**Infant > 28 Days of Age and Children with Severe Sepsis**

1. **Triage Trigger or Concern for Sepsis**
   - If sepsis pathway indicated:
     - Indicated, initiate Sepsis Power Plan
     - **Physician/APP/RN Rapid Assessment**
       - Identify infection source through H&P
       - Monitor and Vital Sign guidelines
       - Administer high flow O2
       - Immediate IV access, IV Escalation Plan
       - Order labs, IV, Antibiotics
     - Assure 1st antibiotic given within 1st hour
     - Rapid Fluid Resuscitation 20ml/kg bolus
     - Vital Sign Targets
     - Correct Hypoglycemia, Hypocalcemia
     - Does patient need additional 20 ml/kg fluid bolus?
       - If patient has received 60 ml/kg of fluid or 40 ml/kg with impaired perfusion: Admit to PICU and consider ordering epinephrine to bedside.
       - No, after 20 ml/kg: Continue monitoring on floor or admit to floor
   - Not indicated: Care/reassessment continues as clinically indicated

2. **Rapid NS 20ml/kg boluses**
   - Repeat as needed with goal of 60 ml/kg in first hour
   - 0-20 min
   - 0-40 min
   - 60 min

**References to learn more:**

**The Sepsis Guideline, initially developed by The Children's Hospital of Philadelphia, has been reconceptualized by Children's Mercy–Kansas City (4/17).**