PIER
Paediatric Innovation, Education and Research Network

Thames Valley and Wessex
PAEDIATRIC CRITICAL CARE
Operational Delivery Network

# Paediatric Sepsis Screening Tool

| DATE | PATIENT ID STICKER |
| --- | --- |
| TIME | |
| LOCATION | |

## RECOGNISE

| **Could this child have an infection? Could it be sepsis? Look for 2 of:** | | | | | **Yes / No** | **Value** |
| --- | --- | --- | --- | --- | --- | --- |
| Temperature **< 36** or **> 38.5ºC** *NOTE: >38ºC for Oncology patients and infants under 3 months* | | | | | Y / N | ºC |
| *Use age-appropriate (national) PEWS chart* Age | 0-11 months | 1-4 years | 5-12 years | 13+ years | | |
| Heart rate (HR) | **>150** | **>140** | **>120** | **>100** | Y / N | /min |
| Respiratory rate (RR) | **>50** | **>40** | **>25** | **>25** | Y / N | /min |

| **Plus 1 of:** *(describe findings)* | **Yes / No** |
| --- | --- |
| **Altered mental state:** Sleepy, floppy, lethargic, irritable | Y / N |
| **Mottled skin** *or* **prolonged capillary refill time** *or* **'flash' capillary refill time** *and/or* **limb pain** | Y / N |
| **Clinical concern** regarding possible sepsis *(use space to expand on concerns)* **Urgent senior review if significant clinical concern, even if trigger criteria not met.** | Y / N |
| **Parental / carer concern** (ie rapid deterioration, multiple attendances for same illness, uncontrollable fever, fever 5+ days) | Y / N |
| **Site / source:** **Confirmed / Suspected** (please circle) **BE AWARE the following are at particular RISK: Neonate / Immunocompromised / Recent burn / Recent chicken pox** | |

**Are 2+1 criteria present? If 'YES', THINK SEPSIS:** ***This is an emergency!***
**Immediate review by Paediatric ST3+ (or equivalent)** ***fundamental requirement of Sepsis Pathway***

## REVIEW

| **Urgent review by Paediatric ST3+ (or equivalent)** *Name and job role* | **Time** | **Signature** GMC number |
| --- | --- | --- |
| Clinical impression: **NOT sepsis**. Document assessment in clinical notes. | | |
| Clinical impression: **NOT SURE**. ½ hourly vital signs, 2nd review in 30 mins. Consider anti-pyretic and further investigations ie bloods / VBG / urinalysis *NOTE: Lactate 2 - 4: 30 min review. Lactate > 4 start Sepsis 6 immediately.* | | |
| Clinical impression: **HIGH likelihood of sepsis**. Start Sepsis 6. | Clock Start: | |

## RESPOND

| | **Paediatric Sepsis 6: Achieve the following within 1 hour** | **Time** | **Sign** |
| --- | --- | --- | --- |
| **1** | **Give High Flow Oxygen** | | |
| **2** | Record Blood Pressure (BP) and start urine collection (fresh nappy) | | |
| **3** | Obtain IV/IO access | | |
| **4** | Take blood cultures & blood gas, include glucose & lactate | | |
| **5** | CYP with severe sepsis (or higher risk*): Ceftriaxone 80mg/kg (see overleaf) administer antibiotics within 1 hour. SORT sepsis guideline Otherwise, appropriate antibiotics should be considered and given within 3 hours following clinical monitoring, assessment and investigation if deemed a significant bacterial infection (AoMRC consensus guidance). ***THINK: If neutropaenic / immunocompromised / neonate, USE local guidance.** | | |
| **6** | Fluid Resuscitation if required: 10ml/kg bolus balanced isotonic crystalloid (If not available, 0.9% Saline). **Reassess** and repeat as required. | | |

## REASSESS

| | **Within 1 hour of treatment** | **Yes / No** |
| --- | --- | --- |
| **1** | HR or RR still above age specific normal range or CRT >3 seconds | Y / N |
| **2** | Lactate >2 | Y / N |
| **3** | Signs of fluid overload (hepatomegaly, desaturations, crepitations) | Y / N |

**If "YES" to ANY of above: Escalate care to Consultant +/- ITU +/- SORT - 02380 775502**
**If patient stabilised: Admit to ward/HDU, review at least hourly with documented observations for the first 4 hours.**

Updated: June 2024

| Call for Senior Help | |
|---|---|
| **Situation** | Identify yourself and role.<br>Identify patient.<br>Reasons for calling and specific concerns. |
| **Background** | Patient's clinical history<br>Recent changes to clinical condition.<br>Most recent vital signs, compared to baseline. |
| **Assessment** | Suspected and differential diagnosis<br>Concerns ie rapid deterioration |
| **Recommendations** | Request review.<br>Recommendations for intervention whilst waiting for review |

*If clear source of infection, treat with **condition specific antibiotics** (consult Microguide)

In 'red flag' sepsis of unknown source or septic shock, give **Ceftriaxone** 80mg/kg.

Less than 1 month of age, give **Cefotaxime IV and Amoxicillin IV**

In severe or life-threatening Penicillin allergic patients:

Give **Gentamicin** (5mg/kg <1month of age *or* 7mg/kg >1month of age, max dose 400mg)

and **Vancomycin** (15mg/kg)

All inpatients require a review of any antibiotic therapy, for any indication, **48 hours** after antibiotic therapy was commenced. This must be documented in the medical notes (paper or electronic).

The review may document decision to de-escalate and/or switch IV to PO therapy, (e.g. in response to Microbiology results and/or improved clinical status and/or a change in diagnosis), or justify continuation of current antibiotic therapy, noting next review or stop date.

Please sign to confirm that clinical decisions have been documented in the Electronic Patient Record or the patient's clinical notes.

Signature and name: ___________________ ______________________

GMC Number: ___________________________

Date: ____________ Time:_____________