blood gas
- ☐ Lactate
- ☐ Blood glucose level (BGL)

- Obtain vascular access **within 5 minutes** (intraosseous access if no vascular access)
- Take blood culture prior to antibiotics (3mL in paediatric or 10mL in adult bottle)
- Where possible collect all relevant cultures

Do not wait for test results: commence fluids and antibiotics

WITHIN 30 min

4. Commence antibiotics

- ☐ First antibiotic commenced

- Use Therapeutic Guidelines: Antibiotic OR local guideline OR Australian Clinical Practice Guidelines – antimicrobial guidelines
- Give IM ceftriaxone if IV or intraosseous access is not obtained within 15 minutes
- Document source of infection if known

5. Commence fluid resuscitation

- ☐ Fluid bolus given

- Administer 20 mL/kg sodium chloride 0.9% IV or intraosseous rapid bolus
- Assess response
- If BGL < 3 mmol/L give 2 mL/kg glucose 10%
- Consider giving a second 20 mL/kg sodium chloride 0.9% IV or intraosseous rapid bolus

WITHIN 60 min

REASSESS & REFER

6. Reassess

- ☐ Repeat lactate taken

Does the patient have any persistent signs of sepsis following 40 mL/kg bolus fluid?

Any of the following RED ZONE criteria:	Any of the following YELLOW ZONE criteria:
☐ Respiratory rate or distress	☐ Blood pressure
☐ Heart rate	☐ Central capillary refill ≥ 3 seconds
☐ Blood pressure (or drop in diastolic / widening pulse pressure)	☐ Urine output < 1 mL/kg/hr
☐ Lactate ≥ 4 mmol/L (or not improving)	
☐ Level of consciousness ACV**PU**	

OR hypoglycaemia, acidosis, low white cell count or abnormal coagulation

YES

7. Refer

Prepare inotropic support and consider respiratory support

- ☐ Intensive Care / NETS contacted
- ☐ Inotropes commenced

Seek advice immediately from local / regional paediatric experts AND

Contact Intensive Care / NETS Tel: 1300 36 25 00

- Prepare adrenaline (epinephrine) infusion as per the NETS Clinical Calculator - can be given via peripheral IV or intraosseous access
- Discuss management plan with the family / carers

Print Name: _____ **Signature:** _____

Designation: _____ **Date:** _____ / _____ / _____