Worcestershire Health and Care NHS
NHS Trust

Worcestershire NHS
Acute Hospitals NHS Trust

NHS
Redditch and Bromsgrove
Clinical Commissioning Group

NHS
South Worcestershire
Clinical Commissioning Group

NHS
Wyre Forest
Clinical Commissioning Group

The Top 10

conditions which children & young people present to urgent care with

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Information regarding guidance in this booklet: -

This guidance is written in the following context

This assessment tool was arrived at after careful consideration of the evidence available including but not exclusively *SIGN, Bristol guideline, EBM data and NHS evidence. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Information for GP's reguarding reviewing children:-

When you feel a GP review in a specific time period is clinically appropriate but that falls outside of the 'in hours' GP service please advise your patient/family to call NHS 111 (at an agreed time interval / level of deterioration – depending on your concerns) and advise that there is a 'predetermined plan to speak with an Out of Hours GP'. Please provide your patient / family with a letter detailing your clinical findings and concerns to help the Out of Hours GP assessment.

The Top 10 conditions which children & young people present to urgent care with

Dear Colleague

The Worcestershire Childrens Transformation Group which includes clinical representatives from acute, community and primary care are working together towards re-designing children & young people services. As part ofthis work it also includes the following objectives:

- To promote evidence-based assessment and management of unwell children & young people for the most common conditions when accessing local Worcestershire NHS services as an emergency;
- To build consistency across Worcestershire, so all healthcare professionals understand the pathway and can access the guidelines to support the needs of children, young people and their families regardless of where they present;
- To support local healthcare professionals, share learning and expertise across organisations in order to drive continuous development of high quality urgent care pathways for children & young people.

The Worcestershire Childrens Transformation Group are keen to promote the use of these guidelines for the ten most common conditions that can cause children and young people to present for emergency care. The ten conditions are:

1. Bronchiolitis
2. Croup
3. Fever
4. Gastroenteritis
5. Wheezy child/Asthma
6. Limping child
7. Purpuric rashes
8. Crying baby
9. Mental Health Pathway
10. Constipation Pathway (TBI)

These guidelines have been developed using both national guidance such as NICE and SIGN publications, along-side local policies and protocols, and have been subject to clinical scrutiny. Whilst it is hoped that all healthcare professionals who work with children and young people will acknowledge and embed the use of this guidance, it must be stressed that the guidance does not override the individual responsibility of the healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with them.

We hope these guidelines will help support you and your colleagues to provide high quality care for children and young people in Worcestershire.

Yours sincerely

Dr Philip Thompson,SWCCG GP Lead for children
Dr Jackie Lewin ,R&B and WF CCG,GP Lead for children
Dr Andrew Short -Consultant Paediatrician ,WAHT
Dr David Lewis-Community Paediatrician, WHACT
Stephanie Court, Childrens Nurse Consultant and Complex Care Manager, WHACT

Clinical Assessment Tool

Babies/Children under 2 years with Suspected Bronchiolitis

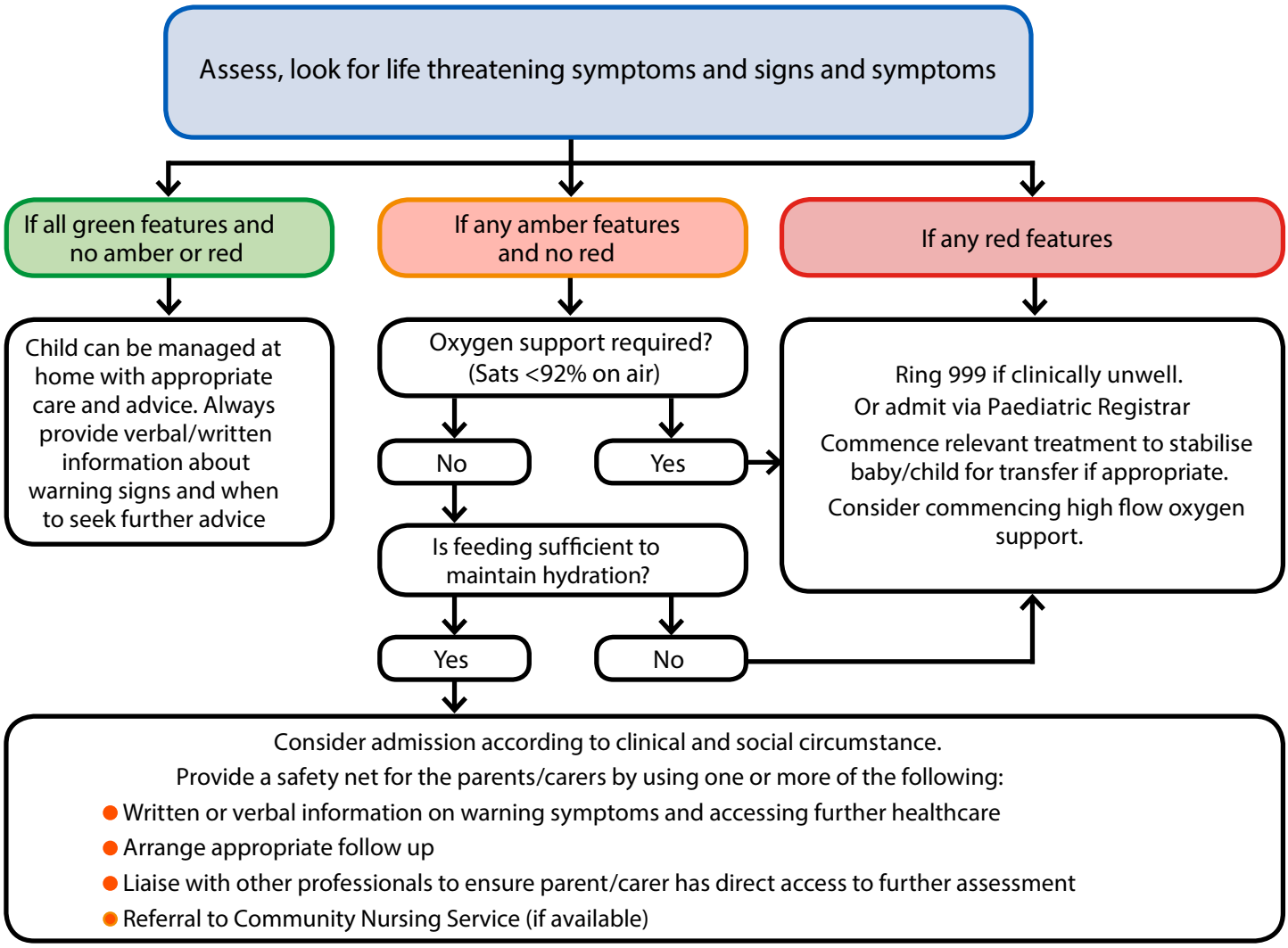


Table 1 Traffic light system for identifying severity of illness

	Green – low risk	Amber – Intermediate risk	Red – high risk
Behaviour	• Alert • Normal	• Irritable • Not responding normally to social cues • Decreased activity • No smile	• Unable to rouse • Wakes only with prolonged stimulation • No response to social cues • Weak, high pitched or continuous cry • Appears ill to a healthcare professional
Circulation	CRT < 2 secs	CRT 2 - 3 secs	CRT over 3 secs
Skin	Normal colour skin, lips & tongue moist mucous membranes	Pale/mottled Pallor colour reported by parent/carer cool peripheries	Pale/Mottled/Ashen blue Cyanotic lips and tongue
Respiratory Rate	Under 12mths <50 breaths/ minute Over 12 mths <40 breaths/ minute No respiratory distress	<12 mths 50-60 breaths/minute >12 months 40-60 breaths/minute	All ages > 60 breaths/minute
SATS in air	95% or above	92 - 94%	<92%
Chest Recession	None	Moderate	Severe
Nasal Flaring	Absent	May be present	Present
Grunting	Absent	Absent	Present
Feeding Hydration	Normal – no vomiting	50-75% fluid intake over 3-4 feeds +/- vomiting. Reduced urine output	<50% fluid intake over 2-3 feeds +/- vomiting. Significantly reduced urine output.
Apnoeas	Absent	Absent	Present*

CRT: Capillary refill time
SATS: Saturation in air

*Apnoea – for 10-15 secs or shorter if accompanied by a sudden decrease in saturations/central cyanosis or bradycardia

Clinical Assessment Tool

Babies/Children under 2 years with Suspected Bronchiolitis

Healthcare professionals should be aware of the increased need for hospital admission in infants with the following:

- Pre existing lung disease, congenital heart disease, neuromuscular weakness, immune-incompetence
- Age <6 weeks (corrected)
- Prematurity
- Family anxiety
- Re-attendance
- Duration of illness is less than 3 days and Amber – may need to admit

Signs and Symptoms can include:

- Rhinorrhoea (Runny nose)
- Cough
- Poor Feeding
- Vomiting
- Pyrexia
- Respiratory distress
- Apnoea
- Inspiratory crackles +/- wheeze
- Cyanosis

Bronchiolitis Advice Sheet – Babies/Children under 2 years

Name of Child ..... Age ..... Date / Time advice given .....

Further advice / Follow up .....

.....

Name of Professional ..... Signature of Professional .....

How is your child?

Red

- Blue lips
- Unresponsive and very irritable
- Finding it difficult to breathe
- Pauses in breathing or irregular breathing pattern

You need urgent help
please phone 999 or go to the nearest Accident and Emergency Department

Amber

- Decreased feeding
- Passing less urine than normal
- Baby/child's health gets worse or you are worried
- If your baby/child is vomiting
- Your babies temperature is above 39°C

You need to contact a doctor or nurse today
please ring your GP surgery or call NHS 111 – dial 111

Green

- If none of the above factors are present

Self Care
Using the advice overleaf you can provide the care your child needs at home

Some useful phone numbers

GP Surgery
(make a note of number here)

NHS 111
dial 111
(available 24 hrs – 7 days a week)

GP Out of Hours Service: appointments booked via the NHS 111 service
(Open from 6.30pm to 8am on weekdays and bank holidays)

For online advice: NHS Choices www.nhs.uk (available 24 hrs – 7 days a week)

To get access to this in another language or easy read please ask a member of staff.

Bronchiolitis Advice Sheet – Babies/Children under 2 years

What is Bronchiolitis?

Bronchiolitis is an infectious disease when the tiniest airways in your baby/child's lungs become swollen. This can make it more difficult for your baby/child to breathe. Usually, bronchiolitis is caused by a virus. It is common in winter months and usually only causes mild cold like symptoms. Most babies/children get better on their own. Some babies/children, especially very young ones, can have difficulty with breathing or feeding and may need to go to hospital.

What are the symptoms?

- Your baby/child may have a runny nose and sometimes a temperature and a cough. After a few days your baby/child's cough may become worse.
- Your baby/child's breathing may be faster than normal and it may become noisy. He or she may need to make more effort to breathe.
- Sometimes, in the very young babies, Bronchiolitis may cause them to have brief pauses in their breathing. If you are concerned see the amber box overleaf.
- As breathing becomes more difficult, your baby may not be able to take the usual amount of milk by breast or bottle.
- You may notice fewer wet nappies than usual.
- Your baby/child may vomit after feeding and become irritable.

How can I help my baby?

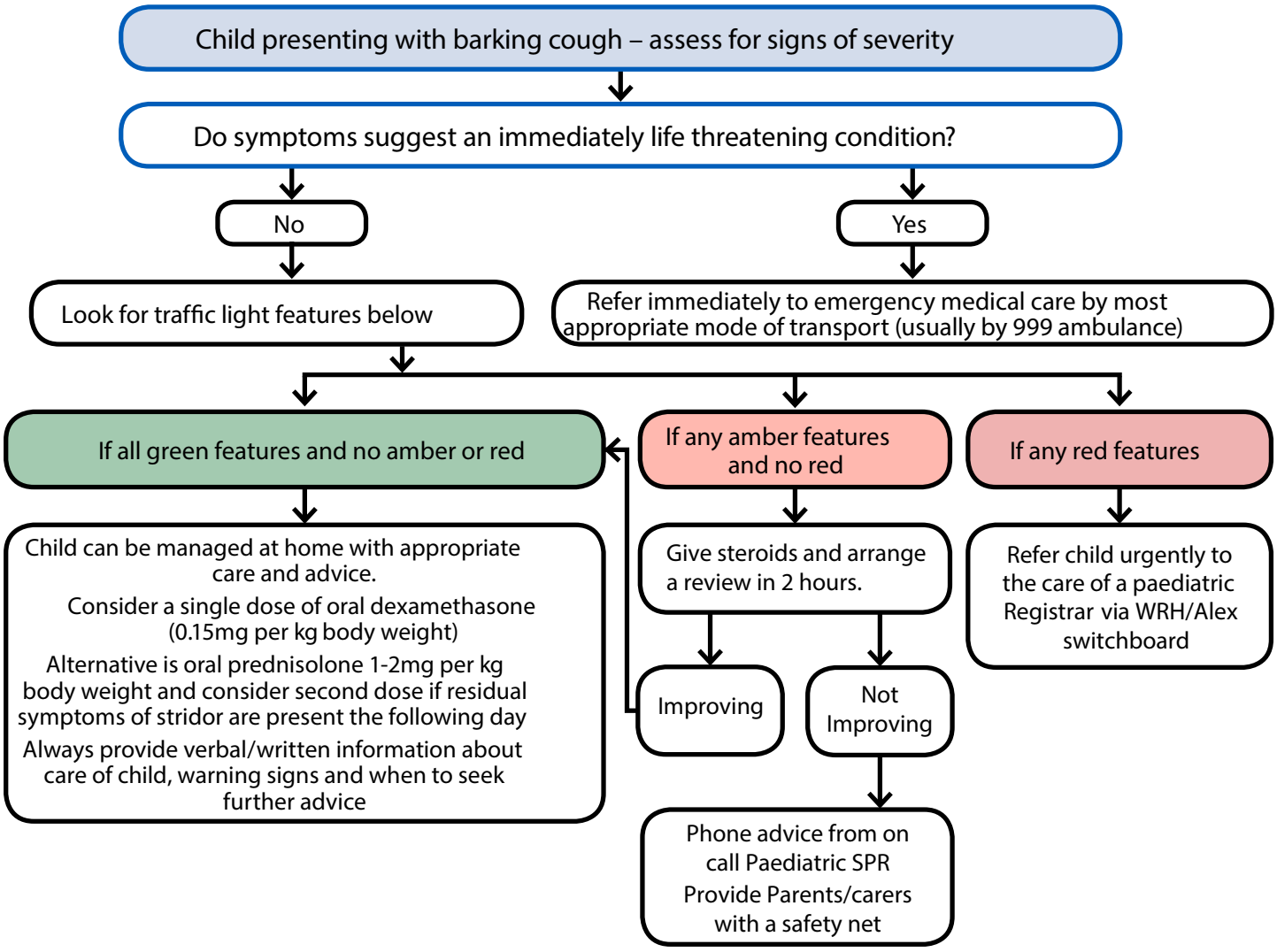
- If your baby/child is not feeding as normal offer feeds little and often.
- If your baby/child has a fever, you can give him or her paracetamol in the recommended doses. If your child is older than 6 months old you may also give Ibuprofen.
- If your baby/child is already taking medicines or inhalers, you should carry on using these. If you find it difficult to get your baby/child to take them, ask your doctor or another healthcare professional for advice.
- Bronchiolitis is caused by a virus so antibiotics won't help.
- Make sure your baby/child is not exposed to tobacco smoke. Passive smoking can seriously damage your baby/child's health. It makes breathing problems like bronchiolitis worse.
- Remember smoke remains on your clothes even if you smoke outside.

How long does Bronchiolitis last?

- Most babies/children with bronchiolitis get better within about two weeks.
- Your baby/child can go back to nursery or day care as soon as he or she is well enough (that is feeding normally and with no difficulty in breathing).
- There is usually no need to see your doctor if your baby/child is recovering well. But if you are worried about your baby/child's progress, contact NHS 111 or discuss this with your doctor.

Clinical Assessment Tool

Suspected Croup in child 3 months – 6 years



	Green	Amber	Red
Colour	Normal	–	Pale
Activity	Child alert	Quieter than normal	Lethargy Distress/agitation
Respiratory	Respiratory rate ⌘ Under 12 months <50 breaths/minute ⌘ Over 12 months <40 breaths/minute Sats 95% or above	Respiratory rate ⌘ Under 12 months 50-60 breaths/minute ⌘ Over 12 months 40-60 breaths/minute Sats 92 - 94%	Respiratory rate >60 (all ages) Sats <92%
Cough	Occasional barking cough No stridor	Frequent barking cough and stridor	Struggling with persistent cough
Chest recession	No chest recession	Subcostal and retrosternal recession	Marked subcostal and retrosternal recession
Circulation and hydration	CRT < 2 seconds		
		Poor response to initial treatment Reduced fluid intake Uncertain diagnosis Significant parental anxiety, late evening/night presentation. No access to transport or long way from hospital	

Croup Advice Sheet

Name of Child ..... Age ..... Date / Time advice given .....

Further advice / Follow up .....

.....

Name of Professional ..... Signature of Professional .....

How is your child?

Red

- Blue lips
- Unresponsive and very irritable
- Finding it difficult to breathe with heaving of chest
- Pauses in breathing or irregular breathing patterns

You need urgent help
please phone 999 or go to the nearest Accident and Emergency Department

Amber

- Not improving with treatment
- Breathing more noisy
- Breathing more laboured (chest 'indrawing')
- Persisting fevers of over 39 degrees centigrade

You need to contact a doctor or nurse today
please ring your GP surgery or call NHS 111 – dial 111

Green

- If none of the above

Self Care
Using the advice overleaf you can provide the care your child needs at home

Some useful phone numbers

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For online advice: NHS Choices www.nhs.uk (available 24 hrs – 7 days a week)

To get access to this in another language or easy read please ask a member of staff.

Croup Advice Sheet – Babies/Children under 2 years

What is Croup?

Croup is an inflammation of the voice box characterised by a typical dry barking cough and sometimes leading to difficulty in breathing.

The condition most often affects small children. It is usually caused by a virus and occurs in epidemics particularly in the autumn and early spring.

Symptoms start with a mild fever and a runny nose. This progresses to a sore throat and a typical barking cough. Young children have smaller air passages and inflammation in the voice box leads to the gap between the vocal cords being narrowed. This may obstruct breathing, particularly when breathing in (stridor), which often starts in the middle of the night.

Croup develops over a period of one or two days, the severity and time that it persists varies, but often symptoms are worse on the second night of the cough

Croup is usually caused by a virus and for that reason antibiotics are not normally effective.

How can I help my child?

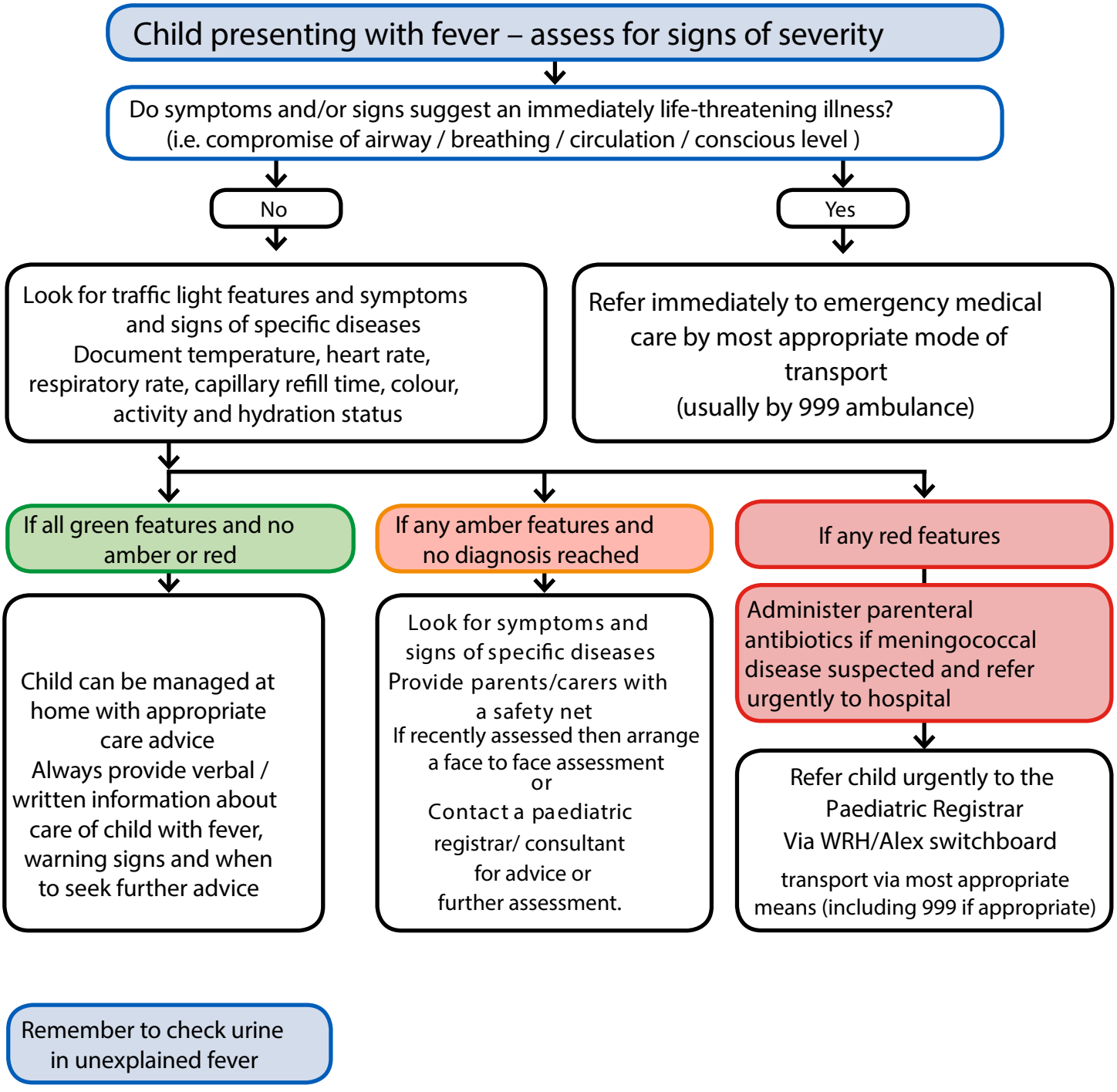
- Be calming and reassuring. A small child may become distressed with croup. Crying can make things worse
- Sit the child upright on your lap if their breathing is noisy or difficult. Let the child find a comfortable position.
- Give the child lots of cool drinks (if they are happy to take them).
- A cool environment such as taking your child outside at night for a brief period may help
- Lower the fever. If a child has a fever (high temperature) their breathing is often faster, and they may be more agitated and appear more ill. To lower a fever:
  - Give paracetamol or ibuprofen.
  - Lightly dress the child if the room is not cold.

Be aware

Steam used to be commonly advised as a treatment. It was thought that steam may loosen the mucus and make it easier to breathe. However, there is little evidence that this does any good. Also, some children have been scalded by steam whilst being treated for croup. Therefore, steam is not recommended. Also, DO NOT make a child with breathing difficulty lie down or drink fluids if they don't want to, as that could make breathing worse.

Clinical Asssessment Tool

Child with fever



Remember to check urine in unexplained fever

Traffic light system for identifying risk of serious illness

	Green – low risk	Amber – intermediate risk	Red – high risk
Colour	⌘ Normal Colour of skin, lips and tongue	⌘ Pallor reported by parent/carer	⌘ Pale/mottled/ashen/blue
Activity	⌘ Responds normally to social cues ⌘ Content/smiles ⌘ Stays awake or awakens quickly ⌘ Strong normal cry/not crying	⌘ Not responding normally to social cues ⌘ Wakes only with prolonged stimulation ⌘ Decreased activity ⌘ No smile	⌘ No response to social cues ⌘ Appears ill to a healthcare professional ⌘ Unable to rouse or if roused does not stay awake ⌘ Weak, high-pitched or continuous cry
Respiratory		⌘ Nasal flaring ⌘ Tachypnoea: - RR > 50 breaths/minute age 6 - 12 months - RR > 40 breaths/minute age > 12 months ⌘ Oxygen saturation < 95% in air ⌘ Crackles in the chest	⌘ Grunting ⌘ Tachypnoea: - RR > 60 breaths/minute
Circulation and Hydration	⌘ Normal skin and eyes ⌘ Moist mucous membranes	⌘ Dry mucous membrane ⌘ Poor feeding in infants ⌘ CRT > 3 seconds ⌘ Tachycardia >160 beats/minute age < 1year >150 beats/minute age 1 - 2 years >140 beats/minute age 2 - 5 years ⌘ Reduced urine output	⌘ Reduced skin turgor
Other	⌘ None of the amber or red symptoms or signs	⌘ Fever for > 5 days ⌘ Swelling of a limb or joint ⌘ Non-weight bearing/not using an extremity ⌘ A new lump > 2 cm ⌘ Age 3-6 months, temperature > 39°C ⌘ Rigors	⌘ Age 0-3 months, temperature > 38°C ⌘ Non-blanching rash ⌘ Bulging fontanelle ⌘ Neck stiffness ⌘ Status epilepticus ⌘ Focal neurological signs ⌘ Focal seizures

CRT: capilary refill time

RR: respiratory rate

Symptoms and signs of specific illnesses

Always check urine in unexplained fever

If meningococcal disease is suspected then administer parenteral antibiotics and refer urgently to hospital

Check blood glucose if possible

Diagnosis to be considered	Symptoms and signs in conjunction with fever
Meningococcal disease	Non-blanching rash, particulary with one or more of the following: ⌘ An ill-looking child ⌘ Lesions larger than 2 mm in diameter (purpura) ⌘ CRT > 3 seconds ⌘ Neck stiffness
Meningitis[1]	Neck stiffness ⌘ Bulging fontanelle ⌘ Decreased level of consciousness ⌘ Convulsive status epilepticus
Herpes simplex encephalitis	Focal neurological signs ⌘ Focal seizures ⌘ Decreased level of consciousness
Pneumonia	⌘ Tachypnoea, measured as: - 0-5 months - RR > 60 breaths/minute - 6-12 months - RR > 50 breaths/minute - > 12 months - RR > 40 breaths/minute ⌘ Crackles in the chest ⌘ Nasal flaring ⌘ Chest indrawing ⌘ Cyanosis ⌘ Oxygen saturation < 95%
Urinary tract infection (in children aged older than 3 months)[2]	⌘ Vomiting ⌘ Poor feeding ⌘ Lethargy ⌘ Irritability ⌘ Abdominal pain or tenderness ⌘ Urinary frequency or dysuria ⌘ Offensive urine or haematuria
Septic arthritis/ osteomyelitis	⌘ Swelling of a limb or joint ⌘ Not using an extremity ⌘ Non-weight bearing
Kawasaki disease[3]	Fever lasting longer than 5 days and at least four of the following: ⌘ Bilateral conjunctival injection ⌘ Change in upper respiratory tract mucous membranes (for example, injected pharynx, dry cracked lips or strawberry tongue) ⌘ Change in the peripheral extremities (for example, oedema, erythema or desquamation) ⌘ Polymorphous rash ⌘ Cervical lymphadenopathy

CRT: capillary refill time

RR: respiratory rate

[1] Classical signs (neck stiffness, bulging fontanelle, high-pitched cry) are often absent in infants with bacterial meningitis.

[2] Urinary tract infection should be considered in any child aged younger than 3 months with fever. See 'Urinary tract infection in children' (NICE clinical guideline, publication August 2007).

[3] Note: in rare cases, incomplete/atypical Kawasaki disease may be diagnosed with fewer features.

Fever advice for children and young people in Worcestershire

What is a fever?

A fever is an increase in body temperature. This in itself is not dangerous. Your child's body temperature is normally between 36˚C and 37˚C, variations between 0.5 and 1 degree are common.

Fevers in children are not uncommon. This leaflet provides advice on when to seek help and on what you can do to help your child feel better. Often the fever lasts for a short duration and many children can be cared for at home if the child continues to drink, remains alert and does not develop any worrying symptoms.

However, if you are worried or your child is getting worse with warning symptoms as listed in this leaflet, then you should seek the advice of a healthcare professional.

Working out the cause of the fever

If you are talking to a healthcare professional on the telephone, they will ask you questions about your child's health and symptoms. This will help them to decide if your child is best cared for at home or needs to see a healthcare professional face to face.

Sometimes your healthcare professional will not find a reason for your child's fever, even after a full examination. If your child is otherwise looking well, then treatment may not be necessary.

Most children can be safely cared for at home if otherwise well. Your healthcare professional may decide that your child needs a follow-up appointment. They will give you information on how to look for symptoms that may suggest more serious illnesses and how to get further help if they occur.

Looking after your feverish child

- Give your child plenty of drinks e.g. water or squash. If you are breastfeeding then continue as breast milk is best.
  Give babies smaller but more frequent feeds to help keep them hydrated.
- Do not worry about food if your child does not feel like eating but encourage them to drink more fluids.
- Look for signs of dehydration such as a dry mouth, lack of tears, sunken eyes, sunken fontanelle – the soft spot on your baby's head, passing less amounts of urine.
- Children with a fever should not be over or underdressed. If your child is shivering or sweating a lot, change the amount of clothes they are wearing.
- Physical methods of cooling your child such as fanning them, cold bathing and tepid sponging can cause discomfort and are not advised.
- It is not necessary to use medicines to treat your child's fever but if your child is distressed, you can help them feel better by giving them medicines like paracetamol or Ibuprofen. Always follow the instructions on the bottle to avoid overdosing your child. These medicines can make your child feel more comfortable but they do not treat the cause of the temperature.
- Check on your child regularly, including during the night, especially if your child is under 6 months old as they are at higher risk of serious infection.
- Keep your child away from nursery or school whilst they have a fever.

The tumbler test

- If a rash appears, do the tumbler test.
  Press a glass tumbler firmly against the rash. If you can see spots through the glass and they do not fade, this is called a 'non blanching rash'. If this rash is present, seek medical advice immediately to rule out serious infection.
  The rash is harder to see on dark skin so check paler areas such as the palms of hands and soles of feet.

This guide will help you to select the right service to contact. You need to regularly check your child and follow the advice below:

- ⌘ If your child becomes unresponsive
- ⌘ If your child becomes blue
- ⌘ If your child is finding it hard to breathe
- ⌘ If your child has a fit
- ⌘ If your child develops a rash that does not disappear with pressure (see the tumbler test)

You need urgent help please phone 999 or go straight to the nearest Accident and Emergency Dept.

- ⌘ If your child's health gets worse or if you are worried
- ⌘ If your child has signs of dehydration including dry mouth, no tears, sunken eyes, sunken fontanelle (soft spot on the baby's head), drowsiness and seems generally unwell
- ⌘ The temperature lasts more than 5 days and your child has not seen a health care professional
- ⌘ If your child is less than 6 months old

You need to see a doctor today. Please ring your surgery/health visitor/ community nurse/ or contact NHS111 by dialling 111 for access to the Out of Hours GP service.

If you have concerns about looking after your child at home

If you need advice please contact NHS 111

Please phone 111

Useful numbers

GP Surgery

Health Visitor

GP Out of Hours Service: Appointments allocated and booked directly via the NHS 111 service. (Open from 6.30pm to 8am on weekdays and all day and all night on weekends and bank holidays)

NHS 111: Dial 111 (24 hour telephone service)

Clinical Asssessment Tool

Child with Suspected Gastroenteritis 0-5 years

Child presenting with diarrhoea and vomiting
Assess for signs of dehydration

If all green features and no amber or red

No clinical dehydration

Preventing Dehydration:
- Continue breastfeeding and other milk feeds.
- Encourage fluid intake.
- Discourage fruit juices and carbonated drinks
- Offer Oral Rehydration solution (ORS) as supplemental fluid to those at increased risk of dehydration

Provide parents/carers with advice. Follow up by arranging a review by an appropriate health care professional.
Direct to local numbers overleaf.

If any amber features and no red

Clinical Dehydration

Depending on severity of child and social circumstances in this category based on clinical judgement

If there is blood or mucus,in the stool send mc&s. If there is a suspicion of septicaemia or if the child is immuno compromised discuss with on call Consultant Paediatrician via hospital switchboard .

*Home with advice to give oral rehydration solution over 4 hours without delay, often and in small amounts.

*Continue breastfeeding.

*Consider supplementing with usual fluids (including milk feeds/water, but not fruit juices or carbonated drinks.

*If after 2 hours child is not tolerating ORS/ vomiting parents should be instructed to attend A&E

If any red features

Clinical shock suspected or confirmed

Send child for urgent assessment in hospital setting via discussion with Paediatric Registrar.
Commence relevant treatment to stabilise baby/child for transfer if appropriate. Consider appropriate transport means (999)

*Consider admission according to clinical and social circumstance.

*Seek further advice (or refer to) Paediatric Registrar via WRH/Alex switchboard

*En-route Parents should be encouraged to give child fluids often and in small amounts (including milk feeds/water, but not fruit juices or carbonated drinks)

Traffic light system for identifying signs and symptoms of clinical dehydration and shock

	Green – low risk	Amber – intermediate risk	Red – high risk
Activity	⌘ Responds normally to social cues ⌘ Content/Smiles ⌘ Stays awake/awakens quickly ⌘ Strong normal cry/not crying	⌘ Altered response to social cues ⌘ Decreased activity ⌘ No smile	⌘ Not responding normally to or no response to social cues ⌘ Appears ill to a healthcare professional ⌘ Unable to rouse or if roused does not stay awake ⌘ Weak, high-pitched or continuous cry
Skin	⌘ Normal skin colour ⌘ Normal turgour	⌘ Normal skin colour ⌘ Warm extremeties	⌘ Pale/Mottled/Ashen blue ⌘ Cold extremeties
Respiratory	⌘ Normal breathing	⌘ Tachypnoea (ref to normal values table 3)	⌘ Tachycardic (ref to normal values table 3)
Hydration	⌘ CRT ≤ 2 secs ⌘ Moist mucous membranes (except after a drink) ⌘ Normal urine	⌘ CRT 2–3 secs ⌘ Dry mucous membrances (except after a drink) ⌘ Reduced urine output	⌘ CRT >3 seconds
Pulses/ Heart Rate	⌘ Heart rate normal ⌘ Peripheral pulses normal		⌘ Tachycardic (ref to normal values table 3) ⌘ Peripheral pulses weak
Blood Pressure	⌘ Normal (ref to normal values table 3)	⌘ Normal (ref to normal values table 3)	⌘ Hypotensive (ref to normal values table 3)
Eyes	⌘ Normal Eyes	⌘ Sunken Eyes	

CRT:capillary refill time RR: respiration rate

Gastroenteritis Advice Sheet

What is Gastroenteritis?

Gastroenteritis is inflammation of the stomach and gut that can cause diarrhoea and vomiting. Most attacks are caused by viruses, are mild, and can usually be managed at home.

What are the symptoms?

Your child may have some, or all of the following – diarrhoea, vomiting, tummy ache and fever. One of the main risks of gastroenteritis in children and especially babies is that they may become dehydrated. However by following simple advice to give fluids regularly most children can be safely managed at home. The vomiting may last up to three days, whereas diarrhoea usually lasts five to seven days and may continue for up to 2 weeks.

Your child's condition may change, and you should get further advice from your doctor or NHS 111 if your child is either:

- very hot (temperature over 39 degrees)
- not improving after 48 hours
- getting irritable or restless
- getting more thirsty despite treatment
- in constant pain from their stomach/ abdomen
- passing blood in the diarrhoea
- showing signs of dehydration (dry mouth and tongue/not passing urine/sunken eyes)

How can I help my Child?

The most important thing is to replace fluid that your child is losing through their sickness and diarrhoea. If you are breast feeding, continue with this. Try to feed little and often. If bottle feeding this should also continue, but offer extra fluids such as water or rehydration drinks, for example dioralyte and electrolade, giving small sips every few minutes (a teaspoon, or 5mls, every 5 minutes for an infant).

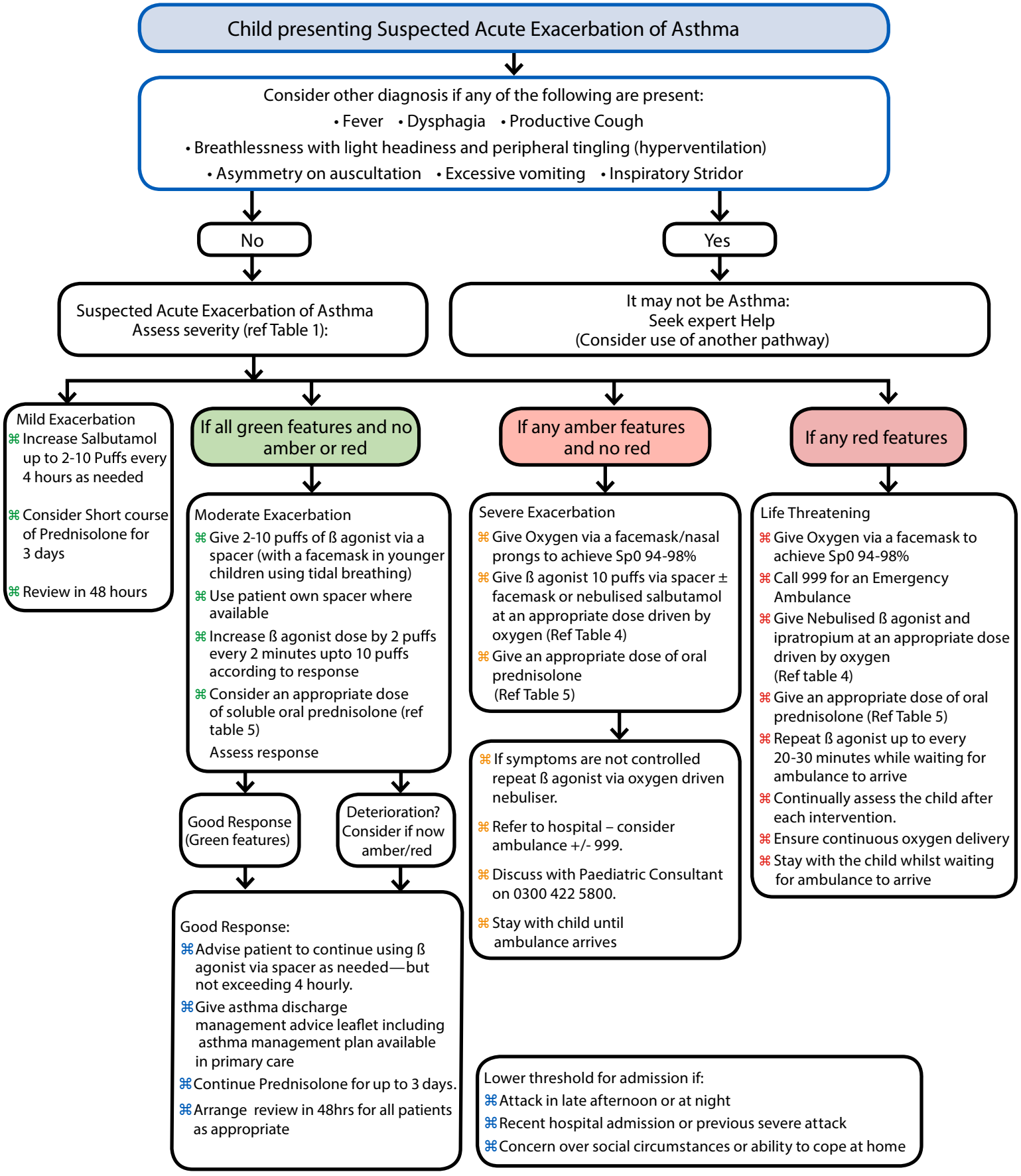
Reintroduce solid food slowly when the vomiting has settled, starting with plain foods like toast, biscuits, pasta or soup.

Things you should not do:

- Do not starve your child
- Do not give fizzy drinks or 'flat' cola
- Do not give sugary/high energy drinks
- Do not worry if your child will not eat solid food straight away

Clinical Asssessment Tool

Child with Acute Asthma 2-16 Years



Clinical Asssessment Tool continued

Child with Acute Asthma 2-16 Years

Table 1: Traffic Light system for identifying signs and symptoms of clinical dehdration and shock

	Light Green - Mild	Green – Moderate	Amber – Severe	Red – Life Threatening
Behaviour	Normal	Normal	Anxious/Agitated	Exhaustion/Confusion
Talking	In sentences	In sentences	Not able to complete a sentence in one breath	Not able
Heart Rate	Within normal range (Ref to table 2)	Within normal range (Ref to table 2)	>140 beats p/min (1-5 years) >125 beats p/min (>6 years) *Consider influence of fever &/or Salbutamol	
Respiratory	<40 breaths/min 1-5 years <30 breaths/min 6-12 years <25 breaths/min 12-16 years	<40 breaths/min 1-5 years <30 breaths/min 6-12 years <25 breaths/min 12-16 years	Rate>40 Breaths/min 1-5 years Rate>30 Breaths/min >6 years Silent Chest	
Sa02	≥95% in air	≥92% in air	<92% in air	
PEFR	>70% expected	>50% of predicted (Ref to table 3)	33-50% of predicted (Ref to table 3)	<33% of predicted (Ref to table 3)

CRT: capillary refill time RR: respiration rate

Table 2: Normal Paediatric Values: (Based on PEWS values)

Respiratory Rate at Rest:
<1 yrs 30-40 breaths/min
1-5yrs 25-30 breaths/min
6-12yrs 20-25 breaths/min
>12yrs 10-20 breaths/min

Systolic Blood Pressure
<1 yrs 70 - 90 mmhg
1-5yrs 80-100 mmhg
6-12yrs 90-110 mmhg
>12yrs 111-130 mmhg

Heart Rate
<1 yrs 100 -160 bpm
2-5yrs 90-140 bpm
5-12yrs 75-110 bpm
>12yrs 61-110 bpm

Table 3: Predicted Peak Flow: For use with EU / EN13826 scale PEF metres only

Height (m)	Height (ft)	Predicted EU PEFR	Height (m) (L/min)	Height (ft)	Predicted EU PEFR (L/min)
0.85	2'9"	87	1.30	4'3"	212
0.90	2'11"	95	1.35	4'5"	233
0.95	3'1"	104	1.40	4'7"	254
1.00	3'3"	115	1.45	4'9"	276
1.05	3'5"	127	1.50	4'11"	299
1.10	3'7"	141	1.55	5'1"	323
1.15	3'9"	157	1.60	5'3"	346
1.20	3'11"	174	1.65	5'5"	370
1.25	4'1"	192	1.70	5'7"	393

Table 4: Guidelines for nebuliser

- Significantly low sats despite inhaler and spacer use
- Oxygen Saturations persistently below 94%
- Requiring oxygen
- Unable to use volumatic/spacer device
- Severe respiratory distress

Salbutomol
2-5 years– 2.5mg, 5-12 years– 2.5-5mg, 12-16 years– 5mg

Ipratropium
under 12 years – 250micrograms,
12-18 years – 500micrograms

Table 5: Prednisolone Guideline BNF2010-2011

Give prednisolone by mouth:

Child:
1-2 mg /Kg
Maximum 40mg

BTS guidelines 2011: (if weight not available)
Use a dose of 20mg for children 2-5 years and 30-40mg for children >5years.

Asthma Advice Sheet

Name of Child ..... Age ..... Date / Time advice given .....

Further advice / Follow up .....

.....

Name of Professional ..... Signature of Professional .....

How is your child?

Red

- Drowsy
- Has severe wheeze
- Unable to speak in sentences
- Unable to take fluids and is getting tired
- Is unable to respond with loss in consciousness
- Breathless, with heaving of the chest

You need urgent help
Ring 999 – you need help immediately. If you have a blue inhaler use it now, 1 puff per minute via spacer until the ambulance arrives.

Amber

- Wheezing and breathless
- Not responding to usual reliever treatment

You need to see or speak to a doctor or nurse today
Please ring your GP surgery or call NHS 111 – dial 111

Green

- Requiring to use their reliever regularly throughout the day for cough or wheeze but is not breathing quickly
- Able to continue day to day activities
- Change in peak flow meter readings

You need to see a doctor or nurse to discuss your child's asthma.
Please ring for a non urgent appointment.

Some useful phone numbers

GP Surgery
(make a note of number here)

NHS 111
dial 111
(available 24 hrs – 7 days a week)

GP Out of Hours Service: appointments booked via the NHS 111 service
(Open from 6.30pm to 8am on weekdays and bank holidays)

For online advice: NHS Choices www.nhs.uk (available 24 hrs – 7 days a week)

To get access to this in another language or easy read please ask a member of staff.

Asthma Advice Sheet – self care

What is asthma?

Asthma is caused by inflammation of the airways. These are the small tubes, called bronchi, which carry air in and out of the lungs. If you have asthma, the bronchi will be inflamed and more sensitive than normal.

Asthma can start at any age, but it most commonly starts in childhood. At least 1 in 10 children, and 1 in 20 adults, have asthma.

In an asthma attack the muscles of the air passages in the lungs go into spasm and the linings of the airways swell. As a result, the airways become narrowed and breathing becomes difficult.

What causes asthma in children?

In young pre-school children, wheezing is usually brought on by a viral infection – causing a cold, ear or throat infection. Some people call this 'viral-induced wheeze' or 'wheezy bronchitis', whilst others call it asthma. Most children will grow out of it, as they get to school age.

In older children, viruses are still the commonest cause of wheezing. But other specific triggers may also cause an asthma attack such as:

- an allergy eg animals
- pollens and mould particularly in hayfever season
- cigarette smoke
- extremes of temperature
- stress
- exercise (However, sport and exercise are good for you if you have asthma. If necessary, an inhaler can be used before exercise to prevent symptoms from developing)

Your child MAY BE having an asthma attack if any of the following happens:

- Their reliever isn't helping or lasting over four hours
- Their symptoms are getting worse (cough, breathlessness, wheeze or tight chest
- They are too breathless or it's difficult to speak, eat or sleep
- Their breathing may get faster and they feels like they can't get your breath in properly
- Young children may complain of a tummy ache.

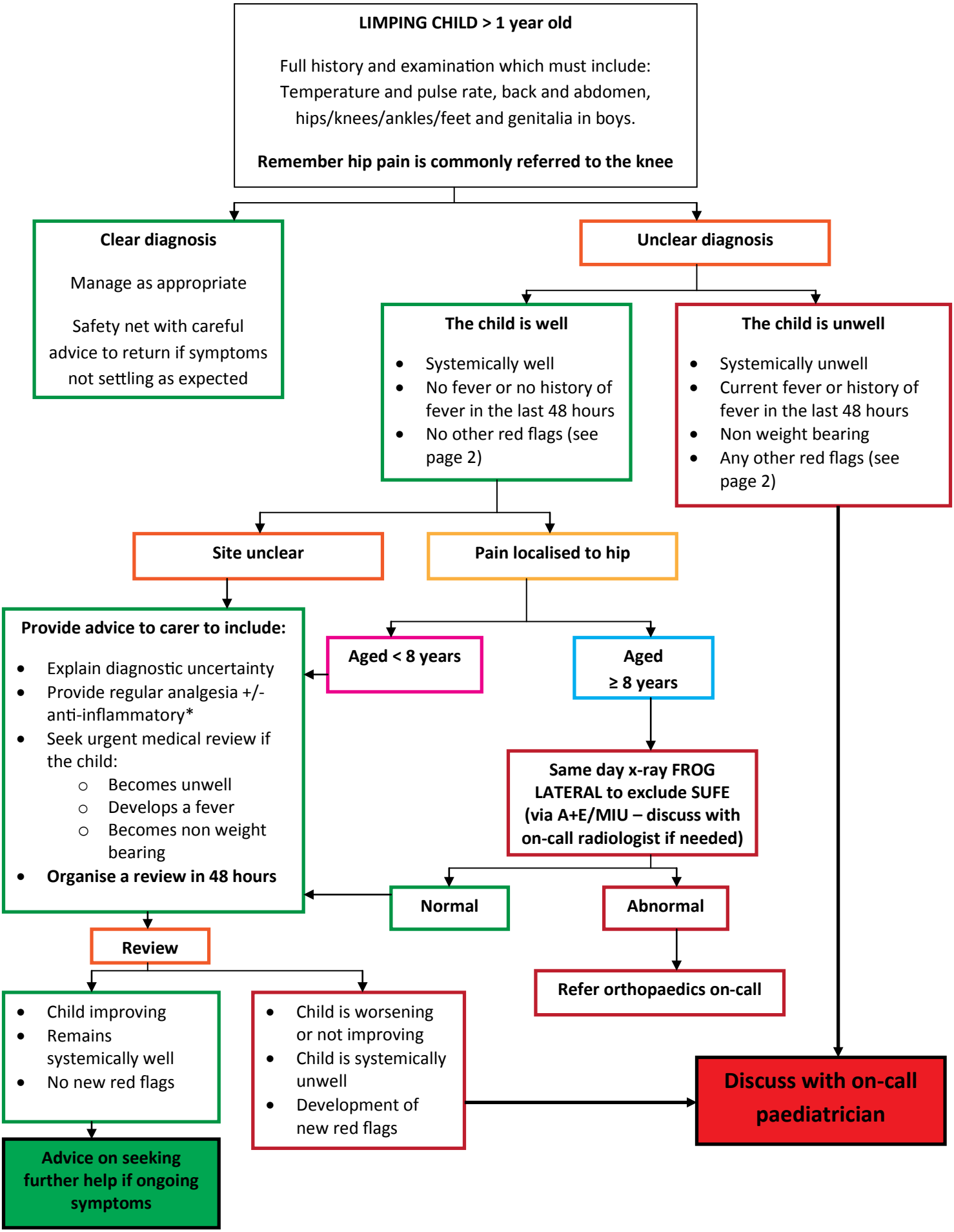
What to do if your child has an asthma attack:

1. Give your child one to two puffs of their reliever inhaler (usually blue), immediately – use a spacer if they need it.
2. Get your child to sit down and try to take slow, steady breaths. Keep them calm and reassure them
3. If they do not start to feel better, give them two puffs of their reliever inhaler (one puff at a time) every two minutes. They can take up to ten puffs
4. If they do not feel better after taking their inhaler as above, or if you are worried at any time, call 999.
5. If an ambulance does not arrive within 10 minutes and they are still feeling unwell, repeat step 3.

If your child's symptoms improve and you do not need to call 999, you still need to take them to see a doctor within 24 hours of an asthma attack.

Most people who have asthma attacks will have warning signs for a few days before the attack. These include having to use the blue reliever inhaler more often; changes in peak flow meter readings, and increased symptoms, such as waking up in the night. Don't ignore these warning signs, as they indicate that your child's asthma control is poor and they risk having a severe attack.

THE LIMPING CHILD



LIMPING CHILD

RED FLAGS

Non-accidental injury	Consider the possibility. Initiate child protection guidance
General	Fever, systemic upset, non-weight bearing
Malignancy	Night or rest pain, pallor or bruising, organomegaly, lymphadenopathy
Haematology	Known or suspected sickle-cell disease
Orthopaedic	Leg length discrepancy, severely reduced range of movement
Rheumatology	Multiple joints affected
Sepsis	Immuno-compromise

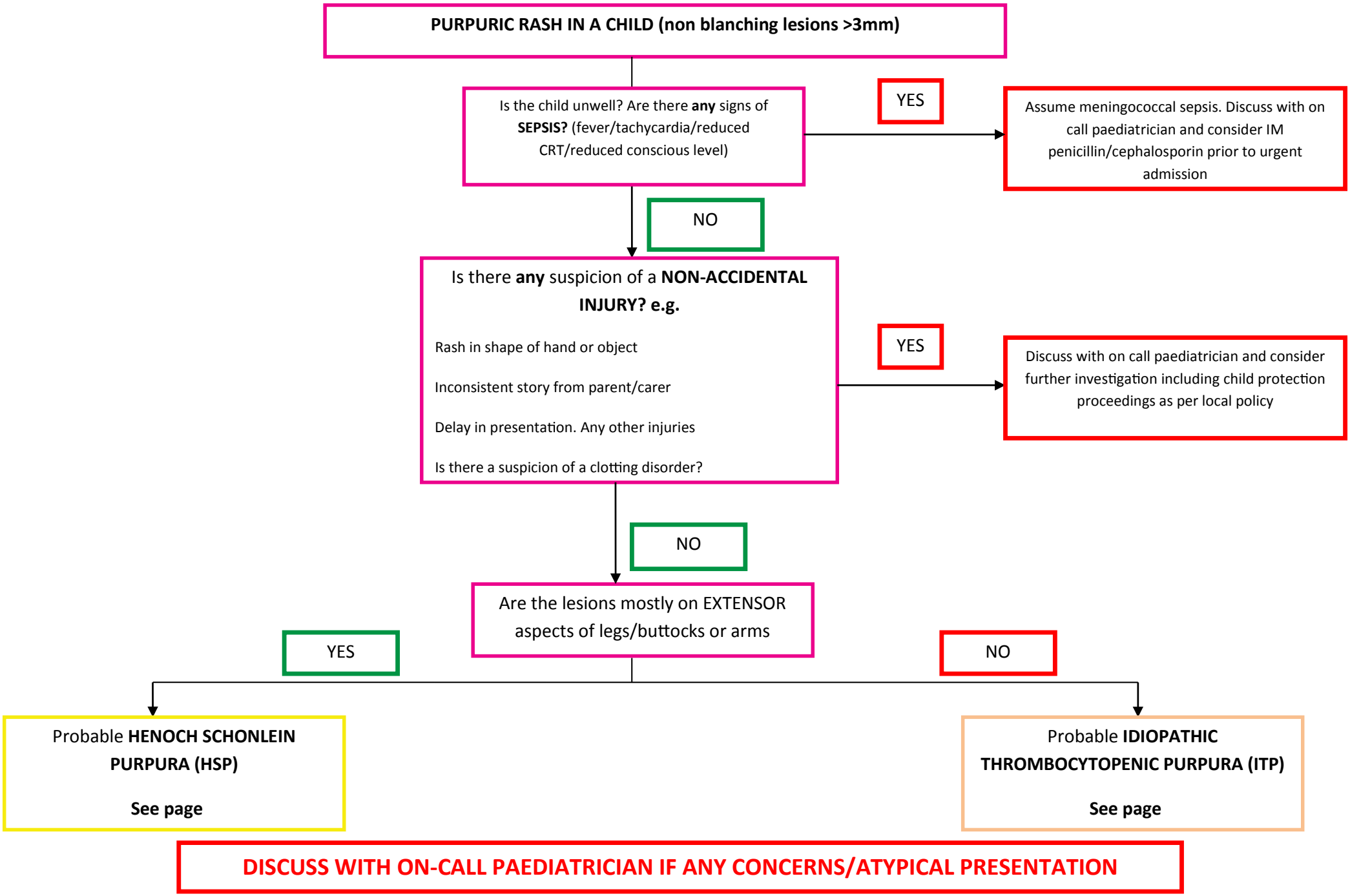
Differential diagnoses

Transient synovitis ("Irritable hip")	Age range: 2-10 years Often history of preceding viral illness Acute onset and child can usually walk but with pain Child otherwise usually systemically well Mild-moderate reduction in hip movements
Perthe's Disease	Age range: 4-8 years. Boys > girls Hip or **knee** pain Similar presentation to transient synovitis but fails to settle with time
SUFE (Slipped Upper Femoral Epiphysis)	Age range: 10-18 years. Boys> girls Often overweight children or rapidly growing Can be triggered by minor trauma May present as hip or **knee** pain FROG LATERAL x-ray required to rule this out
Septic arthritis	Age range: any age. Severe pain in hip or joint Systemic symptoms Severe reduction in range of movement
Others to consider	Non accidental injury – be alert Osteomyelitis – pain more localised, systemic symptoms, risk factors Foreign body – in foot for instance Malignancy – e.g. leukaemia. Consider red flags Testicular torsion – always examine genitalia in boys, Acute abdomen

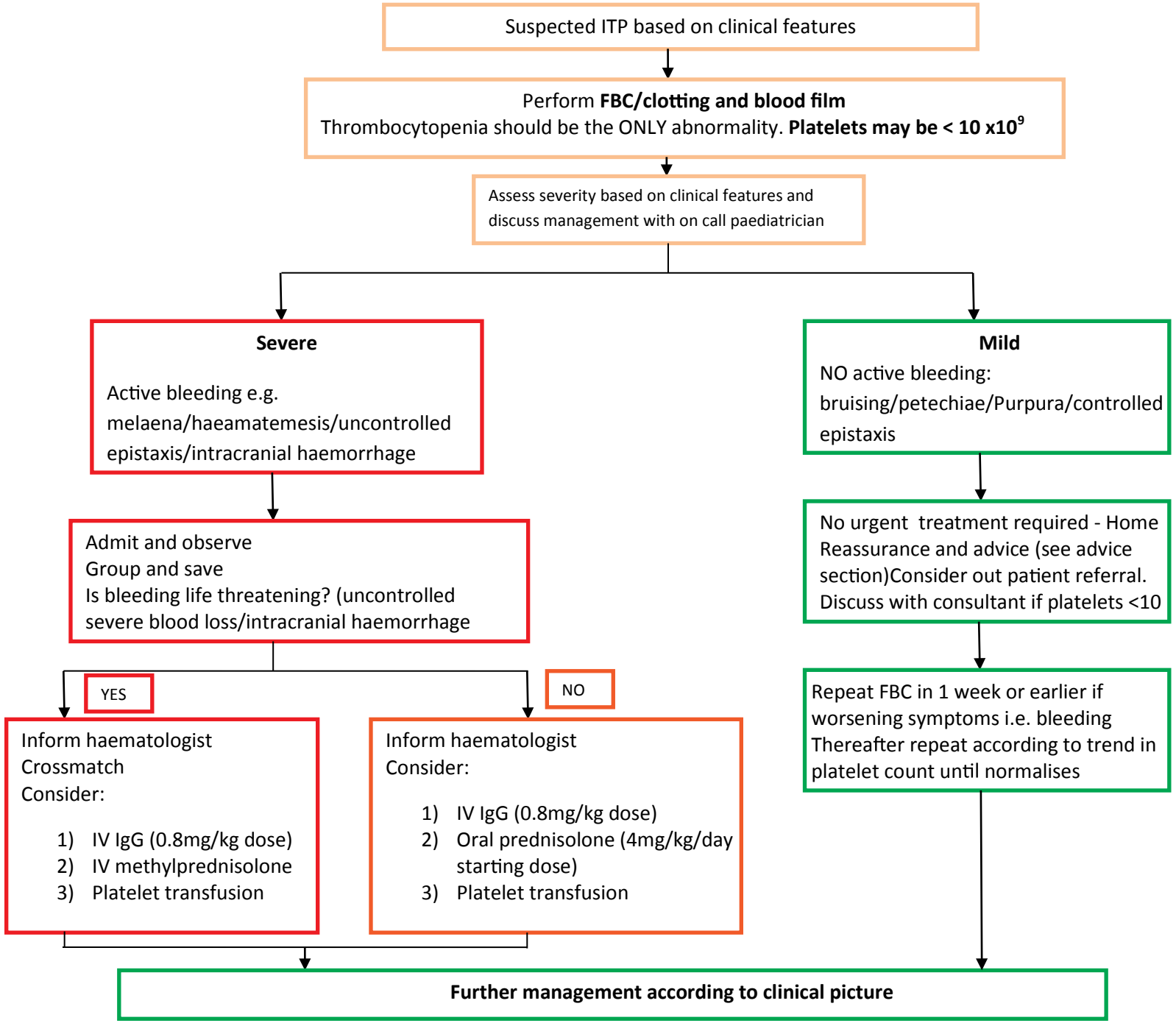
***ANALGESIA/ANTI-INFLAMMATORY DOSES**

Paracetamol:	**Ibuprofen:**
Child 6 months-2 years: 120mg QDS PRN	Child1-4 years: 100mg TDS PRN
Child 2-4 years: 180mg QDS PRN	Child 4-7 years: 150mg TDS PRN
Child 4-6 years: 240mg QDS PRN	Child 7-10 years: 200mg TDS PRN
Child 6-8 years: 250mg QDS PRN	Child 10-12 years: 300mg TDS PRN
Child 8-10 years: 360-375mg QDS PRN	Child 12-18 years: 300-400mg TDS PRN
Child 10-12 years 500mg QDS PRN	
Child 12-16 years – 500-750mg QDS PRN	

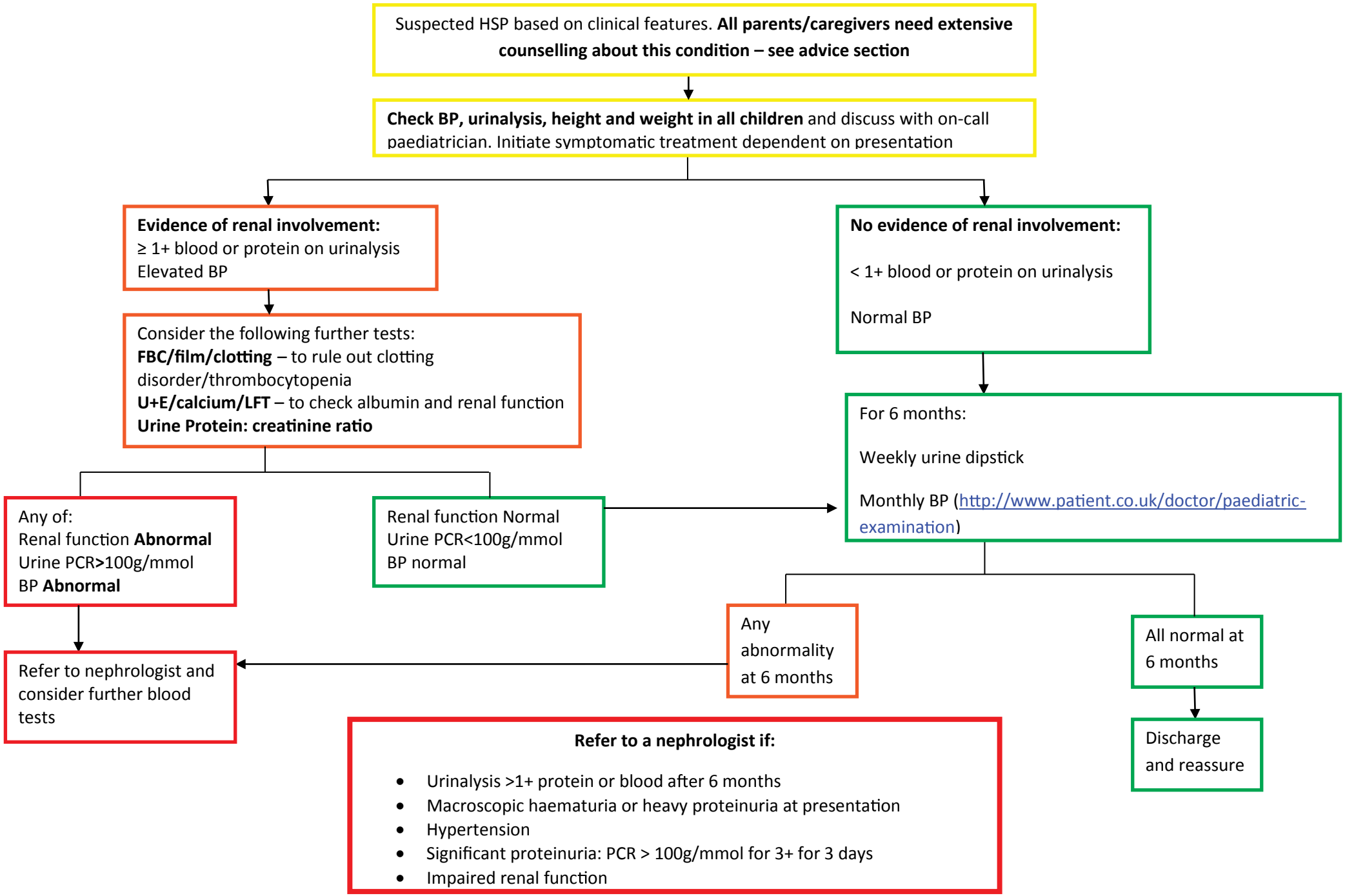
PURPURIC RASHES IN CHILDREN – ITP AND HSP GUIDELINE



Idiopathic Thrombocytopenic Purpura (ITP)



Henoch Schonlein Purpura (HSP)

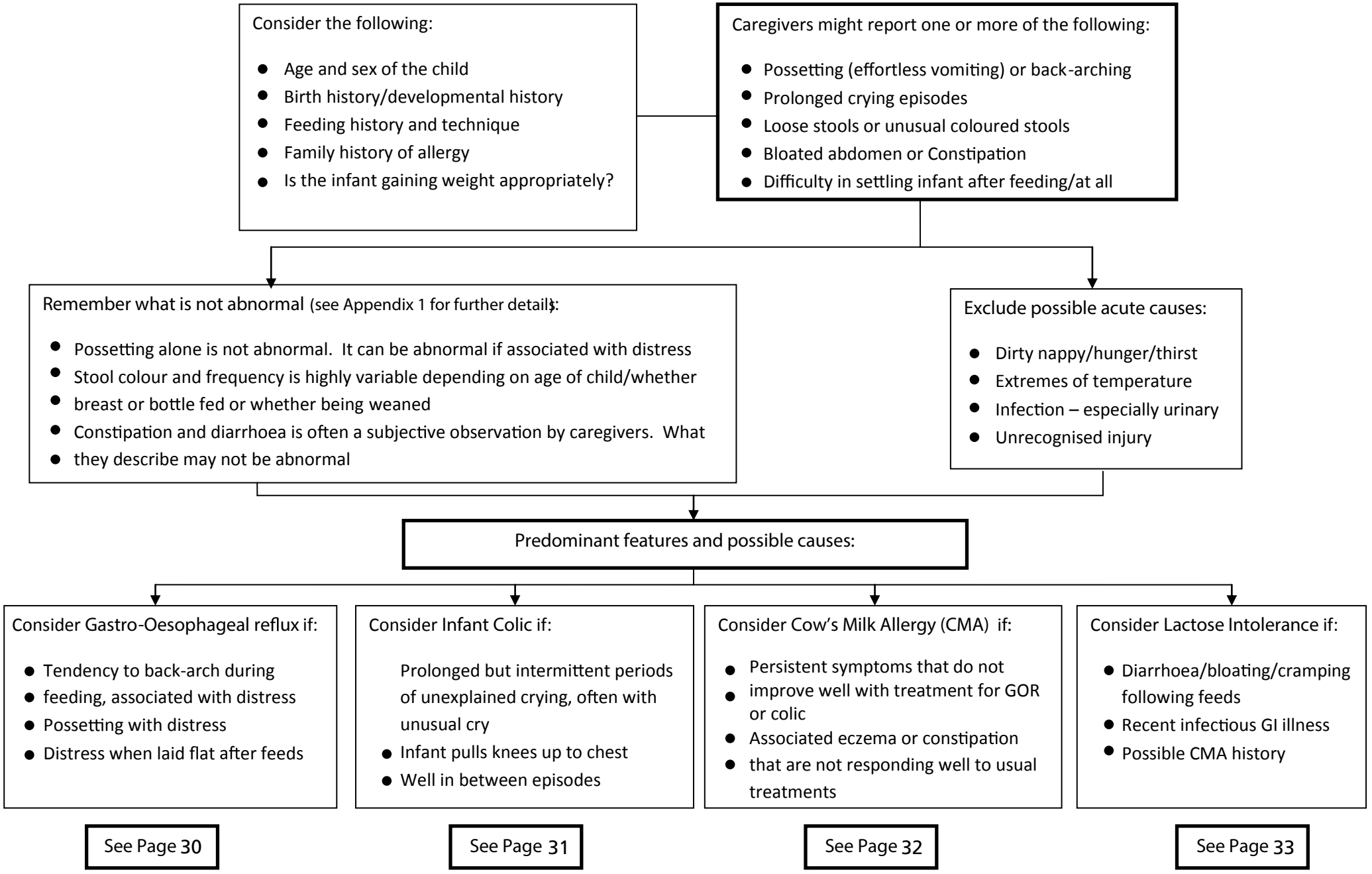


HSP AND ITP – some background and information

Definition	HSP	ITP
	Vasculitic condition of unknown aetiology 50% have URTI preceding Affects skin, gastrointestinal tract, joints and renal tract Typical age group 2-8 years old	Platelets <100 x 10^9/L, usually <20 x 10^9/L Good prognosis Typical age group 2-10 years old
Signs & Symptoms	**Rash:** • Purpuric, raised on extensor surfaces of legs, buttocks and arms, with surrounding erythema **Gastrointestinal tract:** • Abdominal pain mostly idiopathic, typically resolves in 72 hours ➢ If severe or persistent, exclude intussusception, testicular torsion or pancreatitis (rare) • Nausea and vomiting • Intestinal haemorrhage: hematemesis, melaena, bloody stools (rare) **Joints:** • Arthralgia and swelling of large joints, especially ankles and knees. Pain typically resolves in 24-48 hours. **Renal:** • Microscopic haematuria • Proteinuria can present 4-6 weeks after initial presentation • Hypertension • Nephritic syndrome: haematuria with at least one of following ➢ Raised urea and creatinine ➢ Hypertension ➢ Oliguria • Oedema of hands, feet, sacrum and scrotum **Neurological:** • Headache (common) • Seizures, paresis, coma (rare)	**Rash:** Acute onset bruising, purpura and petechiae Serious mucosal bleeding unusual, look for other causes Preceding infection **No:** Hepatosplenomegaly Lymphadenopathy Evidence of serious cause/chronic underlying illness
Investigations	BP (link to normal values http://www.patient.co.uk/doctor/paediatric-examination) Urine dipstick ➢ If proteinuria, send urine for early morning protein: creatinine ratio ➢ If haematuria, send urine for microscopy	FBC , blood film & clotting Sampling by trained nurse or via children's clinic

Definition	HSP	ITP
Immediate Treatment	Condition is self-limiting, symptomatic treatment only **Joint Pain:** NSAIDs (ibuprofen first-line, indomethacin or diclofenac second-line. **Abdominal pain:** ● Give prednisolone 1 mg/kg/day for 2 weeks.	Self-limiting resolve 6 months If significant bleeding (e.g. uncontrollable epistaxis, GI haemorrhage, intracranial bleed), give: ➢ Platelet transfusion ➢ Immunoglobulin ➢ Consider tranexamic acid for small bleeds ➢ Avoid NSAIDs
Monitoring	**Uncomplicated HSP:** (e.g. urine analysis ≤1+ blood and protein, and normal BP) • Monthly BP for 6 months and weekly urine dipsticks at home until urine clear. **Complicated HSP:** • >1+ blood and protein • Raised BP • Refer to Children's outpatient	FBC , blood film monthly until diagnosis clear or recovery Discharge when platelets >100 x10(9)L
Advice to parents/caregivers	Reassure most children recover fully from this condition Careful monitoring is required for several months. There is a rare risk of renal failure so this needs highlighting. The condition may fluctuate for several months but recurrence is rare once properly settled Seek medical advice if child develops headache/PR bleeding or severe abdominal pain	Reassurance is important. Most patients can live comfortably with petechiae etc whilst awaiting remission. Advise against contact sports or activities with a high risk of head trauma Avoid NSAIDS and IM injections Families should be given careful safety netting and a 24 hour phone number to call for advice Contact details for the ITP support association should be given and a leaflet can be downloaded from this site: http://www.itpsupport.org.uk

Management of the Unsettled Infant Where the Cause is Thought to be Related to Feeding



See Page 30 | See Page 31 | See Page 32 | See Page 33

Suspected Gastro-oesophageal Reflux

Red Flags

- Recurrent, forceful (projectile vomits) – might suggest PYLORIC STENOSIS
- Blood stained vomitus or stool
- Melaena
- Abdominal distension or bile-stained vomitus
- Weight loss

Common Symptoms

- Posseting with distress
- Distress when laid flat
- Tendency towards back-arching during feeding

→ **RED FLAGS PRESENT** → Discuss with on-call paediatrician

↓ **No RED FLAGS**

Give advice/reassure and provide leaflet via EMIS Web or http://www.patient.co.uk/health/childhood_-gastro-oesophageal-reflux-leaflet

Bottle fed infants

Step 1

- Review the feeding history and consider advice only
- Consider reducing feed volume if excessive as per weight
- Consider more frequent, small feeds
- Offer trial of thickened formula (e.g. containing rice starch/cornstarch/carob gum)

Step 2

- Trial of alginate therapy (e.g. Gaviscon®) for 1-2 weeks

Step 3

- Consider a 4 week trial of acid suppression therapy for any non-verbal child with overt regurgitation and 1 or more of:
  - Distressed behaviour
  - Faltering growth
  - Unexplained feeding difficulties (choking/refusing feeds)

Step 4

Do not prescribe domperidone, metoclopramide or erythromycin without discussion with a specialist
Consider paediatric outpatient referral

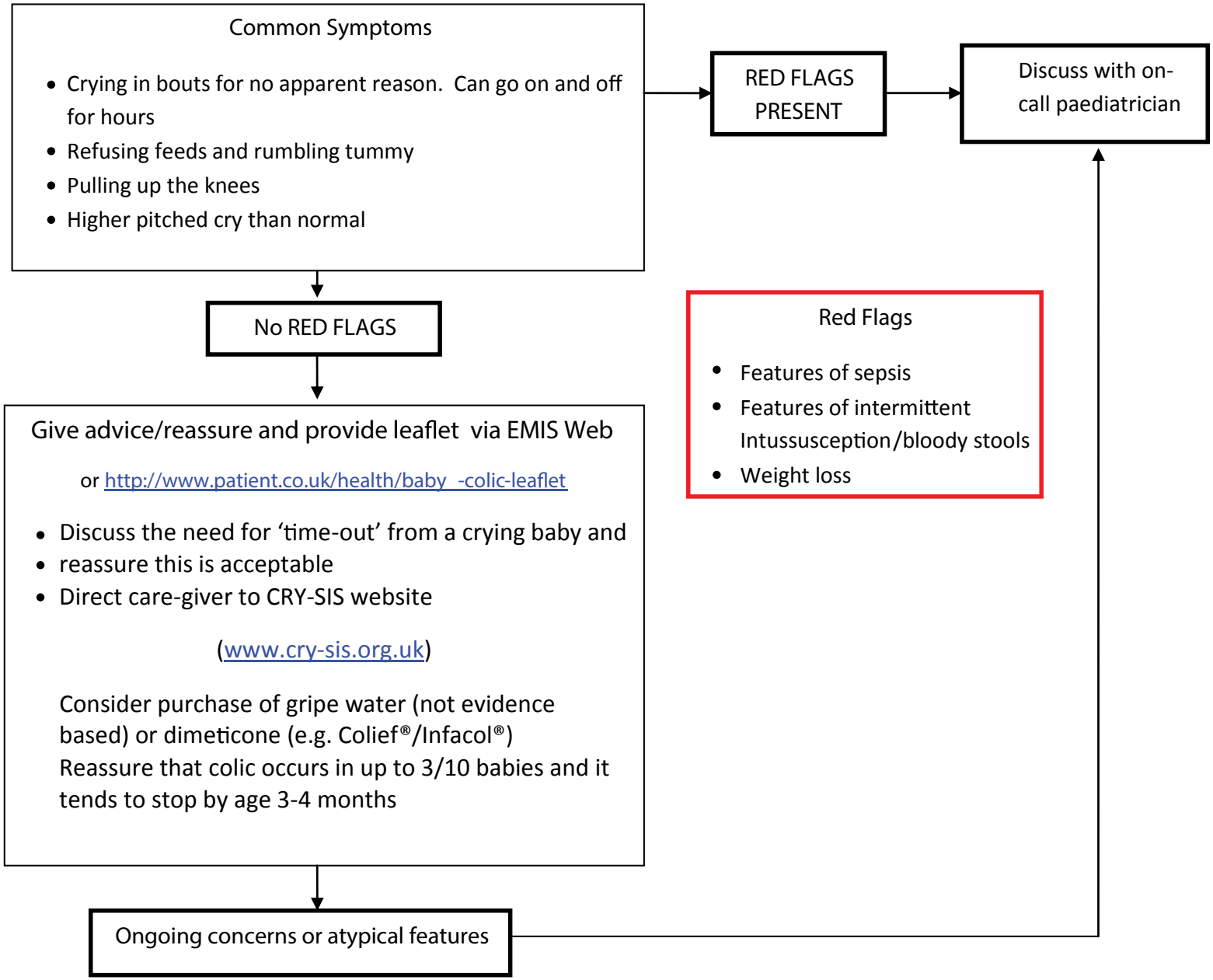
Breast fed infants

Step 1

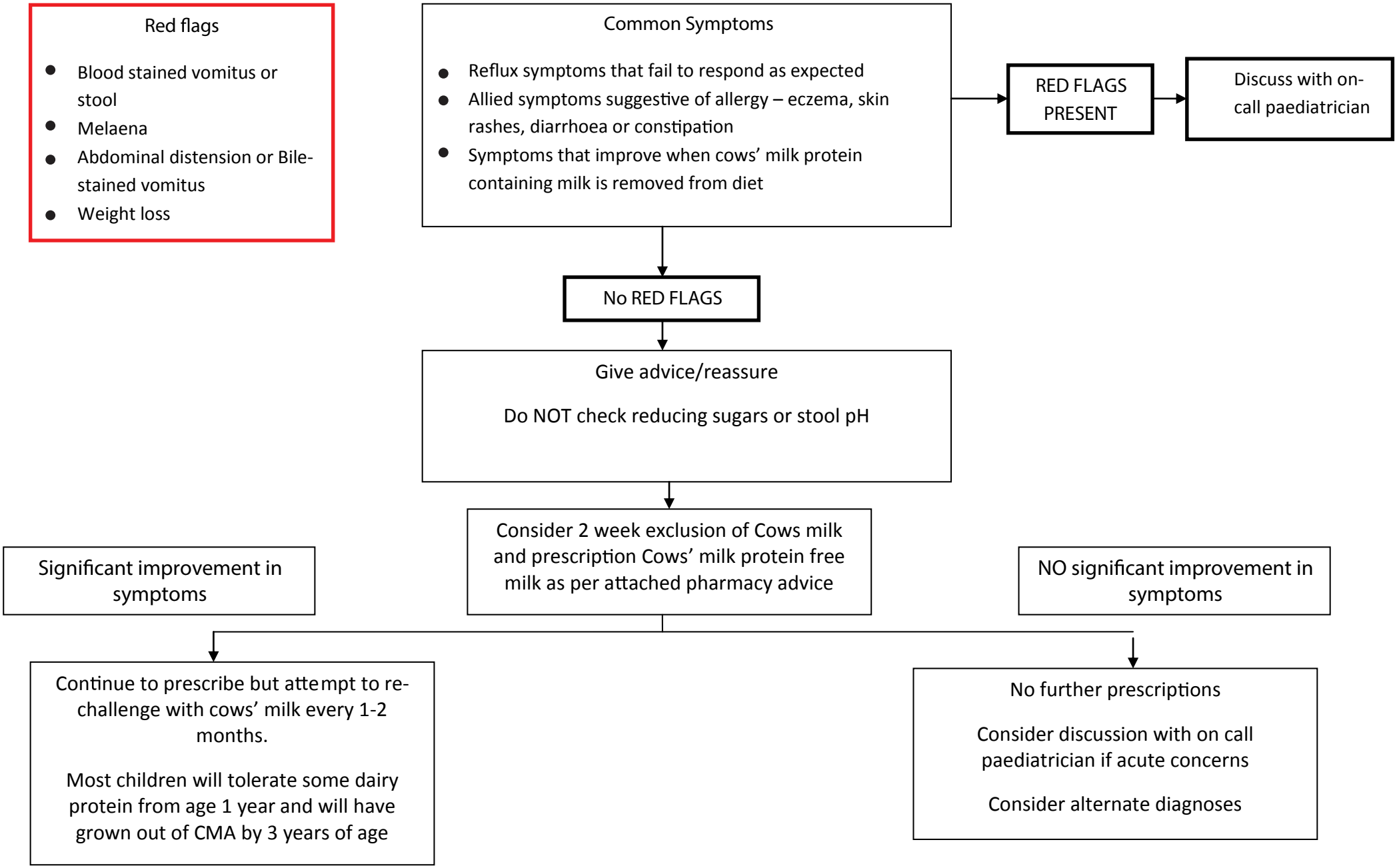
- Ensure breast feeding support is available

Continue any successful management and move to next step if unsuccessful

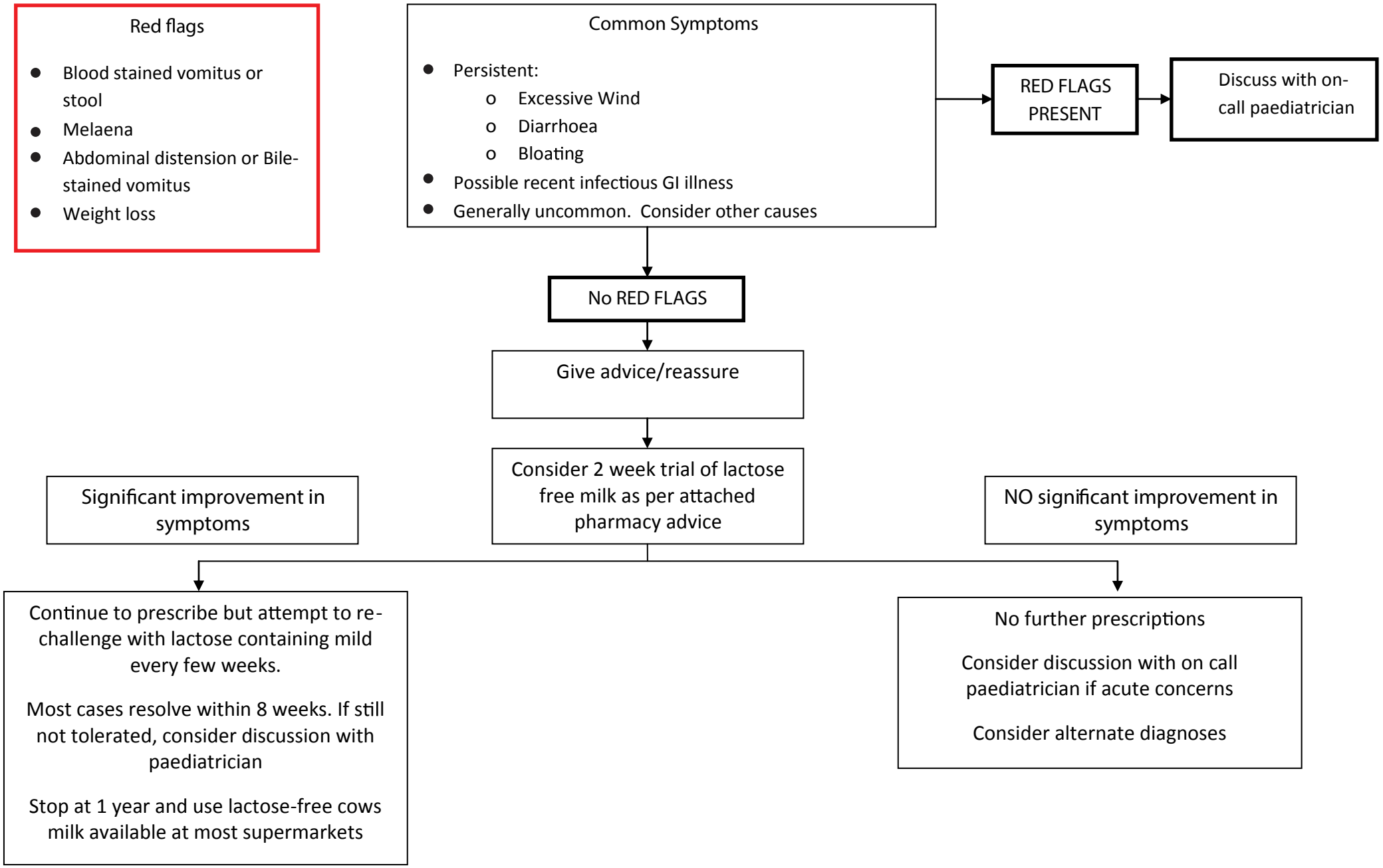
Suspected Infant Colic



Suspected Cow's Milk Protein Allergy (CMA)



Suspected Lactose Intolerance



Prescribing Infant Formula Milk in Primary Care				
Type of milk	Indication	Preferred choices	Prescribe/ Purchase	Review/ stopping
Extensively Hydrolysed Formula (eHF)	Cow's milk allergy (CMA)	Lactose –free: Nutramigen Lipil 1® 0- 6 months Nutramigen Lipil 2® 6 months to 2 yrs Lactose –containing: Aptamil-Pepti 1® 0- 6 months Aptamil- Pepti 2® 6 months to 2 yrs	Prescribe*	See guideline
Lactose-free milk	Lactose intolerance is rare Check allergy - focused clinical history: could this be CMA?	SMA LF® Enfamil-o-Lac®	Prescribe*	See guideline Stop at age 1 year – use lactose- free full fat cow's milk available from supermarkets.
Soya formula	Lactose intolerance Alternative to lactose- free formula in babies over 6 months. <u>Not for use in babies under 6 months due to high phyto- oestrogen content.</u>	Wysoy	Purchase†	On specialist recommendation only Do not use for longer than 8 weeks without review -symptoms usually resolve within this time. Re-challenge with lactose-containing products. If still not tolerated refer to paediatrician. Stop at age 1 year – use lactose- free full fat cow's milk N.B Infasoy was discontinued in April 2015

Prescribing Infant Formula Milk in Primary Care				
'Anti-reflux' formula milk (requires a large hole, fast-flow teat)	Reflux	Various over the counter brands (Cow & Gate® Anti-reflux, Aptamil® Anti-reflux)	Purchase†	Once vomiting resolves, trial standard formula. If not tolerated straight away trial again in 2 to 3 months. Infants are likely to have grown out of reflux by 18 months
Thickening agents Added to usual formula milk or given pre-feed using a spoon) (do not use together with pre-thickened formula or PPI)	Reflux where vomiting is predominant feature	Gaviscon Infant® Carobel®	Prescribe*	2 week trial
Pre-thickened Formula (do not use together with thickening agent or PPI)	Reflux where vomiting is predominant feature	SMA Staydown® Enfamil AR®	Prescribe*	2 week trial
'Comfort' milk Formula Colic relief products	Colic	Various brands (eg Apatamil Comfort, Cow & Gate Comfort, SMA Comfort) Colief Infacol	Purchase†	Although the evidence base for these products is not strong, some babies may obtain relief. Parents may buy if they wish to. Advise to stop treatment if no sustained improvement.

Formula Milk started by specialist- i.e. Paediatrician/ ANP/Dietician Only avaliable on prescription*

Type of milk	Preferred choices	Indication	Review
Amino-acid Formula (AFF)	Nutramigen PURAMINO® from birth Neocate LCP® from birth Neocate Active® / Neocate Advance® from 1 year	Cow's Milk Allergy when eHF not tolerated High calorie formula- not required automatically by all infants over 1 year	As per eHF milk (see page 1)
Extensively Hydrolysed Formula with medium chain triglycerides	Pregestimil Lipil® from birth Pepti – Junior® from birth	Cow's Milk Allergy when accompanied by malabsorption	As per eHF milk (see page 1)
Pre-term Formula	Nutriprem 2® SMA Gold Prem 2®	Pre-term for babies born before 34 weeks gestation (should not be used in primary care to promote weight gain in term infants)	Monitor growth (weight, length and head circumference). Use up to 6 month corrected age (i.e. six months plus the number of weeks premature added on). Stop if there is excessive weight gain. Neonatal vitamins and iron will be needed if stopped before 6 months corrected age. Continue with standard formula or follow on formula
High energy formula	SMA High Energy® Infatrini®	Faltering growth (cannot be detected without using a growth chart)	Monitor growth (weight, length and head circumference). Use until 18 months or 8kgs.

Prescribing Advice - All Milk

Where formula milk is widely available without a prescription parents are encouraged to buy (†)

Initial prescriptions – prescribe 1 or 2 tins initially to ensure tolerance/compliance is achieved.

Make parents aware from the beginning of how long the milk is likely to be needed

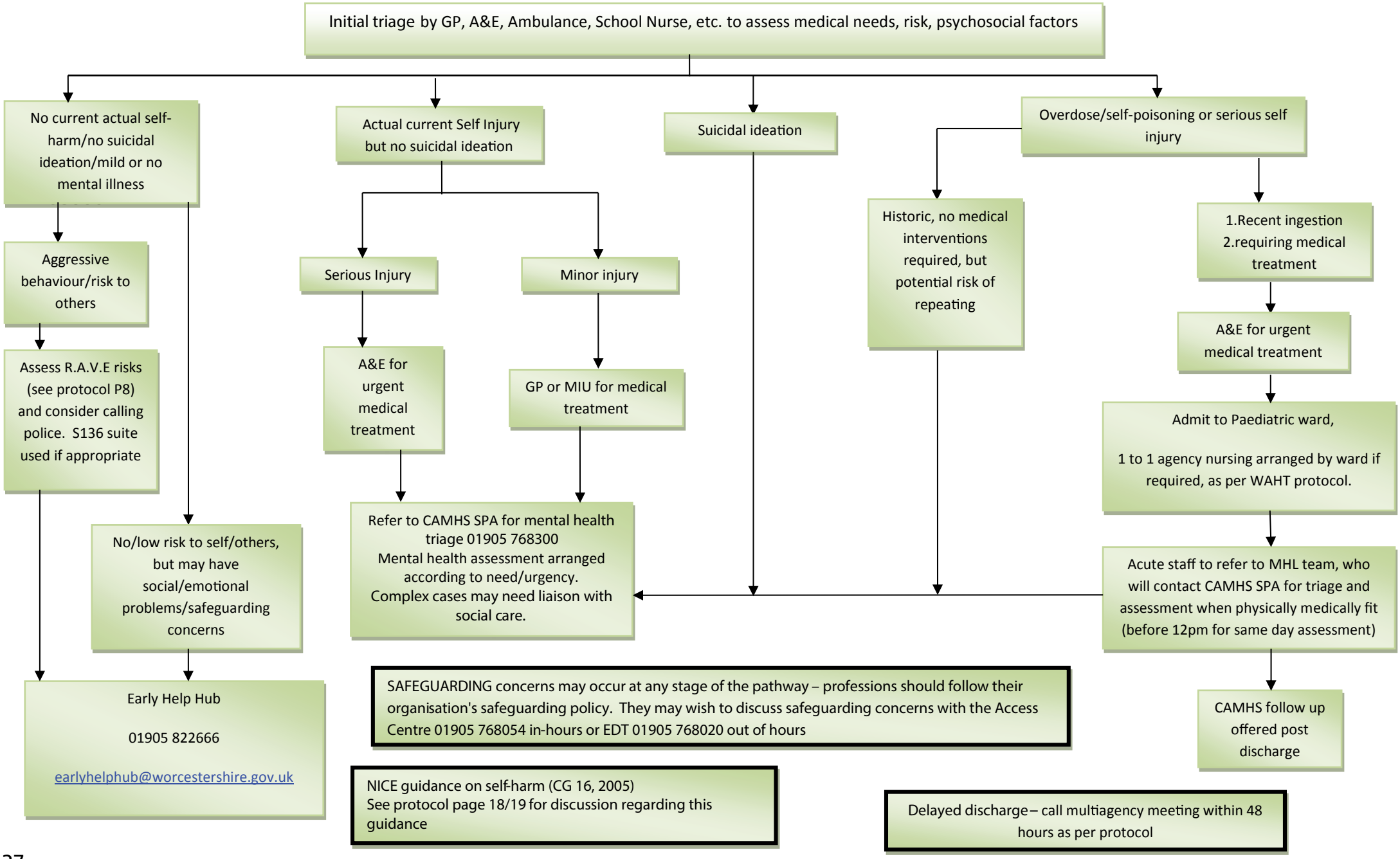
Avoid adding to the repeat prescription unless a review process is agreed. A 'review' or 'stop' date should be stated at the time of each prescription.

Do not prescribe liquid in cartons unless clinically indicated by specialist.

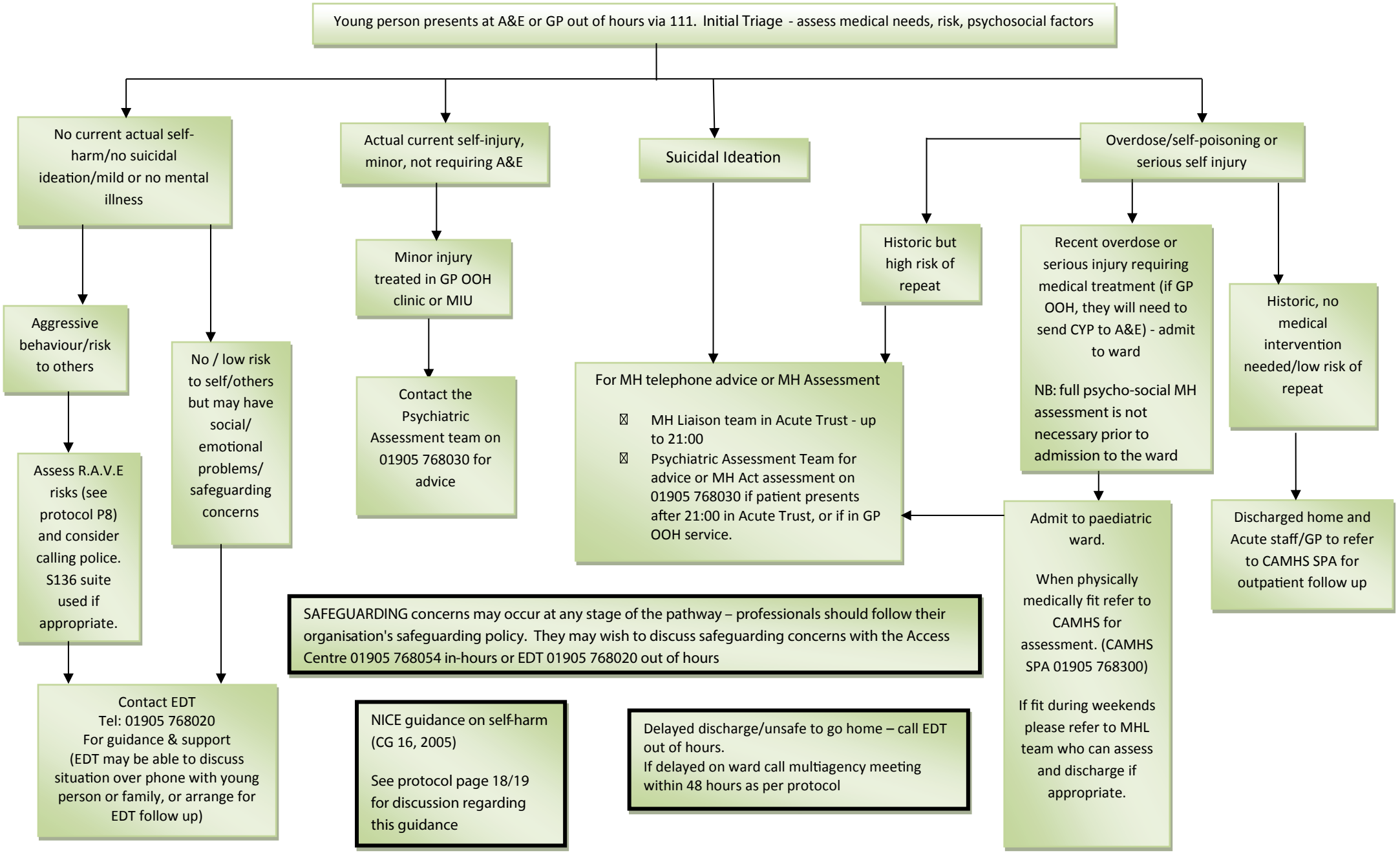
*Quantities of Formula Milk to Prescribe

Age	Amount of formula to prescribe for 28 days	Rationale
0-6 months	13 x 400g tins or 6 x 900g tins	Exclusively formula fed drink around 150ml/kg/day
6-12 months	7-13 x 400g tins or 3-6 x 900g tins	Formula requirement reduces as solid intake increases
Over 1 year	7 x 400g tins or 3 x 900g tins	Recommended intake of milk / milk substitute is 600ml per day

Appendix 3: CYP Under 18s Urgent Mental Health Care Pathway – IN HOURS (0900 – 1700 M-F)



Appendix 2: CYP under 18s Urgent Mental Health Care Pathway - OUT OF HOURS



References

References & Resources:

1. National Institute for Health and Clinical Excellence.NICE Clinical Guideline 16 Food Allergy in Children and Young People 2011 www.nice.org.uk
2. Venter et al. Diagnosis and management of non-IgE-mediated cow's milk allergy in infancy - a UK primary care practical guide. Clinical and Translational Allergy 2013; 3:23 http://www.ctajournal.com/content/3/1/23
3. Pediatric Gastroesophageal Reflux Clinical Practice Guidelines: Joint Recommendations of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN) and the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN).Journal of Pediatric Gastroenterology and Nutrition 49:498–547 # 2009
4. Map of Medicine. GORD in infants-primary care: http://eng.mapofmedicine.com/evidence/map/gastro_oesophageal_reflux_disease_gord_in_children_and_adolescents2.html
5. BNF April 2014
6. 'Prescribing Specialist Infant Formula in Primary Care' (January 2012); NHS Midlands and East; PresQipp Bulletin 11.
7. PrescQIPP Guide to Prescribing Specialist Infant Formulae (draft Match 2014)
8. Baby colic, Patient.co.uk www.patient.co.uk/pdf/4201.pdf CRY-SIS - support group for families www.cry-sis.org.uk
9. BDA Information sheet on milk-free diet: www.bda.uk.com/foodfacts/milkallergy
10. National Institute for Health & Clinical Excellence .NICE Pathways www.nice.org.uk
11. Royal College of Paediatrics and Child Health. Clinical Guidelines and Care Pathways (SIGN)
12. Worcestershire Acute Hospitals NHS Trust. Local Paediatric pathways for a range of Paediatric conditions
13. Other NHS organisations guidelines and protocols

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Dr Jackie Lewin, R&B and WF CCG, GP Lead for Paediatrics
Dr Andrew Short -Consultant Paediatrician ,WAHT
Dr David Lewis-Community Consultant Paediatrician, WHACT
Stephanie Court ,Childrens Nurse Consultant and Complex case manager WHACT
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The Top 10

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