Results Of the 1123 infants (Invasive Bacterial Infection - IBI, 48, 4.2%), 483 (43.4%) were classified as low risk criteria for IBI according to the “step by step” approach (vs 693-61.7% with the Labscore and 458-40.7% with the Rochester criteria). The prevalence of IBI in the low-risk criteria patients was 0.2% (95% CI 0.0-0.6%) using the “step by step” approach (vs 0.7%-95% CI 0.1-1.3% with the Labscore and 1.1%-95% CI 0.1-2% with Rochester). Using the “step by step” approach, 1 patient with IBI was not correctly classified (2.0%, CI95% 0–6.12) vs 5 using the Labscore or Rochester (10.4%, CI95% 1.76–19.04%).

Conclusions A sequential approach to young febrile infants including procalcitonin identifies better patients more suitable for outpatient management.

Background Early warning scores complement clinical decision making and can identify trends depicting deterioration in patient’s condition. Age appropriate Burton Paediatric Early Warning System (BPEWS) score charts were developed in 2011 using nine indicators which included physiological parameters, therapeutic intervention and doctor/nurse concern.

Methods A retrospective analysis of all children transferred to paediatric intensive care setting over the preceding 12 months was carried out to validate BPEWS charts. Detailed case notes review was undertaken to evaluate if BPEWS could have been useful to alert us of patients’ deterioration in the 24 hour period prior to transfer. Each case note was assessed by two reviewers.

Results An average of 8.7 sets of observations per patient was recorded in the 24 hours period prior to intensive care transfer. Of the 200 sets of observations recorded in 23 patients, 93% sets would have triggered based on BPEWS. 44% sets of observation scores were in amber (4–7) while 35% were in red (>7) category. Average highest BPEWS score was 9.5 (range: 4–19). In 43% and 57% of patients, highest BPEWS score fell in amber and red category respectively.

Conclusions BPEWS score charts are effective in identifying children at risk of sudden deterioration. Timely identification is likely to enable early action to reduce the risk of death or serious morbidity thus improving the outcome of care given to hospitalised children.

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Introduction Nowadays it is possible to manage as outpatients selected young febrile infants with low risk criteria for serious bacterial infection. A sequential approach, evaluating, firstly, the appearance of the infant, secondly, the urinalysis, and, finally, the results of the blood biomarkers, including procalcitonin, may identify better low risk febrile infants suitable for outpatient management.

Objective To assess the value of a sequential approach (“step by step”) to febrile young infants in order to identify low risk patients suitable for outpatient management and compare it with other ones previously described (Rochester criteria and Lab-score).

Methods A retrospective comparison of three different approaches (“step by step”, Lab-score and Rochester criteria) was made in 1125 febrile infants less than 3 months of age attended in seven European Pediatric Emergency Departments.

Results Of the 1123 infants (Invasive Bacterial Infection - IBI, 48, 4.2%), 483 (43.4%) were classified as low risk criteria for IBI according to the “step by step” approach (vs 693-61.7% with the Labscore and 458-40.7% with the Rochester criteria). The prevalence of IBI in the low-risk criteria patients was 0.2% (95% CI 0.0-0.6%) using the “step by step” approach (vs 0.7%-95% CI 0.1-1.3% with the Labscore and 1.1%-95% CI 0.1-2% with Rochester). Using the “step by step” approach, 1 patient with IBI was not correctly classified (2.0%, CI95% 0–6.12) vs 5 using the Labscore or Rochester (10.4%, CI95% 1.76–19.04%).

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