Ashford and St. Peter's Hospitals
NHS Foundation Trust

Clinical Guideline

Sepsis in Children and Young People Under 16 - Identification and Management

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Guideline History		
Date	**Comments**	**Approved By**
04/07/16		Dr Aralihond, Dr Mew, Dr Bhatti, Jennie Thompson, Katherine Gumbs
09/03/20	Review and amendment in line with NICE guideline NG51 update and screening tool review. Title change	Dr Ruth Mew, Hannah Spencer, Jennie Thompson
18/03/2026	Review and amendment in line with NICE guideline NG254 update and Evelina STRS Sepsis guidelines.	Paediatric Guidelines Committee

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Supporting References	Fever in under 5s: assessment and initial management. NICE guideline [NG143] (Published date: 07 November 2019, Updated date: 26 November 2021) Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management NICE guideline [NG240] (Published date: 19 July 2024) Suspected sepsis in under 16s: recognition, diagnosis and early management NICE guideline [NG254] (Published date: 19 November 2025) Paediatric Critical Care: Sepsis Evelina STRS guideline (Updated date: 14 May 2025) Paediatric Critical Care: Peripheral Inotropes Evelina STRS guideline (Updated date: 10 September 2025) Sepsistrust.org The UK Sepsis Trust registered charity number (England & Wales)
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THINK SEPSIS – IDENTIFY RISK CRITERIA EARLY

For any child, of any age, think 'Could this be sepsis?' if there are signs or symptoms that indicate infection. Sepsis may have vague, non-localising signs.

Risk stratification tool for under **5 years** with suspected sepsis (NICE):

Category	Age	High risk criteria	Moderate to high risk criteria	Low risk criteria
Behaviour	Any	No response to social cues Appears ill to healthcare professional Does not wake, or if roused does not stay awake Weak high-pitched or continuous cry	Not responding normally to social cues No smile Wakes only with prolonged stimulation Decreased activity Parent or carer concern that child is behaving differently from usual	Responds normally to social cues Content or smiles Stays awake or awakens quickly Strong normal cry or not crying
Respiratory	Any	Grunting Apnoea Oxygen saturation <90% in air or increased oxygen requirement over baseline	Oxygen saturation of <92% in air or increased oxygen requirement over baseline Nasal flaring	No high risk or moderate to high risk criteria met
	Under 1 year	Raised respiratory rate: 60 breaths per minute or more	Raised respiratory rate: 50-59breaths per minute	
	1-2 years	Raised respiratory rate: 50 breaths per minute or more	Raised respiratory rate: 40-49breaths per minute	
	3-4 years	Raised respiratory rate: 40 breaths per minute or more	Raised respiratory rate: 35-39breaths per minute	
Circulation and hydration	Any	Bradycardia: Heart rate less than 60 beats per minute	Capillary refill time of 3 seconds or more Reduced urine output For catheterised patients, passed less than 1ml/kg of urine per hour	No high risk or moderate to high risk criteria met
	Under 1 year	Rapid heart rate: 160beats per minute or more	Rapid heart rate: 150-159 beats per minute or more	
	1-2 years	Rapid heart rate: 150beats per minute or more	Rapid heart rate: 140-149 beats per minute or more	
	3-4 years	Rapid heart rate: 140beats per minute or more	Rapid heart rate: 130-139 beats per minute or more	
Skin	Any	Mottled or ashen appearance Cyanosis of skin, lips or tongue Non-blanching rash of skin	Pallor of skin, lips or tongue	Normal colour
Temperature	Any	Less than 36C		
	Under 3 months	38C or more		
	3-6 months		39C or more	
Other	Any		Leg pain Cold hands or feet	No high risk or high to moderate risk criteria met

NB for neonates (<28 days) normothermia constitutes as 36.5-37.5C as per neonates in CYPED guideline: *https://ashfordstpeters.net/Guidelines_Paediatrics/Neonates-in-CYPED-Sep-2025.pdf*

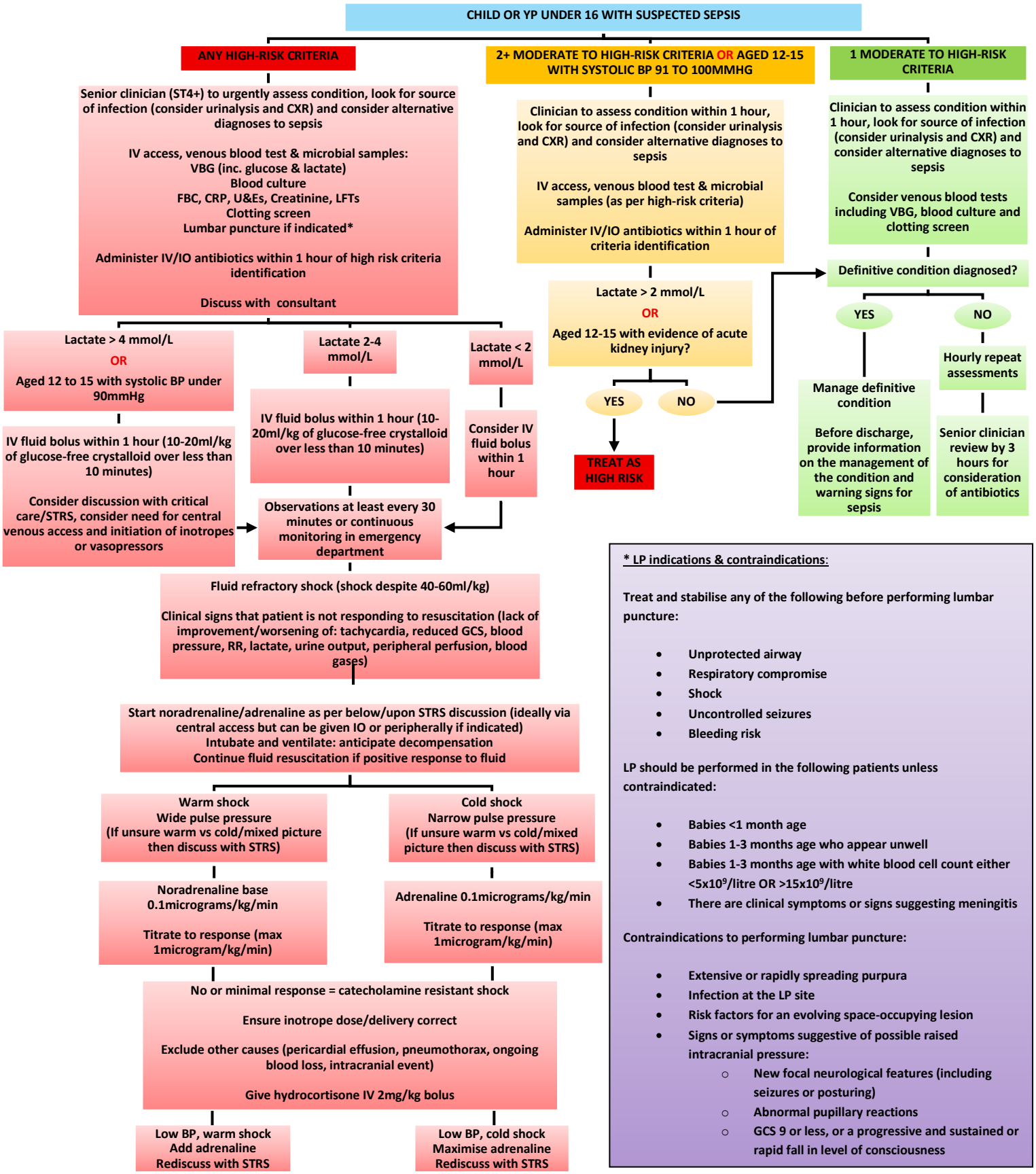
Risk stratification tool for **5-11 years** with suspected sepsis

Category	Age	High risk criteria	Moderate to high risk criteria	Low risk criteria
Behaviour	Any	Objective evidence of altered behaviour or mental state Appears ill to healthcare professional Does not wake, or if roused does not stay awake	Not behaving normally Decreased activity Parent or carer concern that child is behaving differently from usual	Behaving normally
Respiratory	Any	Oxygen saturation <90% in air or increased oxygen requirement over baseline	Oxygen saturation of <92% in air or increased oxygen requirement over baseline	No high risk or moderate to high risk criteria met
	5 years	Raised respiratory rate: 29 breaths per minute or more	Raised respiratory rate: 24-28breaths per minute	
	6-7 years	Raised respiratory rate: 27 breaths per minute or more	Raised respiratory rate: 24-26breaths per minute	
	8-11 years	Raised respiratory rate: 25 breaths per minute or more	Raised respiratory rate: 22-24breaths per minute	
Circulation and hydration	Any	Heart rate less than 60 beats per minute	Capillary refill time of 3 seconds or more Reduced urine output For catheterised patients, passed less than 1ml/kg of urine per hour	No high risk or moderate to high risk criteria met
	5 years	Rapid heart rate: 130beats per minute or more	Rapid heart rate: 120-129 beats per minute or more	
	6-7 years	Rapid heart rate: 120beats per minute or more	Rapid heart rate: 110-119 beats per minute or more	
	8-11 years	Rapid heart rate: 115beats per minute or more	Rapid heart rate: 105-114 beats per minute or more	
Skin	Any	Mottled or ashen appearance Cyanosis of skin, lips or tongue Non-blanching rash of skin	Pallor of skin, lips or tongue	Normal colour
Temperature	Any		Tympanic temperature less than 36C	
Other	Any		Leg pain Cold hands or feet	No high risk or high to moderate risk criteria met

Risk stratification tool for **12-15 years** with suspected sepsis

Category	High risk criteria	Moderate to high risk criteria	Low risk criteria
History	Objective evidence of new altered mental state	History from patient, friend or relative of new onset of altered behaviour or mental state History of acute deterioration of functional ability Impaired immune system (illness or drugs including oral steroids) Trauma, surgery or invasive procedures in the last 6 weeks	Normal behaviour
Respiratory	Raised respiratory rate: 25 breaths per minute or more New need for oxygen (40% FiO2 or more) to maintain saturations more than 92%	Raised respiratory rate: 21-24 breaths per minute	No high risk or moderate to high risk criteria met
Blood Pressure	Systolic blood pressure 90mmHg or less or systolic blood pressure more than 40mmHg below normal	Systolic blood pressure 91-100mmHg	No high risk or moderate to high risk criteria met
Circulation and hydration	Raised heart rate: 130beats per minute Not passed urine in previous 18hours For catheterised patients, passed less than 0.5ml/kg of urine per hour	Raised heart rate: 91-130 beats per minute (for pregnant women 100-130 beats per minute) or new onset arrhythmia Not passed urine in past 12-18hours For catheterised patients, passed less than 0.5-1ml/kg of urine per hour	No high risk or moderate to high risk criteria met
Skin	Mottled or ashen appearance Cyanosis of skin, lips or tongue Non-blanching rash of skin	Signs of potential infection, including redness, swelling or discharge at surgical site or breakdown of wound	No non-blanching rash
Temperature		Tympanic temperature less than 36C	

Flowchart



*** LP indications & contraindications:**

Treat and stabilise any of the following before performing lumbar puncture:

- Unprotected airway
- Respiratory compromise
- Shock
- Uncontrolled seizures
- Bleeding risk

LP should be performed in the following patients unless contraindicated:

- Babies <1 month age
- Babies 1-3 months age who appear unwell
- Babies 1-3 months age with white blood cell count either $<5x10^9$/litre OR $>15x10^9$/litre
- There are clinical symptoms or signs suggesting meningitis

Contraindications to performing lumbar puncture:

- Extensive or rapidly spreading purpura
- Infection at the LP site
- Risk factors for an evolving space-occupying lesion
- Signs or symptoms suggestive of possible raised intracranial pressure:
  - New focal neurological features (including seizures or posturing)
  - Abnormal pupillary reactions
  - GCS 9 or less, or a progressive and sustained or rapid fall in level of consciousness

Summary

Introduction

Sepsis is a life-threatening organ dysfunction due to a dysregulated host response to infection (NICE). If left untreated, sepsis leads rapidly to multi-organ failure, septic shock and death. Recognition of sepsis in children and young people is often very difficult as clinical signs and symptoms can be similar to self-limiting or less severe conditions. National Institute for Health and Care Excellence (NICE) guideline (NG254) outlines the recognition, diagnosis and early management of sepsis. Early recognition, intervention and management can improve survival. The Sepsis Six care bundle has been shown to reduce the risk of death when delivered to patients with severe sepsis within one hour. This policy is based on the evidence base and recommendations from NICE guidelines, Evelina STRS guidelines and UK Sepsis Trust.

Scope

This guideline is applicable to the care of all children and young (CYP) people up to the age of 16 years (15 years+364 days) with suspected or confirmed sepsis on the inpatient ward and presenting to Ashford and St Peter's NHS Foundation Trust Emergency Department. Infants on the Neonatal Unit and Postnatal ward should be managed as per Neonatal Guidelines. Oncology patients should be managed as per Supportive Care Protocol (Pan London 2014).

NB: This guideline is in line with the NICE guideline NG254 which is only applicable to the under 16 demographic. For young people aged 16 to 17+364 days, please use clinical discretion and refer to the adult sepsis guideline as needed to guide further management.

Purpose

Improved recognition and management of sepsis and create a standardised approach to clinical care.

Explanation of terms used

Sepsis is a life-threatening organ dysfunction due to a dysregulated host response to infection

Suspected sepsis is used to indicate people who might have sepsis and further assessment

CYP Children and Young People up to the age of 18 (17 years +364 days)

GBS Group B Streptococcus

Clinical Guideline

Risk factors for developing sepsis or delayed identification of sepsis

- <1yr old
- Ethnicity: being from an ethnic minority background
- Clinical features such as:
  - frailty (e.g. chronic illnesses, disabilities or complex care needs)
  - multimorbidities or severe chronic conditions
  - impaired immune function because of illness or medical treatment
  - surgery or invasive procedures in the past 6 weeks
  - indwelling catheters
  - repeated antibiotic use
  - breach of skin integrity
- Communication challenges (e.g. learning disabilities, cognitive impairment, need an interpreter)
- Drugs or alcohol misuse
- Social, economic or environmental factors (e.g. homelessness, living in deprived areas)
- Additional neonatal risk factors:
  - Suspected or confirmed infection in another baby in case of multiple pregnancy (MAJOR RISK FACTOR)
  - Prematurity (<37 weeks)
  - Invasive Group B Strep (GBS) in a previous baby
  - Maternal GBS bacteriuria, colonisation or infection during this pregnancy
  - Prolonged rupture of membranes (>24hrs in term birth, >18hrs in pre-term birth)

- Maternal intrapartum fever >38C if there is suspected or confirmed bacterial infection
- Clinical diagnosis of chorioamnionitis

Assessment

Any CYP with suspected sepsis requires an urgent assessment to identify markers of increased risk of severe illness or death. An assessment should include observations, a focused history and an examination.

Observations

Refer to appendix for:

Normal values adapted from PEWS

Values associated with high and moderate risk of **sepsis** adapted from NICE

Signs and symptoms

In addition to routine history, ask the patient and carer specifically about:

- Recent fevers or rigors
- Symptoms that suggest a specific infection (dysuria, cough)
- Dehydration, fluid intake and urine output in the last 18hrs
- Altered behaviour, mental state, cognition, irritability, wakefulness, response to social cues
- Change in function or ability
- Risk factors for sepsis
- Risk factors for antibiotic resistance
- Immunisation status

Examination

In addition to a standard clinical examination, examine specifically for clinical features of concern including:

- Cognition and conscious level, weak high-pitched cry
- Ashen or mottled skin
- Capillary refill time and signs of poor peripheral perfusion
- Dehydration, dry mucus membranes
- Source of infection
- Any breach of skin integrity

Risk stratification tools can be helpful in the identification of sepsis and to assess the risk of a clinical deterioration. They should be used at the point of any nursing, clinician or parental concerns. NICE or Sepsis Trust risk stratification may be used. A table of high and intermediate risk criteria for sepsis can be found in the Casualty Card and should prompt reference to age specific risk stratification tools as below:

Risk stratification tool for under **5 years** with suspected sepsis

Risk stratification tool for **5-11years** with suspected sepsis

Risk stratification tool for **12-15 years** with suspected sepsis

Early management of sepsis and suspected sepsis

Use your clinical judgement when assessing a CYP. If you are uncertain whether a CYP has sepsis, consult a senior clinician. Not all children with suspected or proven infections have sepsis, and not all patients with high-risk criteria will need the Sepsis six. A senior doctor may be able to make a definitive diagnosis, manage the underlying condition and de-escalate care. Reasons for de-escalation should be clearly documented and the CYP should be reviewed (within 1 hour) and monitored regularly. Sepsis should be reconsidered at any point.

If sepsis is suspected, the risk stratification tool at the top of the guideline can be used to guide initial management as per the following (summary flowchart can be found on page 6):

1 or more high-risk criteria

- Senior clinician (ST4+ or equivalent) to urgently assess the person's condition, looking for source of infection (consider urinalysis and CXR) and considering alternative diagnoses to sepsis

- IV access, venous blood test and microbial samples- VBG (including glucose & lactate), blood culture, FBC, CRP, U&Es, Creatinine, LFTs, clotting screen, LP if indicated

- Administer IV/IO antibiotics (refer to EOLAS) within 1 hour of high-risk criteria identification

- Discuss with consultant

- If lactate > 4 mmol/L OR aged 12 to 15 with systolic BP under 90mmHg

    - Give IV fluid bolus within 1 hour (10-20ml/kg of glucose-free crystalloid over less than 10 minutes), repeat if necessary and observe for signs of fluid overload (crepitations and hepatomegaly) with caution in at-risk cardiac/kidney disease patients

    - Consider discussion with critical care/STRS, considering need for central venous access and initiation of inotrope or vasopressors

- If lactate 2-4 mmol/L

    - Give IV fluid bolus within 1 hour (10-20ml/kg of glucose-free crystalloid over less than 10 minutes), repeat if necessary and observe for signs of fluid overload (crepitations and hepatomegaly) with caution in at-risk cardiac/kidney disease patients

- If lactate > 2 mmol/L

    - Consider IV fluid bolus within 1 hour (10-20ml/kg of glucose-free crystalloid over less than 10 minutes), repeat if necessary and observe for signs of fluid overload (crepitations and hepatomegaly) with caution in at-risk cardiac/kidney disease patients

<u>Monitoring and escalation</u>

- Monitor those with high-risk criteria continuously or at least every 30 minutes using physiological track and trigger system and monitor GCS

- In cases of fluid refractory shock (where 40-60ml/kg of bolus has been given and there is minimal improvement/worsening of tachycardia, GCS, BP, RR, lactate, urine output,

peripheral perfusion, blood gases), discuss with STRS and initiate inotropes/vasopressors, ideally via central access but can be given IO or peripherally preferably in a large vein if indicated*:

- In warm shock (wide pulse pressure) commence noradrenaline 0.1 micrograms/kg/min, titrating to response with maximum dose 1 microgram/kg/min
- In cold shock (narrow pulse pressure) commence adrenaline 0.1micrograms/kg/min, titrating to response with maximum dose 1 microgram/kg/min
- NB warm vs cold is a guide and often can be a mixed picture, **where unsure discuss early with STRS**

**Indicated for short-term stabilisation prior to insertion of CVC, as an alternative to CVC in patients unlikely to require a CVC for long (e.g. hypotension without other organ dysfunction) or in patients where central access is problematic*

- If no or minimal response indicating catecholamine resistant shock
  - Ensure inotrope dose/delivery correct
  - Exclude other causes (pericardial effusion, pneumothorax, ongoing blood loss, intracranial event)
  - Give hydrocortisone IV 2mg/kg bolus
- If continued low BP
  - In warm shock, add adrenaline
  - In cold shock, maximise adrenaline
  - **Urgently rediscuss with STRS**

<u>2 or more moderate to high-risk criteria OR aged 12-15 with systolic BP 91 to 100mmHg</u>

- Clinician to urgently assess the person's condition, looking for source of infection (consider urinalysis and CXR) and considering alternative diagnoses to sepsis
- IV access, venous blood test and microbial samples- VBG (including glucose & lactate), blood culture, FBC, CRP, U&Es, Creatinine, LFTs, clotting screen, LP if indicated

- Administer IV/IO antibiotics (refer to EOLAS) within 1 hour of high-risk criteria identification

- Is lactate > 2 mmol/L OR aged 12 to 15 with evidence of acute kidney injury?

    - If yes, then escalate and treat as if 1 or more high risk criteria met

    - If no, then de-escalate and treat as if 1 moderate to high-risk criteria met

<u>1 more moderate to high-risk criteria</u>

- Clinician to urgently assess the person's condition, looking for source of infection (consider urinalysis and CXR) and considering alternative diagnoses to sepsis

- Consider IV access, venous blood test and microbial samples- VBG (including glucose & lactate), blood culture, FBC, CRP, U&Es, Creatinine, LFTs, clotting screen, LP if indicated

- Is a definitive condition diagnosed?

    - If yes, then manage condition and before discharge, provide information on the management of the condition and warning signs for sepsis

    - If no, conduct repeat hourly structured assessments and senior review within 3 hours of meeting moderate to high-risk criterion

In addition to above management based on risk stratification, in all patients:

- Oxygen therapy as indicated
- Start a PEWS chart
- Record all vital signs, including BP

Identifying deteriorating patients

The Paediatric Early Warning Score (PEWS) provides a mechanism to assess patients and identify deterioration in hospital. This should be used in conjunction with clinical assessment and risk stratification tools for suspected sepsis. The Sepsis Six should be initiated if sepsis is suspected. In-patients are at high risk of developing new infections and sepsis.

On-going management

- Review antibiotics and antibiotic rationalisation within 72 hours
- Ensure patient has a consultant review within 14 hours of hospital admission

- Ensure the patient has an escalation plan documented in the medical notes
- Ensure early discussion with STRS if clinically indicated

References

Fever in under 5s: assessment and initial management
NICE guideline [NG143] (Published date: 07 November 2019, Updated date: 26 November 2021)
https://www.nice.org.uk/guidance/ng143

Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management
NICE guideline [NG240] (Published date: 19 July 2024)
https://www.nice.org.uk/guidance/ng240

Suspected sepsis in under 16s: recognition, diagnosis and early management NICE guideline [NG254] (Published date: 19 November 2025)
https://www.nice.org.uk/guidance/ng254

Paediatric Critical Care: Sepsis Evelina STRS guideline (Updated date: 14 May 2025)
https://www.evelinalondon.nhs.uk/resources/our-services/hospital/south-thames-retrieval-service/Sepsis.pdf

Paediatric Critical Care: Peripheral Inotropes Evelina STRS guideline (Updated date: 10 September 2025)
https://www.evelinalondon.nhs.uk/resources/our-services/hospital/south-thames-retrieval-service/peripheral-inotropes.pdf

Sepsistrust.org The UK Sepsis Trust registered charity number (England & Wales) | 1158843. Company Reg No 8644039.
www.sepsistrust.org

Appendix

Normal values adapted from PEWS:

Age	HR	RR at rest	Systolic BP
0- 11 months	110-150	30-50	70-90
1-4 years	90-140	20-40	80-100
5-12 years	80- 120	20-25	90-110
13+ years	70-100	15-25	100-120

Values associated with high and moderate risk of **sepsis** adapted from NICE:

Age	Heart Rate		Respiratory Risk	
	High risk	Mod risk	High risk	Mod risk
< 1 year	160+	150-159	60+	50-59
1-2 years	150+	140-149	50+	40-49
3-4 years	140+	130-139	40+	35-39
5 years	130+	120-129	29+	24-28
6-7 years	120+	110-119	27+	24-26
8-11 years	115+	105-114	25+	22-24
12-15 years	130+	91-130	25+	21-24

Guideline Governance

a. Scope

This guideline is relevant to all staff caring for all children under 16 years old across the emergency department, inpatient ward and outpatient department.

b. Purpose

I. This guideline aims to facilitate a common approach to the identification and management of sepsis. At times deviation from the guideline may be necessary, this should be documented and is the responsibility of the attending consultant.

II. This guideline is subject to regular review to ensure ongoing evidence-based practice.

c. Duties and Responsibilities

All healthcare professionals responsible for the care of all children 0-18years should be aware of practice according to this guideline.

d. Approval and Ratification

This guideline will be approved and ratified by the Paediatric Guidelines Group.

e. Dissemination and Implementation

I. This guideline will be uploaded to the trust intranet 'Paediatric Guidelines' page and thus available for common use.

II. This guideline will be shared as part of ongoing education within the Paediatric Department for both medical and nursing staff.

III. All members of staff are invited to attend and give comments on the guideline as part of the ratification process.

f. Review and Revision Arrangements

a. This policy will be reviewed on a 3 yearly basis by the appropriate persons.

b. If new information comes to light prior to the review date, an earlier review will be prompted.

c. Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. Minor amendments will be ratified through the Paediatric Guidelines Group. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

g. Equality Impact Assessment

Background • Who was involved in the Equality Impact Assessment
Author and the supervising consultants.
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
All groups of staff and patients were taken into consideration and there is no bias towards or against any particular group.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
There is no evidence of discrimination.
Conclusion • Provide a summary of the overall conclusions
There is no evidence of discrimination.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
This guideline is appropriate for use.

h. Document Checklist

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Sepsis in Children and Young People- Identification and Management

Policy (document) Author:

Executive Director:

		Yes/No/ Unsure/NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	Y	
	Is the purpose of the document clear?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	Y	
	Who was engaged in a review of the document (list committees/ individuals)?	Y	Dr Shunya Matsumoto, Dr Lynda Ehizode, Dr Fiona MacCarthy, Emily McCrae, Guidelines committee
	Has the policy template been followed (i.e. is the format correct)?	Y	

4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are local/organisational supporting documents referenced?	Y	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	Y	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	N/A	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Y	
	Does the plan include the necessary training/support to ensure compliance?	Y	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Y	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	Y	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the	Y	

	documentation?		
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Y	

Committee Approval (Paediatric Guidelines Group)	
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner	
Name of Chair **Alexandra Smith**	**Date** **21/4/2026**
Ratification by Management Executive (if appropriate)	
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner	
Date:	