



GUIDELINE

Sepsis: Neonatal

Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this [disclaimer](#)

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Aim

To provide guidance on the management of suspected sepsis in the neonate including the initial choice of antibiotics

Risk

Neonatal sepsis has a high risk of morbidity and mortality.

Infection in the Neonate

Bacterial infection is a leading cause of morbidity and mortality in the newborn period. Every effort must be taken to prevent, recognise (with a high level of suspicion) and treat infection. Treatment must be both specific and supportive.

Blood cultures are required prior to commencing antibiotic therapy. Cultures should be obtained from a superficial vein under aseptic technique. Cord blood cultures are not recommended as they have a high rate of bacterial contamination.

There are a wide range of organisms that cause infection and they can be acquired in 2 ways:

- Early-onset sepsis (EOS; transplacental or perinatally acquired; onset <72h).
- Late-onset sepsis (LOS; postnatally acquired / nosocomial; onset >72h).

Group B Streptococcal (GBS) Disease

Early-onset Group B Streptococcal (GBS) disease is the leading cause of EOS. Colonisation of the maternal lower genital tract is common, with 10-30% of pregnant women having positive vaginal or rectal cultures. EOS is vertically transmitted, either before or at the time of delivery. The vertical transmission rate from a GBS colonised mother is approximately 40-70%, with 1-2% of colonised neonates developing invasive disease. EOS usually presents with respiratory symptoms rapidly developing to septicaemia and shock with or without meningitis. Untreated the condition is usually fatal.

Routine screening of all women at 35-37 weeks gestation for recto vaginal GBS colonisation is performed at our hospital. Intrapartum prophylactic antibiotics are administered to all women whose genital tracts are colonised with GBS.

Also refer to [Obstetrics & Gynaecology Clinical Practice Guideline - Group B Streptococcal Disease](#)

Group A Streptococcus

Group A Streptococcus (also called Streptococcus pyogenes or GAS) is an organism of particular significance in an obstetric health setting as it may cause severe, potentially fatal, post- partum sepsis. Exposed neonates are at risk of severe sepsis. Refer to the KEMH [Group A Streptococcus \(GAS\)](#) guideline for more information and neonatal management when the mother is diagnosed with Invasive GAS (iGAS) / puerperal sepsis .

Clinical Presentation of Infection

General or Non-Specific:

- Hypotonia, lethargy.
- Pyrexia, hypothermia, temperature instability.
 - For those infants cared for in an incubator the temperature of the incubator should be considered as well as the infant's temperature.
 - Unusually high or low or variable incubator settings may indicate sepsis.
- Poor skin perfusion.
- Poor feeding, intolerance of feeds.
- Unexplained jaundice.
- Metabolic acidosis.
- Unstable plasma glucose homeostasis.
- Apnoea and seizures.
- Neutropenia, serial counts may help to establish a trend.
- Thrombocytopenia may occur but is usually a late sign, can occur with or without disseminated intravascular coagulation.

Suggestive or Specific:

- Respiratory distress.
- Gastrointestinal: vomiting (may be bile-stained), diarrhoea, abdominal distension.
- Central Nervous System: irritability, seizures, and full fontanel.
- Skin: septic lesions.
- Eyes, umbilicus: discharge.

Risk Factors

Preterm labour and birth	Resuscitation required at birth
Premature rupture of the membranes	Ongoing respiratory disease
Clinical chorioamnionitis and / or discoloured liquor.	Colonisation with pathogens
Maternal peripartum pyrexia (> 38°C).	Invasive presence of indwelling plastic devices
Maternal group B Streptococcal colonisation	Inadequate hand hygiene
Maternal UTI	Parenteral nutrition
Multiple gestation	Nursery colonisation with pathogens

Consequences of Infection

Extremely preterm infants are at high risk of mortality and significant short and long-term morbidity from infection. The site of infection is an important consideration.

Septicaemia may run a fulminant course, as in Group B Streptococcal (GBS) and Gram-negative sepsis.

Sepsis secondary to Coagulase-negative staphylococci (usually late-onset infections) tends to be less severe.

Congenital **pneumonia** is usually due to GBS or Gram-negative organisms. These neonates often require ventilation, and persistent pulmonary hypertension of the newborn (PPHN) can occur. Nosocomial pneumonia depends on the organism with which the neonate is colonised. **Meningitis** has a high (up to 50%) mortality rate in preterm infants, with survivors at risk of long-term neurological abnormalities.

Investigations of Suspected Sepsis

For all infants ≥ 35 weeks gestation refer to the Neonatal Clinical Guideline – Early-onset [Sepsis Risk Calculator: Assessment of Early-Onset Sepsis in Infants \$\geq 35\$ weeks Gestation](#)

Early Onset Sepsis (CHECK ANY MATERNAL CULTURES)

- Blood cultures
- Gastric aspirate (if has not fed)
- Ear swab
- Tracheal aspirate (if intubated)
- FBC, U&Es, PGL, CRP
- Consider LP early in unwell infant
- CXR (if indicated)

Late-onset sepsis

- Blood culture
- CRP, FBC, U&Es, PGL for baseline
- LP (should be performed in all cases of proven bacteraemia)
- CXR (if indicated)
- Suprapubic urine (especially when infant >3 weeks of postnatal age)
- If central line present (UVC, CVC) a blood sample drawn from the line for culture as well as a peripheral blood culture.

General Management and Antimicrobial Treatment

In all cases, close monitoring and supportive management is essential

Early Onset Sepsis

Also refer to [Sepsis Risk Calculator: Assessment of Early-Onset Sepsis in Infants ≥ 35 weeks Gestation](#)

- **Antibiotics should be administered to any neonate with clinical signs of sepsis**
- The presence of risk factors for sepsis may indicate investigation but are not in themselves an indication for antibiotic administration if the neonate is well.
- Common pathogens include Group B Streptococci (*S. agalactiae*) and Gram-negative organisms, esp. *E. coli* and *H. influenzae*.
- Parenteral therapy with Penicillin and Gentamicin should be started immediately after the septic screen.
- If the infant is ill, speed of intervention is of the essence
- For cases where there is immediately life-threatening sepsis or deterioration despite first line antibiotics, a stat dose of Meropenem should be initiated and clinical microbiologist/infectious diseases should be consulted promptly to tailor antibiotic choice for the patient, as there maybe need for additional antibiotics.

Hospital acquired Late-Onset Sepsis

This section refers to the management of patients who were in the NICU/SCN when they developed late-onset sepsis.

- Common organisms include Gram-positives (CoNS; esp. *S. epidermidis*, and *S. aureus*) and Gram-negatives.
- Septic work-up includes blood culture, LP and suprapubic urine collection.

- Antibiotic therapy must be targeted to the sensitivities of the likely causative organism. When considering antibiotic therapy, it is important to take into account the microbiological colonisation (and sensitivity) of the NICU, as well as previous colonisation or infection of the infant.
- Empiric therapy is Vancomycin plus an aminoglycoside Gentamicin. CoNS are almost uniformly Flucloxacillin and Cephalosporin resistant.
- **If antibiotic therapy is started on an infant who has been in close proximity to another infant colonised or infected with a resistant organism (such as ESBL or MRSA) the initial antibiotic choice should be discussed with a clinical microbiologist/infectious diseases specialist.**
- If there is evidence of a GI cause (NEC with intramural gas, perforation, peritonitis or an intra-abdominal collection), a combination of Vancomycin AND Piperacillin/Tazobactam maybe considered.
 - If meningitis is associated or suspected, then consult clinical microbiologist/infectious diseases specialist for advice on antibiotic choice as Piperacillin/Tazobactam has poor CNS penetration.
 - Addition of further anti-anaerobe cover (i.e. Metronidazole or Meropenem) should be considered individually, e.g. in cases of intra-abdominal collection and/or clinical failure of treatment. These cases should be discussed with the clinical microbiologist.
- In cases of CoNS sepsis where a central line is **in situ**, consideration should be given to removal of the line.

Length of treatment is based on laboratory and clinical findings. If cultures are negative and 2 CRPs taken 24 hours apart are normal and the infant has improved, antibiotics may be discontinued.

The typical course of antibiotics would be

	Duration
Suspected but unproven sepsis (negative blood culture)	2 days
More definite diagnosis such as pneumonia, with negative blood culture	5-7 days
Positive blood culture	7-10 days
Meningitis	2 to 3 weeks

Ultimate duration of antibiotics will depend on the pathogen, clinical progress and complications.

Refer to Infection Prevention and Management Manual – [Micro-Alerts and Multi-Resistant Organisms](#)

Antibiotic Administration to Neonates of Mothers with Antibiotic Allergy

Penicillin G, other semisynthetic Penicillins and Cephalosporins are used frequently in the neonatal period for both therapy and prophylaxis. These antibiotics are exceedingly well tolerated in neonates. Anaphylaxis secondary to their use is rare, even when administered to neonates born of mothers with Type I hypersensitivity reactions to penicillin and related agents. Further, there is no evidence that use of Penicillin and related agents in the neonatal period predisposes to subsequent beta-lactam allergy. As neonatal administration of Penicillin and related agents may be lifesaving, their use should not be delayed because of concerns of maternal antibiotic allergy.

Viral Infections

Any symptomatic infant requiring investigation should be immediately placed on contact precautions +/- droplet or airborne precautions

- Isolated in an incubator
- Place in cohort management
- Or if unable to isolate in incubator discuss with CNC /CNC Infection Prevention Management/SNR On-Call to consider use of the Isolation Room.

Refer to Infection Prevention and Management Policy - [Neonatal Viral Infections](#) for screening and isolation management.

Screening Procedures

Blood Cultures

To obtain a blood sample for microbiological examination where clinically indicated. A single blood culture bottle is all that is normally required. However, if an intra-abdominal collection or necrotising enterocolitis is suspected, blood for aerobic and anaerobic pathogens should be sent in separate bottles.

Note: Identify if the infant is study participant where further investigations may be required.

Equipment

Blood culture collection is a standard aseptic procedure, performed by medical staff or nursing staff deemed competent in the insertion of an intravenous catheter.

- Sterile dressing pack
- Blood culture bottle
- 2 mL syringe
- Blunt plastic cannula
- Intravenous cannula
- Skin cleansing swabs (Chlorhexidine 1% Alcohol/ 70% Swab > 27 weeks gestation or Povidone-iodine 10% Swab ≤ 27 weeks gestation)

Procedure

1. Refer to procedure for intravenous line insertion if collecting blood from an intravenous cannula. When there is blood flowing back into the hub, insert blunt needle into the hub and aspirate blood for transfer into culture bottle. For infants ≤ 28 weeks 0.5mL; infants >28 weeks 1mL.
2. Remove seal from culture bottle.
3. Inject blood into blood culture bottle.
4. Ensure bottle is correctly labelled at the bedside. It is important not to attach the patient label to the neck of the bottle as this interferes with processing of the sample.

Ear Swab

The ear folds may reflect microbiological colonisation acquired from amniotic fluid and/or birth canal; this can persist after birth and may indicate the microorganism causing perinatal infection.

Equipment

- Charcoal medium
- Sterile swab stick

Procedure

1. Do not collect ear swab if infant has been bathed.
2. Remove swab stick from packet, taking care not to touch the tip.
3. Swab in a circular motion, around the first curvature of the ear.
4. Place swab into charcoal medium.
5. Label immediately at the bedside.

Gastric Aspirate

To take a gastric fluid specimen for microbiological examination on all newborn infants admitted to the unit with suspected sepsis. The aspirate may reflect microbiological colonisation acquired from amniotic fluid and/or birth canal; this can persist after birth and may indicate the microorganism causing perinatal infection.

Equipment

- Gastric tube
- PH/litmus test strip
- 10mL syringe
- Yellow lid specimen container

Procedure

1. Refer to [Gastric Tube Feeding in the NICU](#) guideline for instructions on insertion of a gastric tube.
2. Gastric aspirate must be collected prior to the infant's first feed.
3. Once tube has been inserted, connect 10 mL syringe and gently aspirate gastric tube to obtain secretions for microbiological examination, the fluid swallowed during birth may reveal organisms of the maternal genital tract that may cause perinatal infections.
4. If the infant requires a gastric tube, leave the tube in and secure it. Ensure the position is checked.
5. Label specimen immediately at the bedside.

Lumbar Puncture

Obtain cerebrospinal fluid (CSF) for:

- Infants with suspected meningitis or sepsis.
- Drainage of CSF in communicating hydrocephalus.
- Diagnoses of metabolic disorder.
- Diagnostic procedure in seizure activity.

Key Points

- Depending on the level of experience, only two attempts should be made to obtain CSF before handing over to another medical officer.
- Needles without a stylet should not be used because of the risk of an intraspinal dermoid.
- The position adopted for a lumbar puncture can cause physiological instability. Throughout the procedure the infant must be monitored for tolerance and stability and the procedure should be stopped if at any time the infant's condition deteriorates.
- The infant must have continuous oxygen saturation and heart rate monitoring throughout the procedure and resuscitation equipment should be available.

Equipment

- Skin cleansing solution. Chlorhexidine 1% Alcohol/ 70% solution > 27 weeks gestation or Povidone-iodine 10% solution ≤ 27 weeks gestation)
- Dressing pack / sterile gown / sterile gloves / sterile drapes.
- Lumbar puncture needle - 25G to be used (22G available if required).
- Sterile specimen bottles - appropriate bottles for specific tests.
- Non-occlusive dressing (Tegaderm 4cm x 4cm).

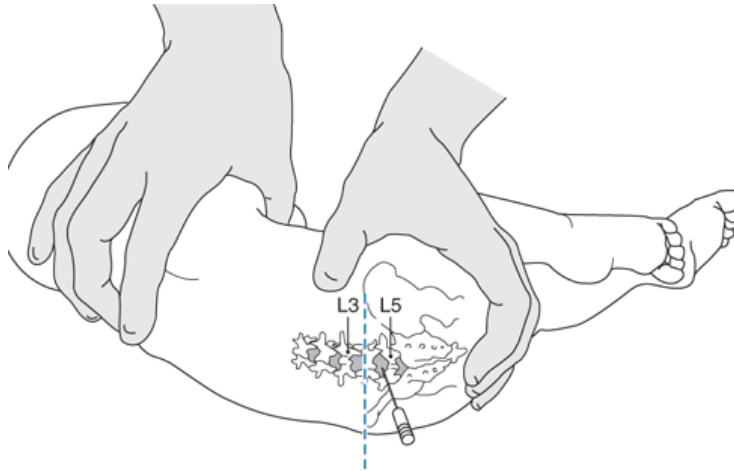


Diagram demonstrating area of puncture and position of infant during the procedure

Procedure

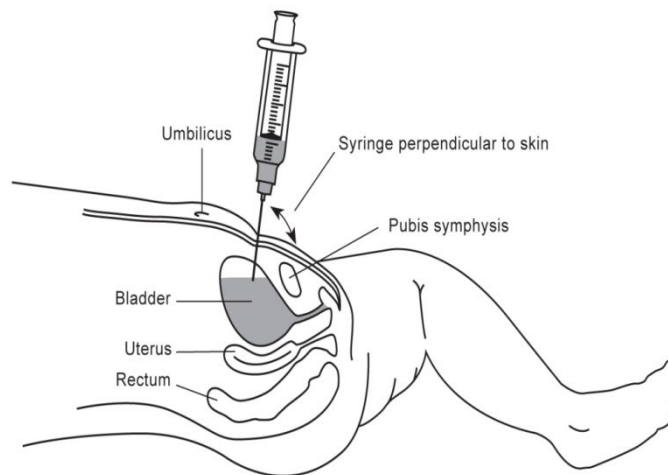
1. Hold the infant firmly in the lateral position, keeping the head and trunk well flexed. This allows for easy detection of landmarks.
2. Observe infant's tolerance closely for possible airway obstruction, apnoea, bradycardias, hypoxia.
3. Identify the L4-L5 interspace as site for lumbar puncture. The space above L4 should **not** be penetrated as this can lead to spinal cord and spinal nerve damage.
4. Clean wide area thoroughly.
5. Insert the needle in the midline with steady force aimed towards the umbilicus.
6. Advance the needle slowly and then remove the stylet to check for appearance of fluid.
7. Collect at least 10 drops in each sterile container.
8. Maintain pressure on the area with sterile gauze until the site has stopped leaking.
9. Wash off povidone-iodine solution, or chlorhexidine solution.
10. Place non-occlusive dressing over site (if skin integrity allows) and leave intact for 24 hours.
11. Label immediately at the bedside.

Supra Pubic Urine

Supra-pubic urine aspirate is performed by medical staff using standard aseptic technique. Ultrasound assessment of the bladder is useful prior to procedure.

Equipment

- 2 mL Syringe
- 23G Needle
- Dressing Pack
- Skin preparation swab
- Sterile container



Procedure

1. Position infant supine. Hold legs in frog-like position.
2. Check infant has not just voided.
3. Locate site of bladder puncture: 0.5 cm-2 cm above the pubic symphysis in the midline of the lower abdomen.
4. Prepare skin (Chlorhexidine 1% Alcohol/ 70% solution > 27 weeks gestation or Povidone-iodine 10% ≤ 27 weeks gestation)
5. Advance needle perpendicular to abdomen to ensure correct anatomical position and avoid bowel perforation.
6. Advance the syringe whilst applying minimal negative pressure.
7. Do not advance any further once urine is obtained to avoid trauma to the posterior bladder wall.
8. Remove needle and apply pressure until bleeding has stopped.
9. Label specimen immediately at the bedside.

Endotracheal Tube (ETT) Aspirate

To obtain pulmonary secretions for microbiological examination in ventilated infants. ETT aspirate is to be collected as part of septic screen on admission or for any other subsequent septic screen for ventilated infant. This is a 2- person standard aseptic procedure

Routine ETT aspirates are collected for every ventilated infant on Mondays.

Equipment

Appropriate size suction catheter (6, 8, 10fr)

Specimen collection Pot (White Lid)

Sterile gloves

Normal Saline ampoule

Procedure

- Turn off continuous milk feed prior to performing the procedure to prevent aspiration of milk.
- Non- sterile assistant turns suction apparatus on at a set pressure (-80 to -100) Connect suction catheter to suction tubing.
- Sterile user to apply sterile gloves and remove specimen collection pot and keep white lid in sterile packaging.
- Measure the depth of the catheter insertion required by noting the length the endotracheal tube is cut at and adding 7cm. Correct measurement prevents deep suctioning which causes mucosal trauma.
- Non-sterile assistant to disconnect ventilator circuit from ETT and remove flow sensor. A 10% increase FiO₂ prior to suctioning may be needed.
- Sterile user to insert catheter to predetermined length. Apply suction to T-piece. Withdraw catheter while maintaining suction pressure, this should not take longer than 10secs to minimise the risk of cerebral and pulmonary vasoconstriction.
 - If the sample is small and remains in the catheter 0.5mL of N/S can be aspirated to clear the catheter so the secretions are collected in the specimen trap.
- Non-sterile assistant turns suction apparatus off and disconnects suction catheter and tubing from specimen pot
- Sterile user connects sterile white lid to top of specimen pot
- Ensure all monitoring parameters have returned to normal. ETT position secure and noted, and ventilator tubing secure.
- Label specimen immediately at bedside.

Nasopharyngeal Specimen - Flocked Swab Collection

To collect respiratory secretions containing epithelial cells from the nasopharynx to assist in the diagnosis of viral respiratory tract infections.

Key Points

- Nasopharyngeal flocked swabs are the preferred method of sample collection for detection of respiratory viruses.
 - Using polymerase chain reaction (PCR) for respiratory virus detection, nasopharyngeal flocked swabs have been shown to be as sensitive as nasopharyngeal aspirates.
 - Nasopharyngeal flocked swab collection is considered safer for sample collectors as there is less risk of aerosol generation than with aspirate collection

Equipment

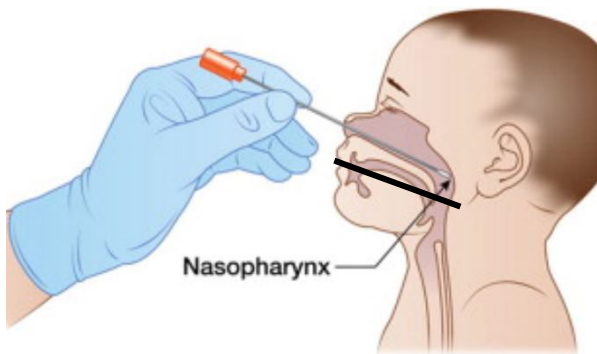
- Flocked Swab with transport medium (UTM™)
- Completed pathology request form
- Stating Full Respiratory Panel, urgent results required.
- Biohazard specimen transport bag
- PPE: Standard - gloves, consider mask and eye protection

Patient Preparation

- Confirm patient identity against pathology request form.
- Consider administration of sucrose prior to procedure.
- Swaddle infant.
- Measure distance from base of ear to nose (**Note** – swab to be inserted half the measured distance).

Procedure

Measure distance from ear to nose



1. Perform hand hygiene and don gloves (PPE).
2. Open swab packaging and remove ready for specimen collection.
 - Check expiry date on kit packaging.
3. Immobilise the infant's head in the sniffing position.
 - You may require another staff member to assist.
4. Insert flocked swab into the anterior nares and gently direct backwards along the base of the nostril as far as possible; but not more than half the measured distance from the base of ear to nose.
 - If resistance is encountered during swab insertion, remove it and attempt insertion into other nostril.
 - Ensure swab is not directed in an upward direction.
5. Hold the swab in the nasopharynx for approximately 5 seconds.
6. Gently rotate 2-3 times before withdrawing swab.
7. Remove swab slowly and place it (without touching) into the transport medium.
8. Break swab stick at designated marked breakpoint.
9. Replace tube cap securely.
10. Ensure specimen is correctly labelled and place into biohazard bag.
11. Remove PPE and perform hand hygiene.

Eye Swabs

To obtain an eye swab for microbiological examination in an infant with persistent discharging eyes. For ongoing care, refer to [Eye Care: Eye Infections and Conjunctivitis](#)

Key Points

- An eye swab for bacterial examination should always be the first line of action. If the eye fails to respond to treatment, a swab for chlamydial and viral examination should be sent.

- The incubation period for Chlamydia is from day 4 up to 2 weeks of age; therefore, a sticky eye in the first 4 days of life is unlikely to be indicative of chlamydial infection.
- If the infant is delivered vaginally through active genital herpes lesions, an eye swab in viral medium should be sent on admission as part of the septic screen.
- Viral transport medium (VTM) contains antibiotics to keep the virus stable on transport to the laboratory; therefore, it is important **not** to use VTM for chlamydial or bacterial examination.

Equipment

- Dressing Pack

Bacterial examination:	Chlamydial examination:	Viral examination:
<ul style="list-style-type: none"> • Normal saline • Charcoal swab • Glass slide and slide carrier 	<ul style="list-style-type: none"> • Normal saline • Aluminium wire shafted swab • Teflon coated slide and slide carrier • Sterile scissors 	<ul style="list-style-type: none"> • Saline • Swab stick • Viral transport medium (VTM) • Sterile scissors

Procedure

1. Perform hand hygiene and don gloves.
2. Perform eye toilet to remove exudate from eye. If both eyes are discharging, a swab from each eye should be sent separately ensuring they are correctly labelled.
3. Moisten swab stick with normal saline to provide optimum medium for bacterial / viral / chlamydial growth.
4. Gently fold down lower eyelid and run swab stick across the inner surface rotating swab to ensure specimen collection. If for chlamydial examination continue on to the inner canthus and rotate the swab across the inner canthus - cells need to be collected not just exudate.
5. Avoid causing trauma to eye mucosa.
6. Smear swab along glass slide if applicable and place into transport medium.
7. The chlamydial swab and viral swab will need to be cut with sterile scissors.
8. Remove gloves and perform hand hygiene.

Related CAHS internal policies, procedures and guidelines

Neonatology Guidelines

- [Candida Infections](#)
- [Cytomegalovirus \(CMV\) Neonatal Pathway](#)
- [Eye Care: Eye Infections and Conjunctivitis](#)
- [Gastric Tube Feeding in the NICU](#)
- [Sepsis Calculator: Assessment of Early On-set Sepsis in Infants \$\geq\$ 35 weeks Gestation](#)


WNHS: Obstetrics & Gynaecology Clinical Practice Guideline

- [Group B Streptococcal Disease](#)

Infection Prevention and Management Policies (KEMH)

- [Micro Alerts and Multi-Resistant Organisms](#)
- [Neonatal Respiratory Viral Infections](#)
- [Group A Streptococcus](#)

This document can be made available in alternative formats on request.

Document Owner:	Neonatology		
Reviewer / Team:	Neonatology Coordinating Group / Infectious Diseases / Microbiologist		
Date First Issued:	February 2010	Last Reviewed:	November 2022
Amendment Dates:	Jan 2024, ETT aspirate procedure	Next Review Date:	November 2023
Approved by:	Neonatology Coordinating Group	Date:	22 nd November 2022
Endorsed by:	Neonatology Coordinating Group	Date:	
Standards Applicable:	NSQHS Standards:  Child Safe Standards: 1,10		

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