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

Sepsis not suspected

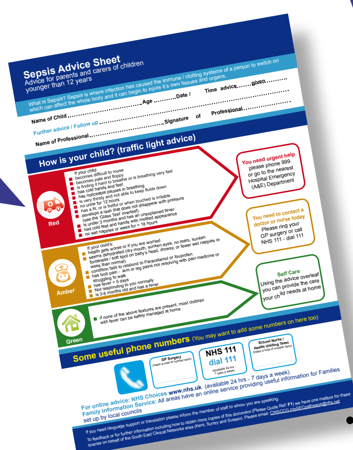
No Moderate or High Risk Criteria met

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



- Safety netting sheet children <5 years
- Safety netting sheet children ≥5 years

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		O_2 sat	<90% in air or increased oxygen requirement					
150-159	140-149	130-139	120-129	90-100	Heart Rate (bpm)	>160	>150	>140	>120	>100	<60
3-6 months >39°C					Temperature	Less than 3 months (or oncology patient) >38°C					<36°C
Plus 1 of:											
• 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	• Altered behaviour or mental state: - 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	• Grunting • Apnoea					
• 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	• Appearance of skin: mottled, ashen or cyanotic • Cyanosis of lips or tongue					
					Skin	• Non-blanching rash of skin					

RECORD ALL CLINICAL FINDINGS

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**

NO ↓

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

NO → Safety-Netting

YES ↓

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

YES → Clinical Action / Safety-Netting

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**

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This guidance was written in collaboration with the SE Coast SCN and involved extensive consultation with healthcare professionals in Wessex

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer.