

Facility:

FAMILY NAME

MRN

GIVEN NAME

☐ MALE ☐ FEMALE

D.O.B. ____ / ____ / ____

M.O.

ADDRESS

PAEDIATRIC SEPSIS PATHWAY

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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:

- | | |
|---|---|
| <input type="checkbox"/> Looks sick or toxic – grunting, rigors, pallor, poor feeding | <input type="checkbox"/> Parental, carer or clinician concern |
| <input type="checkbox"/> Change in behaviour or decreased level of consciousness | <input type="checkbox"/> Immunocompromised or complex medical history |
| <input type="checkbox"/> Persistent tachycardia | <input type="checkbox"/> Re-presentation or worsening with same illness |
| <input type="checkbox"/> Severe unexplained pain | <input type="checkbox"/> Under 3 months of age |
| <input type="checkbox"/> Non-blanching rash | <input type="checkbox"/> Central line or invasive device |
| | <input type="checkbox"/> Recent surgery, burn, wound |
| | <input type="checkbox"/> 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 ACVPU

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

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

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

RESPOND & ESCALATE



Facility:

PAEDIATRIC SEPSIS PATHWAY



RESUSCITATE



REASSESS & REFER

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

1. Get help

- Consult with Paediatrician / Emergency Physician / ICU / NETS

WITHIN


2. Commence monitoring

- Give oxygen as required to maintain SpO₂ ≥ 95%

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

WITHIN


Do not wait for test results: commence fluids and antibiotics

4. Commence antibiotics

- ☐ First antibiotic commenced

- Use [Therapeutic Guidelines: Antibiotic](#) OR local guideline OR [Australian Paediatric 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


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:

- ☐ Respiratory rate or distress
- ☐ Heart rate
- ☐ Blood pressure (or drop in diastolic / widening pulse pressure)
- ☐ Lactate ≥ 4 mmol/L (or not improving)
- ☐ Level of consciousness ACVPU

Any of the following YELLOW ZONE criteria:

- ☐ Blood pressure
- ☐ Central capillary refill ≥ 3 seconds
- ☐ Urine output < 1 mL/kg/hr

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: ____ / ____ / ____

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

SMR060399

