Infant > 28 Days of Age and Children with Severe Sepsis

+ Triage Trigger or Concern for Sepsis

Is sepsis pathway indicated?

Not indicated

Care/reassessment continues as clinically 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, IVF, 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

Green area care can occur in ED or inpatient unit

Yes

Does patient have signs of shock after receiving 60 mL/kg of fluid?

No, Fluid Responsive Shock

Admit to PICU

Yes, Fluid Refractory Shock

Is patient in cold or warm refractory shock?

Warm Shock

Cold Shock

Tritrate Norepinephrine*

*If norepinephrine is not immediately available, start with epinephrine infusion and convert to norepinephrine when available

Consider Hydrocortisone

For Catecholamine Resistant Shock (draw cortisol level prior to administering)

Transfer to PICU

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).