PIER
Paediatric Innovation, Education and Research Network

Thames Valley & Wessex
PAEDIATRIC CRITICAL CARE
Operational Delivery Network

Paediatric Sepsis Screening Tool

Date Time Location	Patient ID sticker

Recognise

Could this child have an infection? Could it be sepsis? Look for 2 of:							Yes/No	Value
Temperature **<36** or **>38.5°C** *(NB >38°C for Oncology patients or <3/12)*							Y/N	°C
Tachycardia (↑HR). Tachypnoea (↑RR) - use age appropriate PEWS chart								
Age	***<1yr***	***1-2yrs***	***3-5yrs***	***6-11yrs***	***12-16yr***	***16+***		
HR	**>160**	**>150**	**>140**	**>120**	**>100**	**>90**	Y/N	/min
RR	**>50**	**>50**	**>40**	**>25**	**>20**	**>20**	Y/N	/min
Plus 1 of :							**Yes / No**	
Altered mental state: Sleepy, floppy, lethargic, irritable								
Mottled skin OR prolonged capillary refill time OR 'flash' capillary refill time OR limb pain								
Clinical concern regarding possible sepsis – seek review if significant concern even if trigger criteria not met.								

Site/source: **Confirmed / Suspected** (please circle)

(BEWARE : The following are at particular RISK : Neonate / Immunocompromised / Recent Burn / recent VZV)

Are 2+1 criteria present? **Yes / No**

If 'YES', THINK SEPSIS: ***This is an emergency***

Immediate ST4+ (or equivalent) review and follow Sepsis 6 (see below)

Date : Time : Sign :

If senior decision not to proceed to sepsis 6 immediately, Tick here ***AND document overleaf***

If diagnosis unclear / sepsis not excluded, consider bloods (VBG/FBC/UE/CRP/BC/lact) & repeat senior review

Respond

Paediatric Sepsis 6: Achieve the following within 1 hr Refer to SORT sepsis pathway *(www.sort.nhs.uk)*		Time	Sign
1	**Give High Flow Oxygen**		
2	Record Blood Pressure and start urine collection (fresh nappy)		
3	Obtain iv/io access		
4	Take blood cultures, blood gas (include glucose & lactate)		
5	Give iv Ceftriaxone 80mg/kg * (see overleaf) **Think: If neutropaenic / immunocompromised / neonate, USE local guidance.**		
6	Fluid Resuscitation if required: 20ml/kg 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	
2	Venous (or arterial) Lactate >2	
3	Signs of fluid overload (hepatomegaly, desaturations, crepitations)	

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.

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

In 'red flag' sepsis of unknown source or septic shock, give 80mg/kg Ceftriaxone
<1month of age, give Cefotaxime iv and Amoxicillin iv
In SEVERE or LIFE THREATENING Penicillin allergic patients, give GENTAMICIN (5mg/kg if <1month of age or 7mg/kg if >1month of age, max dose 400mg) AND VANCOMYCIN (15mg/kg)

ALL inpatients require a **review of ANY antibiotic therapy**, for ANY indication, documented in the medical notes or electronically (e.g. on Doctors Worklist), **48-72 hours (i.e. day 3) after antibiotic therapy was commenced**.

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.

Document Clinical Decisions :

Call for senior help :

S	Current presentation Criteria identified
B	Any "high risk" factors (eg neonate, immunocompromised, oncology, steroids, indwelling line, recent burn, recent chicken pox)
A	Infection : *Inflammatory response to micro-organisms, or invasion of normally sterile tissues.* Sepsis: *Infection PLUS one or more organ dysfunction* Septic shock : *Sepsis in which there are profound circulatory, cellular and metabolic abnormalities.* Decompensation
R	Attend or advice sought? Shall I call SORT?