Paediatric Sepsis 6

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Severe sepsis is a CLINICAL EMERGENCY!

Early treatment improves outcomes

STOP THINK DO
Recognition: A child with suspected or proven infection AND at least 2 of the following:

- Core temperature < 36°C or > 38°C
- Inappropriate tachycardia
- Altered mental state (including: sleepiness / irritability / lethargy / floppiness)
- Reduced peripheral perfusion / prolonged capillary refill / cool or mottled peripheries
Reduce Threshold: Some children are at higher risk of sepsis. You may consider treatment with fewer signs than above. These include, but are not restricted to:

- Infants < 3/12
- Immunosuppressed / compromised
- Recent surgery
- Indwelling devices / lines
- Complex neurodisability / Long term conditions
- High index of clinical suspicion (tachypnoea, rash, leg pain, biphasic illness, poor feeding)
- Significant parental concern
**DO**

Respond with Paediatric Sepsis 6 (within 1 hour);

1. Give high flow oxygen

2. Obtain IV or IO access and take blood tests:
   - Blood cultures
   - Blood glucose - treat low blood glucose
   - Blood lactate (or gas)

3. Give IV or IO antibiotics:
   - Broad spectrum as per local policy
If shocked:

4. Treat shock aggressively with fluid resuscitation:
   - Titrate 20 ml/kg isotonic fluid over 5 - 10 min and repeat if necessary
   - Aim to reverse shock; trend to normal heart rate, BP, peripheral perfusion.
   - Assess for fluid overload after ≥ 40 ml/kg fluids.
   - If no signs of fluid overload and remains shocked titrate further 20mls/kg fluid
DO

If shocked:

5. Consider inotropic support early:

• Adrenaline (reconstitute whilst administering 3rd fluid bolus).
• 0.3mg/kg in 50mls 5% dextrose.
• Commence 1ml/hr = 0.1mic/kg/ min).
• Can be given via peripheral IV or IO access
DO

If shocked:

6. Involve senior clinicians / specialists early:
   • Discuss with PICU if inotropes commenced