

CLINICAL PATHWAY
NEONATAL SUSPECTED SEPSIS

Infant Risk Factors

- Clinical Presentation**
 Premature <34 weeks

Symptomatic Infant

- Respiratory distress
 Apnea within first 24 hours
 Bradycardia
 Temperature instability
 Poor perfusion/low BP
 Irritability/lethargy
 Feeding intolerance

Maternal Risk Factors

- GBS Carrier or prior offspring with GBS
 Maternal fever >38 degrees (101 F) for >4 hrs
 Chorioamnionitis/endometritis/UTI
 Preterm labour <34 weeks
 ROM >18 hours

Lab Values:

- Absolute neutrophil count <10,000 x 10(9)/L
 PLT count <150,000 x 10(9)/L
 I:T ratio >0.2

Clinical Pathways are not considered a substitute for professional judgement.

Phase:	Observation (4 hours)	Treatment (less than or equal to 48 hours)	Evaluation/Completion
	Date: ___/___/___ hrs	___/___/___ hrs	___/___/___ hrs
PATIENT OUTCOMES	Temperature 36.5 - 37.5 degrees HR 100-160 BPM RR 40-60 Air entry equal, clear and symmetrical bilaterally No indrawing/grunting/nasal flaring Colour pink Lusty cry Vigorous symmetrical tone Tolerates induction feed Clinical Indicator #1: All outcomes met within 4 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, Reason: _____ All outcomes met, Date/Time: ___/___/___ @ _____ Signature: _____	Temperature 36.5 - 37.5 degrees HR 100-160 BPM RR 40-60 Air entry equal, clear and symmetrical bilaterally Chest x-ray results reported No indrawing/grunting/nasal flaring Colour pink Lusty cry Alert & active when awake Tolerates feeding Culture negative All outcomes met within 48 hrs? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, Reason: _____ All outcomes met, Date/Time: ___/___/___ @ _____ Signature: _____	Temperature 36.5 - 37.5 degrees HR 100-160 BPM RR 40-60 Air entry equal, clear and symmetrical bilaterally Chest x-ray results reported No indrawing/grunting/nasal flaring Colour pink Lusty cry Alert & active when awake Voiding/stool quantity sufficient Parents independent with feeding and baby care plan All outcomes met. <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, Reason: _____ Date/Time: ___/___/___ @ _____ Signature: _____
TEACHING	Familiarize parent with normal newborn characteristics _____ OR Case specific characteristics _____ _____ _____	Newborn care Lactation/feeding/pumping _____ Developmental care _____ IV/antibiotic treatment _____ Treatment Plan _____ Clinical Indicator #2: Patient Education material given? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, Reason: _____ _____	Teaching and discharge documentation completed and reviewed with parents
DISCHARGE PLANNING CRITERIA	If all outcomes not met within 4 hrs, progress to Treatment Phase. Consults in progress: _____ If all outcomes met, pathway completed. Date/Time: ___/___/___ @ _____ Signature: _____	Culture results as ordered 24 HR _____ 48 HR _____ Remain in Treatment Phase until all outcomes met, then progress to Evaluation Discharge Phase	All test results reviewed Weight loss less than 10% Voiding & stooling quantity sufficient Postpartum/Breastfeeding Clinic prn Make appt. for NNC if criteria met Physician visit within 5-7 days Evaluate need for referral or support Check ID bands Metabolic screening Discharge Summary completed
Pathway Reviewed with Patient/Family (Initial):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient/Family Satisfied with Progress?	Yes <input type="checkbox"/> No <input type="checkbox"/> If NO, see progress notes	Yes <input type="checkbox"/> No <input type="checkbox"/> If NO, see progress notes	Yes <input type="checkbox"/> No <input type="checkbox"/> If NO, see progress notes
Signatures:	_____ _____ _____ Initials _____ _____ _____	_____ _____ _____ Initials _____ _____ _____	_____ _____ _____ Initials _____ _____ _____



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INTERVENTIONS:			
Assessments	Review Maternal/Intrapartum/Newborn History VS q1h x 4 Cardioresp monitor O2 sat monitor +/- weight +/- Psychosocial Assessment Head-to-toe Assessment Infectious diseases status	Ongoing head-to-toe assessment VS q1-3h Cardioresp monitor O2 sat monitor Weight q24h If IV present: assess site q1h & prn	Head-to-toe Assessment q shift VS q3h to q6h Discharge weight
Consults	PRN: [] Dietitian [] Social Worker [] Psychologist [] OT [] Genetics [] Lactation Consultant	Referrals and counseling with Multidisciplinary Team prn	Lactation prn Multidisciplinary Team Members prn
Tests	Glucometer CBC, cultures +/- Imaging	Hypoglycemia Protocol CBC Gentamicin levels with 3rd dose +/- Venous blood gas if baby not requiring O2 +/- LP +/- Blood cultures +/- Imaging +/- N Bili +/- Urine culture	PKU TSH
Treatments		IV D5W or D10W or saline lock O2 as required to keep sat>92	D/C IV TKVO or saline lock In room air
Medications	Vitamin K Erythromycin Ung +/- Infectious disease prophylaxis as identified	Antibiotics 24 h culture results and infant clinically asymptomatic Vitamin/mineral supplement as per orders	D/C antibiotics pending 24 h culture results and infant clinically asymptomatic Vitamin/mineral supplement as per orders
Nutrition	NPO +/- induction feed	Total fluid intake (TFI) to start at 80cc/kg/day and increase by 20cc/kg/day q24h to a maximum of 160cc/kg/day Start breast/bottle if RR <70/min and no O2 required Gavage feed as required	Breast/bottle feeding quantity sufficient
Activity/Safety	Identification Minimal handling	Identification Minimal handling	Check bands q shift and upon discharge
Elimination	Meconium passed Voided	Meconium passed Voided	Voiding quantity sufficient Stooling quantity sufficient
Developmental Care	Minimal stimulation	Kangaroo care Refer to Policy & Procedure: Developmental Care	As per Policy & Procedure: Developmental Care

