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

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**Perform assessment to identify likely source of infection, risk factors and clinical indicators of concern (see below)**

**Sepsis not suspected**

**Suspected sepsis**

**Stratify risk of severe illness and death from sepsis using risk criteria**

<table>
<thead>
<tr>
<th>Moderate to High Risk</th>
<th>RISK CRITERIA</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look for 2 of:</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE (yr)</th>
<th>Resp Rate (bpm)</th>
<th>O₂ sat</th>
<th>&lt;90% in air or increased oxygen requirement</th>
<th>Heart Rate (bpm)</th>
<th>Temperature</th>
<th>&lt;90% in air or increased oxygen requirement</th>
<th>Less than 3 months (or oncology patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>&gt;60</td>
<td>&gt;60</td>
<td>&gt;90% in air or increased oxygen requirement</td>
<td>&gt;160</td>
<td>&gt;150</td>
<td>&gt;90% in air or increased oxygen requirement</td>
<td>&gt;36°C</td>
</tr>
<tr>
<td>1-2</td>
<td>&gt;50</td>
<td>&gt;50</td>
<td>&lt;92% in air or increased oxygen requirement</td>
<td>&gt;140</td>
<td>&gt;140</td>
<td>&lt;90% in air or increased oxygen requirement</td>
<td>&gt;33°C</td>
</tr>
<tr>
<td>3-5</td>
<td>&gt;40</td>
<td>&gt;40</td>
<td>&lt;92% in air or increased oxygen requirement</td>
<td>&gt;120</td>
<td>&gt;120</td>
<td>&lt;90% in air or increased oxygen requirement</td>
<td>&gt;30°C</td>
</tr>
<tr>
<td>6-11</td>
<td>&gt;30</td>
<td>&gt;30</td>
<td>&lt;92% in air or increased oxygen requirement</td>
<td>&gt;100</td>
<td>&gt;100</td>
<td>&lt;90% in air or increased oxygen requirement</td>
<td>&gt;25°C</td>
</tr>
<tr>
<td>12-17</td>
<td>&gt;25</td>
<td></td>
<td>&lt;90% in air or increased oxygen requirement</td>
<td></td>
<td>&lt;60</td>
<td>&lt;90% in air or increased oxygen requirement</td>
<td>&lt;36°C</td>
</tr>
</tbody>
</table>

**Risk Criteria met**

- Not responding normally to social cues e.g. no smile
- Weak or 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
- Apgar

**CRT > 3 seconds or flash fill**

**Palle 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

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**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

**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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**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

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**Clinical Action**

- If clinical concern of possible sepsis remains, seek advice even if trigger criteria not met

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

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

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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.