Paediatric Sepsis 6

Severe sepsis is a **CLINICAL EMERGENCY**. Signs and symptoms of sepsis in children can be subtle and deterioration to shock rapid. Early initiation of simple treatment has been shown to improve outcomes.

YOU CAN MAKE A DIFFERENCE

Patient Name: **Date of Birth:** **Unit number:**

Recognition:

If a child with suspected or proven infection AND has at least 2 of the following:

- Core temperature < 36°C or > 38.5°C
- Inappropriate tachycardia (Refer to local criteria / APLS Guidance)
- Altered mental state (including: sleepiness / irritability / lethargy / floppiness)
- Reduced peripheral perfusion / prolonged capillary refill

Think: could this child have SEPSIS or SEPTIC SHOCK?

Time	Initials

If in doubt, consult a senior clinician.

- **If not sepsis → complete front and back of form, sign, and place in CED "Sepsis 6" box**
- **Remember to consider child for FIC study if taking bloods between 09.00 – 16.30**

Complete all elements within 1 hour

Respond with Paediatric Sepsis 6:

	Time	Initials
1. Give high flow oxygen if clinically indicated:		
2. Obtain intravenous or intraosseous access and take blood tests:		

a. Blood cultures
b. Blood glucose - treat low blood glucose
c. Blood gas (+ FBC, lactate & CRP as able for baseline + FIC bloods if applicable)

3. Give IV or IO antibiotics:		

- Broad spectrum cover as per paediatric antimicrobial formulary

4. Consider fluid resuscitation:		

- Aim to restore normal circulating volume and physiological parameters
- Titrate 20 ml/kg Isotonic Fluid over 5 - 10 min and repeat if necessary
- Caution with fluid overload > Examine for crepitations & hepatomegaly

5. Involve senior clinicians / specialists early:		
6. Consider inotropic support early:		

- If normal physiological parameters are not restored after ≥ 40 ml/kg fluids
- NB adrenaline or dopamine may be given via peripheral IV or IO access

Record any reasons for variation from Paediatric Sepsis 6 overleaf

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Use your clinical judgement when assessing a child. Not all children with suspected or proven infection has sepsis, however rapid initiation of simple timely treatment following recognition of sepsis is key to improved outcomes.

NB: Children under the age of 3 months, or with chronic disease, or had recent surgery, or who are immunocompromised, require a lower threshold for initiating treatment.

Practice consistent with ACCM-PALS guideline for management of paediatric sepsis is associated with improved outcomes, however adherence to these guidelines is poor. Paediatric Sepsis 6 is an operational tool to help deliver the initial steps of the ACCM-PALS guideline in a simple and timely fashion.

Document below any reason(s) for variation from the Paediatric sepsis 6:

Met recognition criteria but not initiated on Paediatric Sepsis 6
Recognised as having an infection but 1 or more element not completed

Definitions (adapted from the international paediatric sepsis consensus conference definitions):

1. **Infection**
   - Proven infection by positive culture, microscopy, or PCR test caused by any pathogen **OR**
   - Clinical syndrome associated with a high probability of infection, as evidenced from clinical examination, imaging, or laboratory tests
2. **Sepsis**
   - Infection + Systemic Inflammatory Response Syndrome (tachycardia, tachypnoea, core temperature >38.5°C or <36°C, white cell count elevated or depressed for age)
3. **Severe sepsis**
   - Sepsis plus one of the following: cardiovascular dysfunction OR acute respiratory distress syndrome **OR**
   - Two or more other organ dysfunctions (respiratory, renal, neurologic, hematologic, or hepatic).
4. **Septic shock**
   - Severe Sepsis with cardiovascular dysfunction