Blank Children's Hospital
UnityPoint Health

SEPTIC SHOCK TRIGGER TOOL

ED patient with concern for infection and/or temperature abnormality

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Is patient critically ill? — Yes → Transfer pt to ED and immediately alert physician

↓ No

1. Obtain a full set of vitals.
2. Perform a brief H&P assessing mental status, skin, pulses, and cap refill
3. Is the patient *high risk* (see Table 1)

Septic Shock Checklist

◊ Temperature abnormality (Table 2)
◊ Hypotension (Table 2)
◊ Tachycardia (Table 2)
◊ Tachypnea (Table 2)
◊ Capillary refill abnormality (Table 3)
◊ Mental status abnormality (Table 3)
◊ Pulse abnormality (Table 3)
◊ Skin abnormality (Table 3)

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Is patient hypotensive? — Yes → Initiate the septic shock protocol and mobilize resources

↓ No

Does patient meet 3 (2 if high risk patient) or more clinical criteria? — No → Continue routine triage process

↓ Yes

Triage 2 and alert physician and if their assessment concurs continue septic shock management

Table 1. High Risk Conditions

- Malignancy
- Asplenia (including Sickle cell)
- Bone marrow transplant
- Central line or PICC line
- Severe MR/CP
- Immunodeficiency/immunosuppression

Table 2. Vital Signs (PALS)

Age	HR	RR	Systolic BP	Temp (C)
0-1m	>205	>60	<60	<36 or >38
≥1m-3m	>205	>60	<70	<36 or >38
≥3m-1y	>190	>60	<70	<36 or >38.5
≥1y-2y	>190	>40	<70 + (age in yr x2)	<36 or >38.5
≥2y-4y	>140	>40	<70 + (age in yr x2)	<36 or >38.5
≥4y-6y	>140	>34	<70 + (age in yr x2)	<36 or >38.5
≥6y-10y	>140	>30	<70 + (age in yr x2)	<36 or >38.5
≥10y-13y	>100	>30	<90	<36 or >38.5
>13y	>100	>20	<90	<36 or >38.5

Table 3. Exam Abnormalities

	Cold Shock	Warm Shock	Non-specific
Pulses (central vs. peripheral)	Decreased or weak	Bounding	
CRT (central vs. peripheral)	≥3 Seconds	Flash (<1 sec)	
Skin	Mottled, cool	Flushed, ruddy, erythroderma (other than face)	Petechia below the nipple, any purpura
Mental Status			Decreased, irritability, confusion, inappropriate crying or drowsiness, poor interaction with parents, lethargy, diminished arousability, obtunded

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