

Sepsis: Risk stratification tools

How to use these tools

1. Think ‘**could this be sepsis?**’ – use the flowchart on the next page to decide if the person has **suspected sepsis**
2. If **sepsis is suspected**, then use the algorithm appropriate to the person’s **age group** and the **setting** (either **out of hospital** or **in hospital**) to:
 - stratify their risk (**low**, **moderate to high** or **high**)
 - see what care NICE recommends.

Always refer back to the [NICE guideline](#) for recommendation details

Could this be sepsis?

For a person of **any age** with a possible infection:

- Think **could this be sepsis?** if the person presents with **signs or symptoms that indicate infection**, even if they do not have a high temperature.
- Be aware that people with sepsis may have non-specific, non-localised presentations (for example, feeling very unwell).
- Pay particular attention to concerns expressed by the person and their family or carer.
- Take particular care in the assessment of people who might have sepsis if they, or their parents or carers, are unable to give a good history (for example, people with English as a second language or people with communication problems).



Assessment

Assess people with suspected infection to identify:

- possible source of infection
- risk factors for sepsis (see right-hand box)
- indicators of clinical concern such as new onset abnormalities of behaviour, circulation or respiration.

Healthcare professionals performing a remote assessment of a person with suspected infection should seek to identify factors that increase risk of sepsis or indications of clinical concern.



Risk factors for sepsis

- The very young (under 1 year) and older people (over 75 years) or very frail people.
- Recent trauma or surgery or invasive procedure (within the last 6 weeks).
- Impaired immunity due to illness (for example, diabetes) or drugs (for example, people receiving long-term steroids, chemotherapy or immunosuppressants).
- Indwelling lines, catheters, intravenous drug misusers, any breach of skin integrity (for example, any cuts, burns, blisters or skin infections).

If at risk of neutropenic sepsis – refer to secondary or tertiary care

Additional risk factors for women who are pregnant or who have been pregnant, given birth, had a termination or miscarriage within the past 6 weeks:

- gestational diabetes, diabetes or other comorbidities
- needed invasive procedure such as caesarean section, forceps delivery, removal of retained products of conception
- prolonged rupture of membranes
- close contact with someone with group A streptococcal infection
- continued vaginal bleeding or an offensive vaginal discharge.



Sepsis not suspected

- no clinical cause for concern
- no risk factors for sepsis.

Use clinical judgement to treat the person, using NICE guidance relevant to their diagnosis when available.



SEPSIS SUSPECTED

If sepsis is suspected, use a structured set of observations to assess people in a face-to-face setting. Consider using early warning scores in acute hospital settings. Parental or carer concern is important and should be acknowledged.

Stratify risk of severe illness and death from sepsis using the tool appropriate to age and setting > > >

Sepsis risk stratification tool: children aged under 5 years in hospital

High risk criteria

- Behaviour:
 - no response to social cues
 - appears ill to a healthcare professional
 - does not wake, or if roused does not stay awake
 - weak high-pitched or continuous cry
- Heart rate:
 - aged under 1 year: 160 beats per minute or more
 - aged 1–2 years: 150 beats per minute or more
 - aged 3–4 years: 140 beats per minute or more
 - heart rate less than 60 beats per minute at any age
- Respiratory rate:
 - aged under 1 year: 60 breaths per minute or more
 - aged 1–2 years: 50 breaths per minute or more
 - aged 3–4 years: 40 breaths per minute or more
 - grunting
 - apnoea
 - oxygen saturation of less than 90% in air or increased oxygen requirement over baseline
- Mottled or ashen appearance
- Cyanosis of skin, lips or tongue
- Non-blanching rash of skin
- Temperature:
 - aged under 3 months: 38°C or more
 - any age: less than 36°C

Moderate to high risk criteria

- Behaviour:
 - 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
- Heart rate:
 - aged under 1 year: 150–159 beats per minute
 - aged 1–2 years: 140–149 beats per minute
 - aged 3–4 years: 130–139 beats per minute
- Respiratory rate:
 - aged under 1 year: 50–59 breaths per minute
 - aged 1–2 years: 40–49 breaths per minute
 - aged 3–4 years: 35–39 breaths per minute
 - oxygen saturation less than 92% in air or increased oxygen requirement over baseline
 - nasal flaring
- Capillary refill time of 3 seconds or more
- Reduced urine output, or for catheterised patients passed less than 1 ml/kg of urine per hour
- Pallor of skin, lips or tongue
- Temperature:
 - aged 3–6 months: 39°C or more
- Leg pain
- Cold hands or feet

Low risk criteria

- Responds normally to social cues
- Content or smiles
- Stays awake or awakens quickly
- Strong normal cry or not crying
- No high risk or moderate to high risk criteria met
- Normal colour

1 or more high risk criteria met

2 or more moderate to high risk criteria met

Only 1 moderate to high risk criterion met

Suspected sepsis, no high or high to moderate risk criteria met

Arrange immediate review by senior clinical decision maker (paediatric or emergency care ST4 or above or equivalent)

Carry out venous blood tests for the following:

- blood gas for glucose and lactate
- blood culture
- full blood count
- C-reactive protein
- urea and electrolytes
- creatinine
- clotting screen

Give intravenous antibiotics without delay (within a maximum of 1 hour)

Discuss with consultant

Carry out venous blood tests for the following:

- blood gas for lactate
- blood culture
- full blood count
- C-reactive protein
- urea and electrolytes
- creatinine

Clinician review and results review within 1 hour

Clinician review and consider blood tests within 1 hour

Clinical assessment and manage according to clinical judgement

Can definitive condition be diagnosed and treated?

YES

NO

Lactate over 4 mmol/L

Lactate 2–4 mmol/L

Lactate less than 2 mmol/L

Lactate over 2 mmol/L
escalate to high risk

Lactate 2 mmol/L or less
definitive condition diagnosed?

Give intravenous fluid (bolus injection) without delay and within 1 hour
Discuss with critical care

Give intravenous fluid (bolus injection) without delay and within 1 hour

Consider intravenous fluid (bolus injection) without delay and within 1 hour

If no definitive condition identified, repeat structured assessment at least hourly

Manage definitive condition. If appropriate, discharge with information depending on setting

Carry out observations at least every 30 minutes or continuous monitoring in emergency department
Consultant to attend (if not already present) if the person does not improve

Ensure review by a senior decision maker within 3 hours for consideration of antibiotics