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Inclusion Criteria:

- Infant or child with suspected sepsis, sepsis or septic shock

Considerations:

For febrile ($\geq 38^{\circ}\text{C}$) full-term infants aged 0 to 60 days, refer to the [Febrile Infant Clinical Pathway](#)

Acutely ill infant or child
at risk for sepsis or septic shock

Systematic Screening for Sepsis/Septic Shock

or

EMR alert by Care Area
[ED Alert](#) [Inpatient Alert](#)

Sepsis Huddle

Is there suspicion for
shock or sepsis-associated
organ dysfunction?

Low

Low Suspicion for Sepsis

Suspected infection or non-infectious
syndrome without evidence of shock
or concern for sepsis-associated
organ dysfunction

*Sepsis Pathway
not presently
indicated*

Suspected Sepsis

Sepsis, Severe Sepsis

Suspected Sepsis

Suspected Infection, no evidence of shock

Evaluation

- Complete expedited work-up
- Obtain IV access
- [Laboratory considerations](#)

Treatment

- **Initiate IVF Resuscitation:** LR or NS 10-20 mL/kg
- **Antibiotics:** Administer within 180 minutes of sepsis alert if concern persists -or- within 60 minutes of arrival or sepsis alert for children with sickle cell disease or oncology diagnoses.

Reassessment

- Assess mental status, work of breathing, perfusion, and vital signs every 30-60 minutes
If developing signs of shock, escalate care

Septic Shock or Sepsis-Associated Organ Dysfunction

- Complete expedited work-up
- Obtain IV access, [IV Escalation Plan](#)
- [Order labs](#)

- **Initiate IVF Resuscitation:** LR or NS 10-20 mL/kg as indicated
- **Antibiotics:** Administer within 60 minutes of sepsis alert

- Assess mental status, work of breathing, perfusion, and vital signs every 15 minutes

IVF Resuscitation and Antibiotics

- LR and ceftriaxone are incompatible
- If administered together, there is risk of precipitation in the tubing
- If only one IV, contact the provider to discuss prioritization

Laboratory Studies

Antibiotics

Fluid Choice and Blood Products

Intubation and Sedation Medications

Respiratory Support

Family Education

Intervention Cycle

1. [Monitor Response & Vital Sign Targets](#)
2. If continued signs of compensated shock or hypotensive shock, continue [IV fluid boluses 10-20 mL/kg](#)
3. Correct electrolyte abnormalities (calcium, glucose)
4. Identify foci of infection and implement source control measures

Consider the following interventions for infection source control:

- CT/US imaging of the abdomen
- CT of head, sinus
- CT of the chest, pleural US, chest x-ray
- Echocardiogram, vascular US
- US/MRI to evaluate for septic hip; osteomyelitis
- Pelvic exam
- Lumbar puncture
- Infectious Diseases consult
- Surgical consult
- ENT consult

ED or Inpatient provider discuss with PICU/NICU provider on call to determine placement for admittance

≥ 40 mL/kg IVF given
& needs additional
resuscitation?

No

[Consider care de-escalation](#)

Yes

Order **vasopressors**
and continue fluid
resuscitation while waiting for
vasopressors to arrive

Assess for risk of adrenal
insufficiency & administer
stress dose **hydrocortisone**,
1-2 mg/kg if present.

Vasoactive Medications*

Ordering and starting
vasopressors through
peripheral access may be
necessary while awaiting
transfer to ICU

Fluid Refractory Shock

Shock persists despite 40-60 mL/kg fluid resuscitation

Vasoactive Medications to Address Fluid Refractory Shock*

Epinephrine Dosing:

- Starting dose 0.05 mcg/kg/min
- Titrate by 0.02 - 0.05 mcg/kg/min
- Maximum dosing 0.2 mcg/kg/min

Norepinephrine Dosing:

- Starting dose 0.05 mcg/kg/min
- Titrate by 0.02 - 0.05 mcg/kg/min
- Maximum dosing 0.2 mcg/kg/min

Epinephrine or norepinephrine may be administered through peripheral access if central line access is not available

Admit to **PICU** or **NICU**