PAEDIATRIC SEPSIS PATHWAY

Med Rec. No: .	ERE
Surname:	PELME
Eoronamo:	LIV LAB

..... D.O.B.

Results / Investigations	
Document key results; handover outstanding results and investigations to	to be followed up

Gender:

Additional clinical notes		

Disposition					
Ward	☐ PCH ED	☐ PCH Critical Care	Other:		

Signed:

Post Resuscitation Care Guide

Time:

Date

Patients with presumed sepsis are at a high risk of deterioration despite initial resuscitation, IV antibiotics Ongoing management plans are to be documented in the health care record.

Medical review	Document time for next medical review (w)
	Document plan for timing of repeat blood t and coagulation profile
	Document required frequency of observati

Ongoing monitoring • Monitor closely for deterioration

thway commencement)

Clinician:

- Reassess and re-examine ection, including invasive devices Source of sepsis nd viral swabs of skin lesion, EDTA blood for meningococcal. Consider urine sample, bact pneumococcal and Group A streptococcal PCR, CSF collection and imaging
- res and PCR results and notify (when required) public health Antimicrobial review robial regimen within 24 - 72 hours
 - om Infectious Diseases physician and/or Microbiologist

Sepsis diagnosis **Family**

Confirm and document sepsis diagnosis in health care record

- Discuss sepsis diagnosis and management plan with patient and carers, and document discussion Antibiotic prophylaxis for household contacts (meningococcal, Group A streptococcal sepsis)
 - Referral to Allied Health and support services as required
 - Consider cultural needs, and use an interpreter for families with limited English proficiency
 - Consider and discuss pre-existing goals of care and advanced care plans

Discharge Guide

- Discharge Summary completed with sepsis as a diagnosis
- Follow-up appointments, referrals and surveillance e.g. audiology, developmental etc.
- PCH Patient and visitor sepsis resources provided to patient and carers (Scan QR code)



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PAEDIATRIC SEPSIS PATHWAY

Med Rec. No:
Surname:
Forename:
Gender: D.O.B

For use in infants, children and adolescents (< 16 years) with suspected or confirmed sepsis (excluding those admitted to the Neonatal Intensive Care Unit) Clinical pathways / guidelines never replace expert clinical judgement.

SEPSIS is infection with organ dysfunction and is a MEDICAL EMERGENCY

Could this be sepsis?

If sepsis is considered, perform full set of observations then follow the Paediatric Sepsis Pathway

High-risk patients - consider a lower threshold for requesting Senior Clinician Review in the following groups one tick box constitutes high risk

☐ Infants less than 3 months
Immunosuppression, chemotherapy, long-term steroids or asplenia
Central venous access devices (CVAD), indwelling medical devices
Unimmunised or incomplete immunisation
Remote delayed access to health care or natient transfer

urn or wound medical condition Re-presentation (including GP)

Family and/or clinician concern

Screening initiated:

Date

BARCODE

SERT

ı	77
	Suspected infection and/or abnormal
)	temperature and ANY of the following:

≥ 3 or cold peripheries

- Drowsy or confused
- Unexplained pain
- Lactate 2 4 mmol/L Family and/or clinician concern is continuing or increasing

Suspected infection and/or abnormal temperature and ANY of the following:

Clinician:

- ___ EWS ≥ 8
- Any observation in red zone AVPU score P (if unresponsive, call a CODE
- BLUE / Other) Lactate > 4 mmol/L
- BGL < 3 mmol/L

Request Treating Doctor or (Insert applicable clinician / process here) review within 15 mins

- State 'sepsis review required'
- Treating doctor to notify Senior Clinician / Consultant responsible for the patient
- Request Senior Clinician Review within 5 mins **ED:** (Insert applicable clinician / process here) Ward: (Insert applicable clinician / process here)
- State 'sepsis review required'
- No response within 5 mins or clinically indicated call a CODE BLUE / Other
- Treating doctor to notify Senior Clinician / Consultant responsible for the patient

Outcome of Senior Clinician review

NO - Unlikely sepsis

- Patient unlikely to have sepsis now. Consider differential
- RESUS diagnosis. Re-evaluate & escalate WARD - (Insert applicable as indicated
- Patient and carers directed to appropriate consumer resources
- ED & WARD call (Insert

YES - Suspected sepsis

ED - consider moving to

WITHOUT shock

- **Urgently commence** resuscitation and sepsis management as per page 3
- WARD call a CODE BLUE / ED & WARD - call (Insert

YES - Suspected sepsis

ED - move to RESUS

WITH shock

Urgently commence resuscitation and sepsis management as per page 3

Date Clinician: Time: Signed:

PCXXX

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H	OSPITAL NAME / HEALTH SITE	Med Rec. N	No:	ERE
		Surname:		BEL HE
PAEDIA	ATRIC SEPSIS PATHWAY	Forename:	-IX LF	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
		Gender:	VELL	
Initial Medic	cal Assessment	Condor		Allergies
				<u> </u>
				Medications
				
Primary As	ssessment		Comments	
A irway	☐ Patent ☐ Compromised			
Breathing	RR: SpO2:			
Dreating	Effort:			
	Auscultation:			
Circulation	HR: BP: Centr	al CRT:		10
	Heart sounds:			Lill
	Pulse Volume: Normal Reduced	Bounding		~11U
	Femoral pulses (in neonates)	, ah a dO	1.4	ALI
	Skin: Pale, mottling, cool peripheries, flu	usnea?	41	
Disability	A V P U BGL: Photophobia: Yes No. 14	nile:		
	Photophobia: Yes No Pu	pils:		
	Anterior fontanelle: Normal Bulgi	ng Sunken		
	Seizures:	1		
	Tone:			
	Irritable or unexplained pain?			
Exposure	Temperature.			
	Rash?			
	Consider source, document other key e.	xamination		
	findings (e.g. abdominal exam)			
Impression	- include likely source of infection			
Senior Clinic	ian to select appropriate box on page 1 and	sign		
Date	Time: Signed:		Clinician:	

	HOSPITAL NAME / HEALTH SITE	Med Rec. No: .		nE.
		Surname:	ael Hi	
PAEC	NATRIC SEPSIS PATHWAY	Forename:	ABE	
		N	D.O.B	
		Gerider		
	Management CH Sepsis Recognition and Management Guidelin	ne for further detail	京 (((((((((((((((((((
Airway	Assess and maintain airway If airway compromised (Insert emergency call process here), intubation in sepsis / septic shock is high risk.			
Breathing	Assess and apply oxygen as required to keep SpO2 ≥ 93% Supplemental oxygen Type:			
Circulation				
	Vascular access: In septic shock aim for access Consider intraosseous access after 2 failed attempted	pts at cannulation.	Vascular access Time:	
	Blood sample: Don't delay resuscitation and a collection is not possible.	ntibiotics if blood	Glucose checked	WITHIN 15 MINS
	Aim for the following (in order of priority) • Glucose - if < 3 mmol/L treat with 2 mL/kg gluco	se 10%	Result: mmol/L	
	VBG including lactate Blood Gultures		Result: mmol/L	
. "	FBC UEC, LFTS, CRP, coagulation studies Normal blood test results do not exclude sepsis; Cultures are still useful post antibiotics.		Blood cultures taken Time:	
	Antibiotics: Prescribe as per the PCH • Check aller Sepsis and Bacteraemia ChAMP Guideline • Give first d	gy status	Antibiotics commenced	
Λ,	injection if	no access within	Time:	
		are suitable for IM ot vancomycin		
	Fluid Resuscitation	ad via vaagular	1st fluid bolus	
	10 - 20 mL/kg sodium chloride 0.9% bolus push access for patients with septic shock or circulate	ory compromise	mL/kg:	
	Review after each bolus for reversal of shock e. clinical condition	g. CRT, HR, BP,	Additional boluses	
	Repeat boluses, as required, total volume up to (may exceed on Consultant / PCH Critical Care)		mL/kg: Time:	WITHIN
	Consider balanced fluids (e.g. Plasma-Lyte 148	,	mL/kg:	60 MINS
	if patient is acidotic or hyperchloraemic		Time: mL/kg:	
	Inotropes considered (PCH Critical Care consult recommended 08 6456 2222):	tation	☐ Inotropes commenced	
	 If circulatory failure / shock persists after 40 mL/ 	kg fluids or if	Time:	
	deemed appropriate by Consultant • Peripheral adrenaline infusion is appropriate firs most circumstances	t line choice in	Discuss with (Insert applicable eg. PCH ED /	
Disability	Assess level of consciousness		Critical Care and RFDS) Glucose rechecked	
Disability	Repeat BGL as appropriate Consider need for airway support if low GCS / level of consciousness		Result: mmol/L	
Exposure	Targeted history and re-examine the patient for sources of sepsis Commence Fluid Balance Chart and monitor strict fluid input / output Consider indwelling urinary catheter Monitor for signs of fluid overload (e.g. worsening breathlessness, new onset wheeze,		s	
Fluids				
Steroids	hepatomegaly) • Children on long-term steroid therapy or with adrenal insufficiency should receive stress steroids • IV hydrocortisone should be considered for catecholamine resistant shock • Refer to local policy regarding intra-hospital and inter-hospital transfer			
Refer				
Date	Time: Signed:		Clinician:	1

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