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Royal Cornwall Hospitals
NHS Trust

The Big Six
Common conditions children present with for urgent care.
Clinical Guideline

V3.0

July 2019

1. Aim/Purpose of this Guideline

1.1. This Guideline is aimed to assist primary care settings when treating children and includes parental information and escalation advice.

1.2. This version supersedes any previous versions of this document.

1.3. **Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can't rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net

2. The Guidance

Please see guidance document below. (Adapted with kind permission from Gloucestershire Clinical Commissioning Group).

The Big 6

most common conditions children present with for urgent care

bronchiolitis/croup

fever

gastroenteritis

head injury

asthma

abdominal pain

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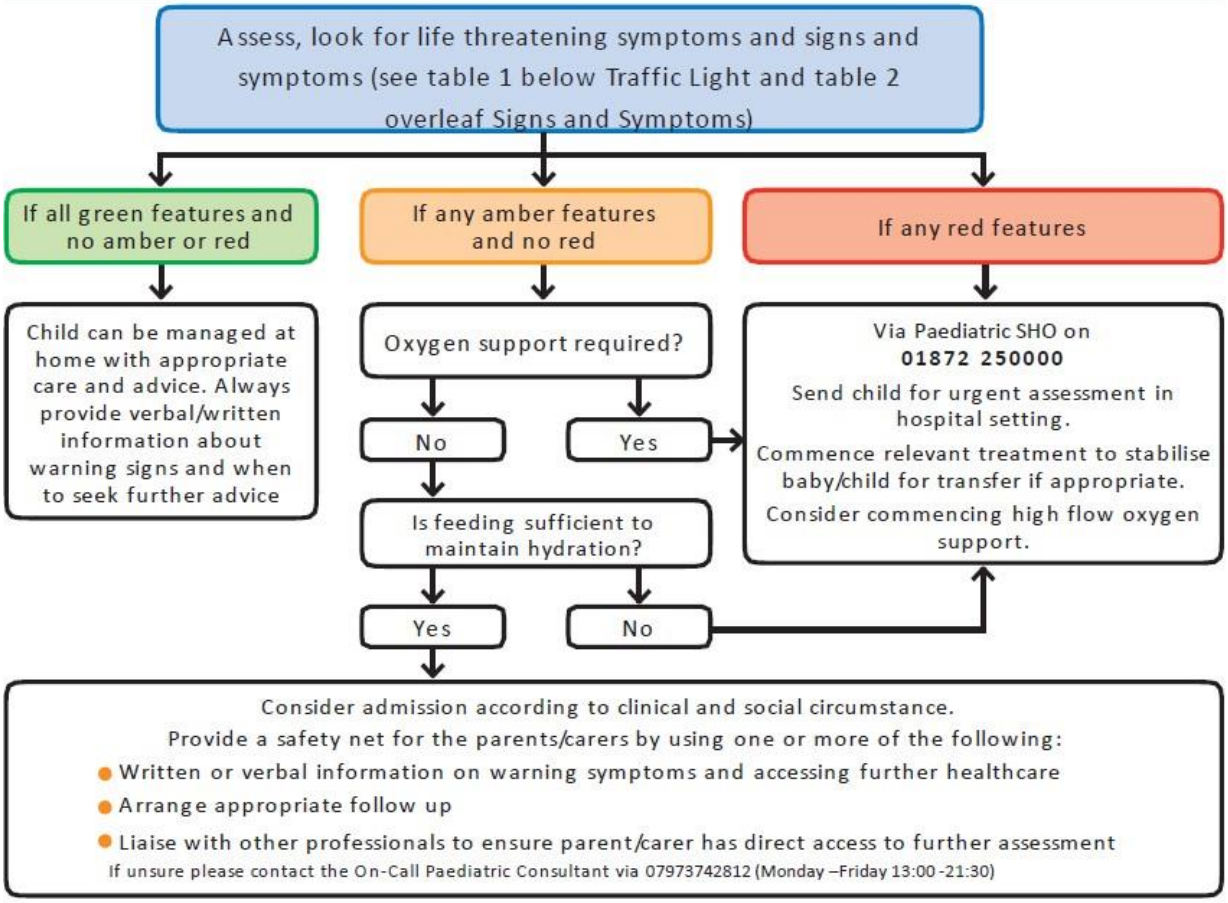

Table 1 Traffic light system for identifying severity of illness

	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 > 70 breaths/minute
SATS in air	95% or above	< 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 *Apnoea – for 10-15 secs or shorter if accompanied by a sudden decrease in saturations/central cyanosis or bradycardia
SATS: Saturation in air

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

Table 2 – Signs and Symptoms can include:

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

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 the surgery to be connected to the out of hours service (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.

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.

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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)

Royal Cornwall Hospital Trust
01872 250000
Ask for Paediatric Admissions Unit if you have been given Open Door Access

GP Out of Hours Service: Ring your GP surgery to be connected to the out of hours service.

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

If you need language support or translation please inform the member of staff to whom you are speaking.

For more copies of this document, please email:

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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?

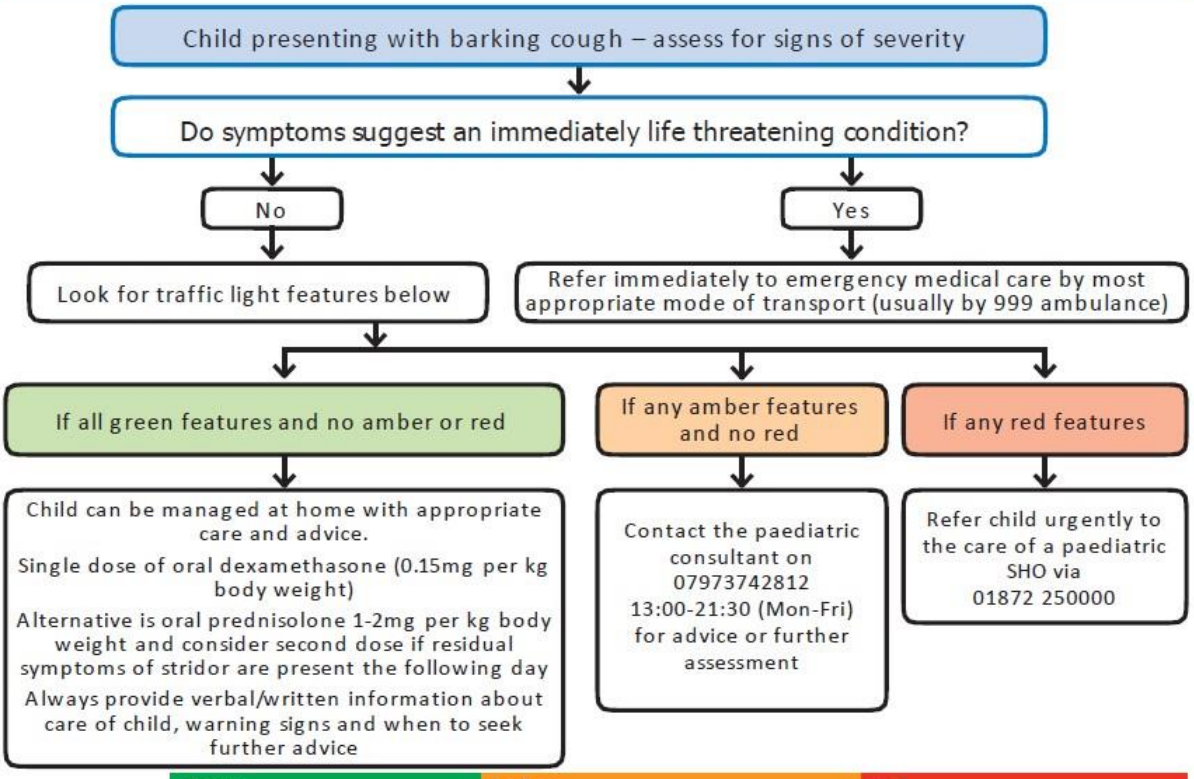
- If your baby/child is not feeding as normal offer feeds little and often.
- If your baby/child has a fever, you can give him or her paracetamol in the recommended doses. If your child is older than 6 months old you may also give Ibuprofen.
- If your baby/child is already taking medicines or inhalers, you should carry on using these. If you find it difficult to get your baby/child to take them, ask your doctor 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	–	Cyanosis, dusky appearance or extreme pallor
Activity	Child alert	Quieter than normal	Distress/agitation Decreased level of consciousness
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%	Paradoxical breathing (unsynchronised expansion of the chest and abdominal wall) Child tiring from effort of breathing
Cough	Occasional barking cough/ No stridor	Barking cough and stridor	Frequent barking cough-may reduce if impending respiratory failure
Chest recession	No chest recession	Subcostal and retrosternal recession	Marked recession of the chest wall and tracheal tug Inspiratory (and possibly expiratory) stridor persisting at rest (stridor may become quiet if in impending respiratory failure)
Circulation and hydration	CRT < 2 seconds		Tachycardia
		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	

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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

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Croup Advice Sheet – Babies/Children under 2 years

What is Croup?

Coup 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?

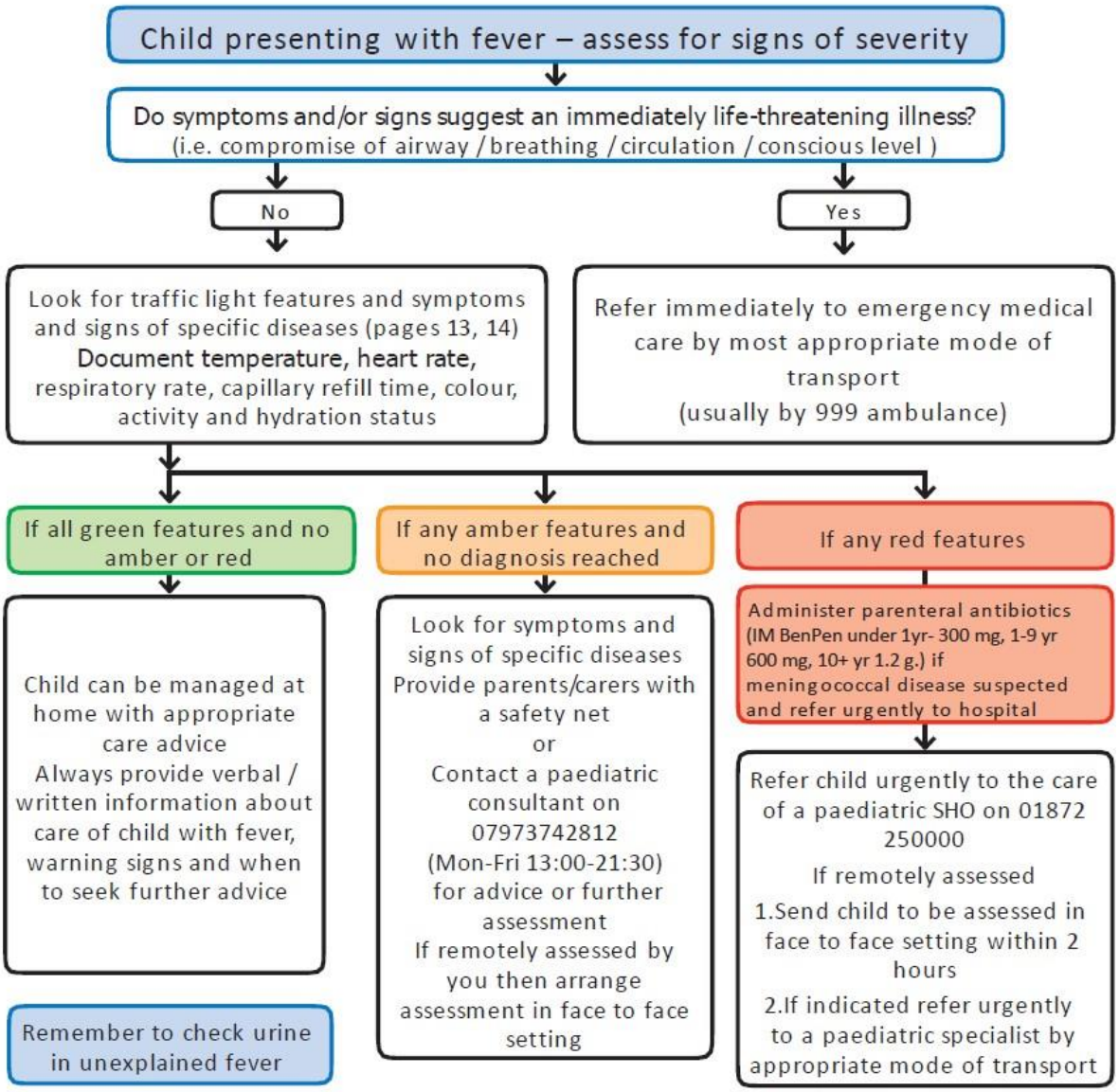
- Be calming and reassuring. A small child may become distressed with croup. Crying can make things worse
- Sit the child upright on your lap if their breathing is noisy or difficult. Let the child find a comfortable position.
- Give the child lots of cool drinks (if they are happy to take them).
- Lower the feverparticularly iftheir breathing is faster, and they are more agitated and appear increasingly unwell. 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



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Traffic light system for identifying risk of serious illness

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

CRT: capilary refill time

RR: respiratory rate

Symptoms and signs of specific illnesses

- Always check urine in unexplained fever- As pyelonephritis can present without urinary symptoms
- 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: Z An ill-looking child Z Lesions larger than 2 mm in diameter (purpura) Z CRT > 3 seconds Z Neck stiffness
Meningitis[1]	Neck stiffness Z Bulging fontanelle Z Decreased level of consciousness Z Convulsive status epilepticus
Herpes simplex encephalitis	Focal neurological signs Z Focal seizures Z Decreased level of consciousness
Pneumonia	Z Tachypnoea, measured as: - 0-5 months - RR > 60 breaths/minute - 6-12 months - RR > 50 breaths/minute - > 12 months - RR > 40 breaths/minute Z Crackles in the chest Z Nasal flaring Z Chest indrawing Z Cyanosis Z Oxygen saturation < 95%
Urinary tract infection (in children aged older than 3 months)[2]	Z Vomiting Z Poor feeding Z Lethargy Z Irritability Z Abdominal pain or tenderness Z Urinary frequency or dysuria Z Offensive urine or haematuria
Septic arthritis/ osteomyelitis	Z Swelling of a limb or joint Z Not using an extremity Z Non-weight bearing
Kawasaki disease[3]	Fever lasting longer than 5 days and at least four of the following: Z Bilateral conjunctival injection Z Change in upper respiratory tract mucous membranes (for example, injected pharynx, dry cracked lips or strawberry tongue) Z Change in the peripheral extremities (for example, oedema, erythema or desquamation) Z Polymorphous rash Z 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.

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

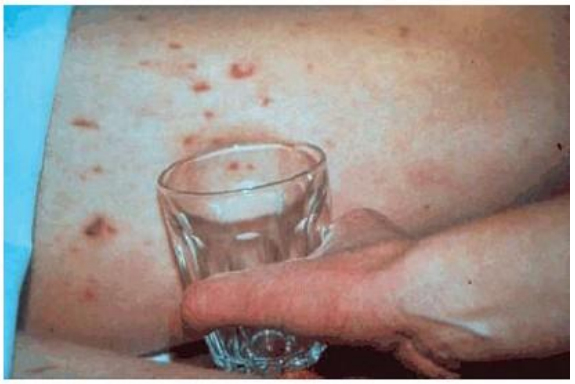
- Give your child plenty of drinks e.g. water or squash. If you are breastfeeding then continue as breast milk is best.
  Give babies smaller but more frequent feeds to help keep them hydrated.
- Do not worry about food if your child does not feel like eating but encourage them to drink more fluids.
- 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 paracetamol . Ibuprofen can be given if your child does not respond to paracetamol. 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.

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 nurse or doctor today. Please ring your surgery/health visitor/ community nurse or contact NHS 111 by dialing 111.

Useful numbers

GP Surgery

Health Visitor

GP Out of Hours Service: Contact your GP surgery to be connected to an out of hours service.

Royal Cornwall Hospitals Trust 01872 2500000

Ask for the Paediatric Observation Unit IF you have been given Open Door Access.

NHS 111: Dial 111 (24 hour telephone service)

If you have concerns about looking after your child at home

If you need advice
please contact NHS 111
Please phone 111

Clinical Asssessment Tool

Child with Suspected Gastroenteritis 0-5 years

Child presenting with diarrhoea and vomiting
Assess for signs of dehydration, see table 1 below (consider Boxes 1 and 2 overleaf)

If all green features and no amber or red	If any amber features and no red	If any red features
No clinical dehydration	Clinical Dehydration	Clinical shock suspected or confirmed
Preventing Dehydration: • Continue breastfeeding and other milk feeds. • Encourage fluid intake. • Discourage fruit juices and carbonated drinks (especially those children in Box 2) • Offer Oral Rehydration solution (ORS) as supplemental fluid to those at increased risk of dehydration (Box 2) • Refer to Box 4 for stool microbiology advice.	Depending on severity of child and social circumstances in this category based on clinical judgement (Consider Box 2) If these is blood or mucus in the stool or if the child is immunocompromised discuss with the Paediatric consultant on 07973742812 (Mon-Fri 13:00-21:30) *Home with advice to give oral rehydration solution over 4 hours without delay, often and in small amounts. See p.19 for details. *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 child needs review on Paediatric Assessment Unit (GP review may be alternative) Refer to Box 4 for stool microbiology advice *Give advice sheet	Send child for urgent assessment in hospital setting via Paediatric SHO on 01872 250000 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 consultant on 07973742812 (Mon-Fri 13:00-21:30) *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)
Provide parents/carers with advice. Follow up by arranging a review by an appropriate health care professional. Direct to local numbers overleaf.		

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

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

CRT:capillary refill time RR: respiration rate

Box 1 Consider the following that may indicate diagnoses other then gastroenteritis:

- Temperature of 38°C or higher (younger than 3 months)
- Temperature of 39°C or higher (3 months or older)
- Shortness of breath or tachypneoa
- Altered concious state
- Neck-stiffness
- Abdominal distension or rebound tenderness
- History/Suspicion of poisoning
- Bulging fontanele (in infants)
- Non-blanching rash
- Blood and/or mucus in stool
- Bilious (green) vomit
- Severe or localised abdominal pain
- History of head injury

Box 2 These children are at increased risk of dehydration:

- Children younger than 1 year, especially those younger than 6 months
- Infants who were of a low birth weight
- Children who have passed six or more diarrhoeal stools in the past 24 hours.
- Children who have vomited three times or more in the last 24 hours.
- Children who have not been offered or have not been able to tolerate supplementary fluids before presentation.
- Infants who have stopped breastfeeding during the illness.
- Children with signs of malnutrition.

Box 3 Normal Paediatric Values:

Mean Respiratory Rate:	**Mean Heart Rate:**
Infant: 40	Infant: 120-170 bpm
Toddler: 35	Toddler: 80-110 bpm
Pre-School: 31	Pre-School: 70-110 bpm
School age: 27	School age: 70-110 bpm

Box 4 Stool Microbiology Advice:

Consider performing stool microbiological investigations if:

- the child has recently been abroad or
- the diarrhoea has not improved by day 7

Some Useful Telephone Numbers

Ensure the parent/carer has the number of their GP/Practice Nurse .....

Community Nurse .....

Walk in Centre .....

NHS Direct .....

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GP Fluid Challenge Guidelines

The table below gives the normal maintenance fluid volumes based on weight for mild to moderately dehydrated children. For the first 10kg of weight- 4ml/kg /hour, for the second 10kg – 2ml/kg /hr, for all remaining kg – 1ml/kg /hr. Aim for 75-100% of the fluid volumes listed below per hour when awake, given gradually over the hour via syringe. Fluid should be clear, ideally oral rehydration solutions eg dioralyte.
If the child is breast-fed continue breastfeeding. Seek review if the patient

- Is not taking fluids
- Is not keeping fluids down
- Is becoming more unwell
- Has reduced urine output

If the assessment shows "Red" features refer patient to Paediatric Assessment Unit.

Child's weight in kg	Maintenance fluid volume – ml per hour
2	8
3	12
4	16
5	20
6	24
7	28
8	32
9	36
10	40
11	42
12	44
13	46
14	48
15	50
16	52
17	54
18	56
19	58
20	60
21	61
22	62
23	62
24	64
25	65
26	66
27	67
28	68
29	69
30	70

Child's weight in kg	Maintenance fluid volume – ml per hour
31	71
32	72
33	73
34	74
35	75
36	76
37	77
38	78
39	79
40	80
41	81
42	82
43	83
44	84
45	85
46	86
47	87
48	88
49	89
50	90
51	91
52	92
53	93
54	94
55	95
56	96
57	97
58	98
59	99

Children's Oral Fluid Challenge

Dear Parent / carer,

Your child needs to drink fluid in order to prevent dehydration.

Date .....

Name .....

ED Number/ Hospital .....

Number/ NHS Number .....

Dob.....

Weight .....

Please give your child ... ... ml of the suggested fluid, measured using the syringe provided, and given by usual method of feeding every ten minutes.

You need to tick the boxes below each time your child has a drink, and also mark down if your child vomits or has diarrhoea. Show this chart to the Doctor when your child is seen.

Thank you.

Time	Fluid given (tick please)	Vomit or diarrhoea?

Gastroenteritis (Diarrhoea and/or Vomiting) Advice Sheet (0-5 years)

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

Further advice / Follow up .....

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

How is your child? (traffic light advice)

Red

If your child:
- becomes difficult to rouse / unresponsive
- becomes pale and floppy
- is finding it difficult to breathe
- has mottled (blotchy) skin
- has diabetes and you have been unable to access specialist advice from your PDSN

You need urgent help
please phone 999 or go to the nearest Hospital Emergency (A&E) Department

Amber

If your child:
- seems dehydrated: ie. dry mouth, sunken eyes, no tears, sunken fontanelle (soft spot on baby's head), drowsy or passing less urine than normal
- has blood in the stool (poo) or constant tummy pain
- has stopped drinking or breastfeeding and / or is unable to keep down
- becomes irritable or lethargic
- their breathing is rapid or deep
- is under 3 months old

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 features are present, most children with Diarrhoea and / or Vomiting can be safely managed at home.

(However some children are more likely to become dehydrated including: children younger than 1 year old or if they had a low birth weight. In these cases or if you still have concerns about your child please contact your GP surgery or call NHS 111)

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

Most children with diarrhoea and / or vomiting get better very quickly, but some children can get worse. You need to regularly check your child and follow the advice given to you by your healthcare professional and / or as listed on this sheet.

Some useful phone numbers (You may want to add some numbers on here too)

GP Surgery
(make a note of number here)

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

Royal Cornwall Hospitals Trust
01872 250000
Ask for Paediatric Admissions Unit if you have been given Open Door Access.

GP Out of Hours Service: Ring your GP surgery to be connected to the out of hours service.

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

If you need language support or translation please inform the member of staff to whom you are speaking.

For more copies of this document, please email:

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Gastroenteritis (Diarrhoea and/or Vomiting) Advice Sheet (0-5 years)

About Gastroenteritis

Severe diarrhoea and / or vomiting can lead to dehydration, which is when the body does not have enough water or the right balance of salts to carry out its normal functions. If the dehydration becomes severe it can be dangerous. Children at increased risk of dehydration include: young babies under 1 year old (and especially the under 6 months), those born at a low birth weight, those who have stopped drinking or breastfeeding during the illness and children with malnutrition or with faltering growth.

How can I look after my child?

- Diarrhoea can often last between 5 – 7 days and stops within 2 weeks. Vomiting does usually not last for more than 3 days. If your child continues to be ill longer than these periods, seek advice.
- Continue to offer your child their usual feeds, including breast or other milk feeds.
- Encourage your child to drink plenty of fluids – little and often. Water is not enough and ideally Oral Rehydration Solution (ORS) is best. ORS can be purchased over the counter at large supermarkets and pharmacies and can help prevent dehydration from occurring.
- Your healthcare professional may recommend that you give your child a special fluid known as Oral Rehydration Solution (ORS) eg. Dioralyte. It is also used to treat children who have become dehydrated.
- Mixing the contents of the ORS sachet in dilute squash (not "sugar-free" squash) instead of water may improve the taste.
- Do not worry if your child is not interested in solid food, but offer food if hungry. It is advisable not to give fizzy drinks and/or fruit juices as they can make diarrhoea worse.
- If your child has other symptoms like a high temperature, neck stiffness or rash please ask for advice from a health care professional.
- Your child may have stomach cramps; if simple painkillers do not help please seek further advice.
- If your child is due routine immunisations please discuss this with your GP or practice nurse, as they may not need to be delayed.
- **Hand washing is the best way to stop gastroenteritis spreading.**

Based on: Diarrhoea and vomiting in children under 5, 2009 NICE clinical guideline 84 *Reference: BNF for Children Volume 1.4.2 (Page 47)

First Version: May 2011 • Final Version: Nov 2013 • Review Date: Nov 2015

After Care

Once your child is rehydrated and no longer vomiting:

- Reintroduce the child's usual food.
- If dehydration recurs, start giving ORS again.
- Anti-diarrhoeal medicines (also called Antimotility drugs) should not be given to children*.

*Reference: BNF for Children Volume 1.4.2 (Page 47)

Preventing the spread of Gastroenteritis (diarrhoea and / or vomiting):

You and/or your child should wash your hands with soap (liquid if possible) in warm running water and then dry them carefully:

- After going to the toilet
- After changing nappies
- Before touching food

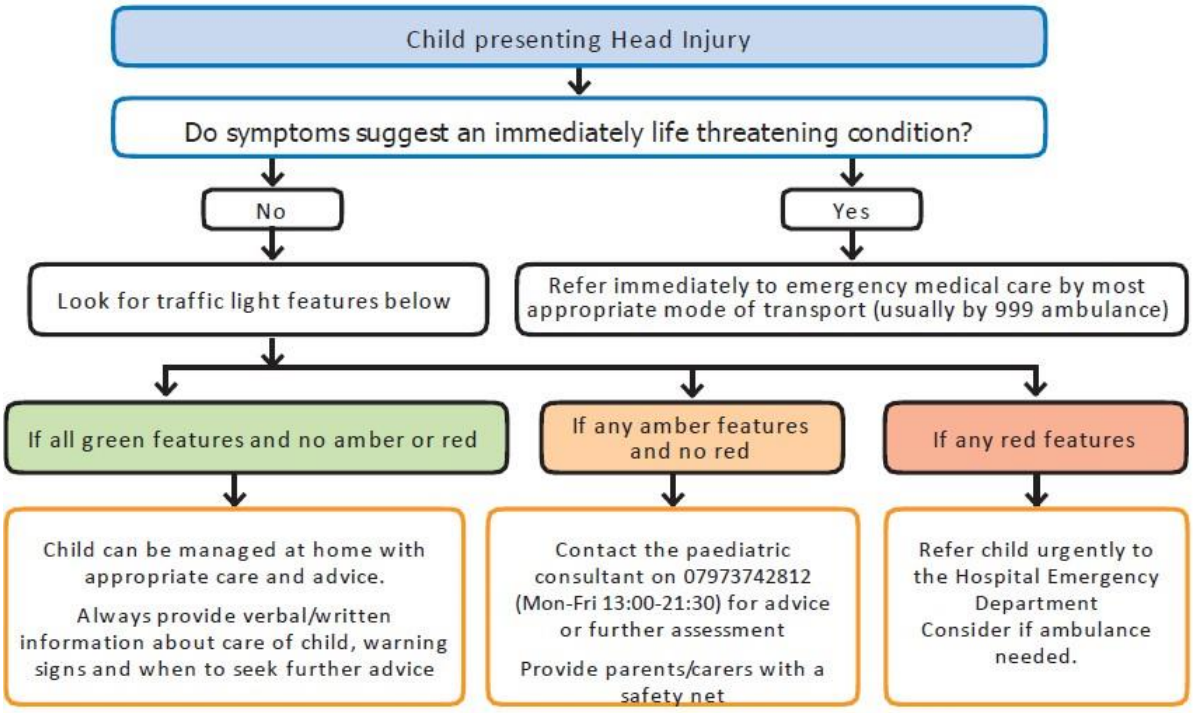
Your child should not:

- Share his or her towels with anyone
- Go to school or any other childcare facility until 48 hours after the last episode of diarrhoea and / or vomiting
- Swim in swimming pools until 2 weeks after the diarrhoea has stopped

This guidance is written in the following context: This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. 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 carer.

Clinical Asssessment Tool

Head Injury



Green	Amber	Red
Has not been knocked out at any time	Has fallen from a height greater than the child's own height	Witnessed loss of consciousness lasting more than 5 minutes
Is alert and interacts with you	Has fallen from a height greater than a metre	Amnesia lasting more than 5 minutes
Has been sick but only once	Has fallen down stairs	Abnormal drowsiness
Has bruising or minor cuts to the head	Has had a persistent headache since the injury	3 or more discrete episodes of vomiting
Cried immediately but is otherwise normal	Has a blood clotting disorder	Clinical suspicion on non-accidental injury
15 on GCS	Has consumed alcohol	Post traumatic seizure but no history of epilepsy
		Age > 1 year: GCS < 14 on assessment
		Age < 1 year: GCS (Paediatric) < 15 on assessment At 2 hours after the injury, GCS less than 15
		Suspicion of open or depressed skull injury or tense fontanelle For children under 1 year, presence of bruise, swelling or laceration of more than 5 cm on the head. Any sign of basal skull fracture (haemotympanum, "panda" eyes, cerebrospinal fluid leakage from ears or nose, Battle's sign) Focal neurological deficit
		Dangerous mechanism of injury (high speed road traffic accident, fall from >3m, high speed injury from a projectile or an object)

Glasgow Coma Scale – assess child against scale. The lowest possible GCS (the sum) is 3 (deep coma or death), while the highest is 15 (fully awake person).

	1	2	3	4	5	6
Eye	Does not open eyes	Opens eyes in response to painful stimuli	Opens eyes in response to voice	Opens eyes spontaneously	N/A	N/A
Verbal	Makes no sounds	Incomprehensible sounds	Utters inappropriate words	Confused, disoriented	Oriented, converses normally	N/A
Motor	Makes no movements	Extension to painful stimuli (decerebrate response)	Abnormal flexion to painful stimuli (decorticate response)	Flexion / Withdrawal to painful stimuli	Localizes painful stimuli	Obeys commands

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 the surgery to be connected to the out of hours service (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.

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 BTS Guidelines 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.

Head Injury 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

- Has been "knocked out" at any time
- Been sick more than once
- Has clear fluid dribbling out of their ears, nose or both
- Has blood coming from inside one or both of their ears
- Has difficulty speaking or understanding what you are saying
- Is sleepy and you cannot get them to wake up
- Has weakness in their arms and legs or is losing their balance
- Has had a convulsion or fit

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

Amber

- If you are concerned that you child may have been deliberately harmed
- Has fallen from a height greater than the child's own height
- Has fallen from a height greater than a meter or a yard
- Is under 1 year old
- Has fallen down stairs (from top to bottom poses more risk than bumping down the stairs)
- Had a persistent headache since the injury
- Has a blood clotting disorder
- Has consumed alcohol

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

Green

- Has not been "knocked out "at any time
- Is alert and interacts with you
- Has been sick but only once
- Has bruising or minor cuts to the head
- Cried immediately but is otherwise normal

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)

Royal Cornwall Hospitals Trust
01872 250000
Ask for Paediatric Admissions Unit if you have been given Open Door Access

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Head Injury Advice Sheet

Things that will help your child get better

If you follow this advice it should help your child get better more quickly and it may help any symptoms they have to go away.

- Do encourage your child to have plenty of rest and avoid stressful situations.
- Do not give them sleeping pills, sedatives or tranquilisers unless they are prescribed for your child by a doctor.

Self care

- Clean any wound with tap water.
- If the area is swollen or bleeding apply pressure.
- Give your child paracetamol or ibuprofen if they are in pain. Always follow the manufacturers' instructions for the correct dose.
- Observe your child closely for the next 2-3 days and check that they are behaving normally and they respond to you as usual.
- If the area is swollen or bruised, try placing a cold facecloth over it for 20 minutes every 3-4 hours.
- Make sure your child is drinking enough fluid – water is best, and lukewarm drinks can also be soothing.
- Keep the room they are in at a comfortable temperature, but well ventilated
- It is OK to allow your child to sleep, but observe them regularly and check they respond normally to touch and that their breathing and position in bed is normal.
- Give them plenty of rest, and make sure they avoid any strenuous activity for the next 2-3 days or until their symptoms have settled.
- You know your child best. If you are concerned about them you should seek further advice.

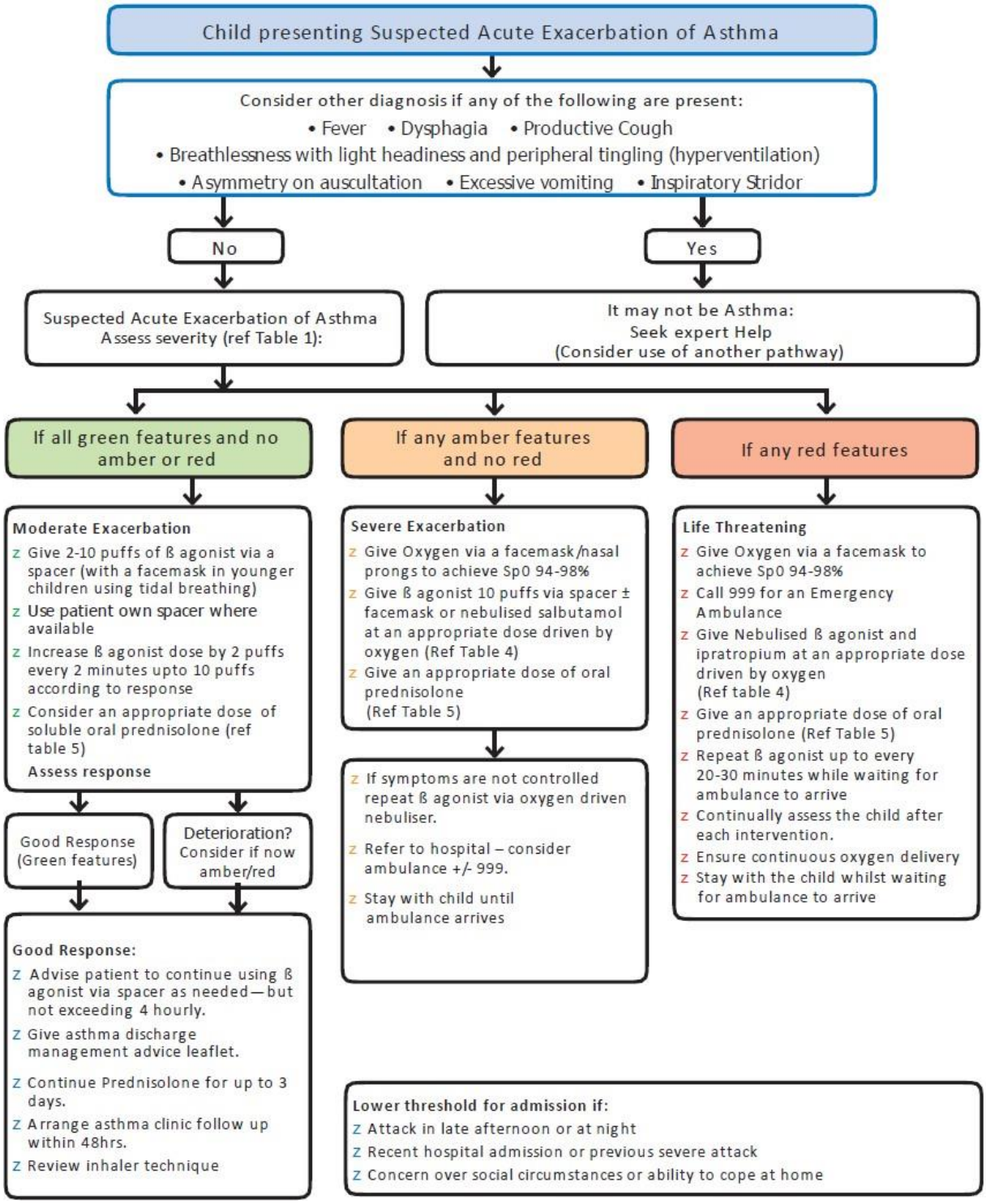
These things may be expected after a head injury

- Intermittent headache especially whilst watching TV or computer games
- Being off their food
- Tiredness or trouble getting to sleep
- Short periods of irritability, bad temper or poor concentration

NB- Seek medical advice before playing contact sports following a head injury.

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

	Green – Moderate	Amber – Severe	Red – Life Threatening
Behaviour	Normal	Anxious/Agitated	Exhaustion/Confusion
Talking	In sentences	Not able to complete a sentence in one breath	Not able to talk
Respiratory	<40 breaths/min 2-5 years <30 breaths/min 5-12 years <25 breaths/min 12-16 years	>40 breaths /min 2-5 yrs >30 breaths /min >5 yrs	Severe recession /exhausted Silent chest
Heart Rate	Within normal range (Ref to table 2)	>140 beats /min 2-5 yrs >125 beats/min >5 yrs	Marked tachycardia (consider influence of temperature and /or Salbutamol)
Sa02	≥92% in air		<92% in air
PEFR	>50% of predicted (Ref to table 3)	33-50% of predicted (Ref to table 3)	<33% of predicted (Ref to table 3)

Table 2: Normal Paediatric Values:

Respiratory Rate at Rest:	Systolic Blood Pressure
2-5yrs 25-30 breaths/min	2-5yrs 80-100 mmhg
5-12yrs 20-25 breaths/min	5-12yrs 90-110 mmhg
>12yrs 15-20 breaths/min	>12yrs 100-120 mmhg
Heart Rate	
2-5yrs 95-140 bpm	
5-12yrs 80-120 bpm	
>12yrs 60-100 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 92%
- 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 under 12 years 1–2 mg/kg (max. 40 mg) daily for up to 3 days or longer if necessary, if the child has been taking an oral corticosteroid for more than a few days give prednisolone 2mg/kg (max. 60mg). Child12-18 years 40-50mg daily for at least 5 days.

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

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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)

Royal Cornwall Hospitals Trust
01872 250000
Ask for Paediatric Admissions Unit if you have been given Open Door Access.

GP Out of Hours Service: Ring your GP surgery to be connected to the out of hours service.

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

If you need language support or translation please inform the member of staff to whom you are speaking.

For more copies of this document, please email:

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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:

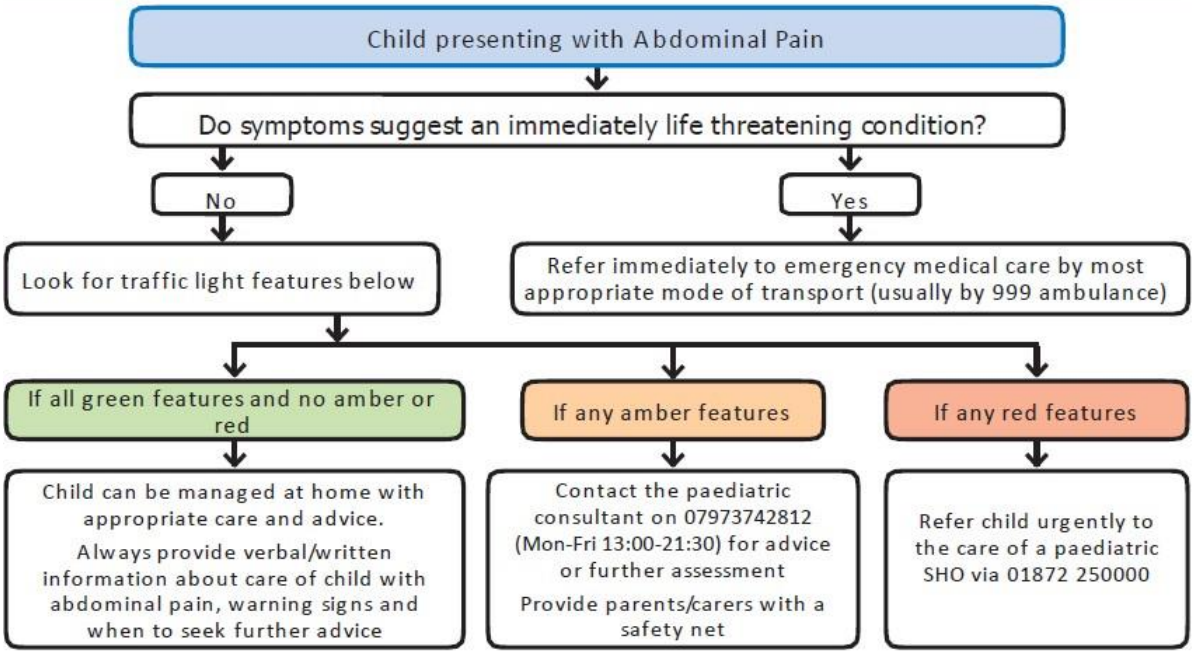
1. **Give your child one to two puffs of their reliever inhaler (usually blue), immediately – use a spacer if they need it.**
2. **Get your child to sit down and try to take slow, steady breaths. Keep them calm and reassure them**
3. **If they do not start to feel better, give them two puffs of their 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 or asthma nurse 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.

Clinical Asssessment Tool

Abdominal Pain



	Green	Amber	Red
Activity	Active/responds normally to social cues		Drowsy/ no response to social cues
Respiratory	Respiratory Rate Normal (RR) Infant 40 Toddler 35 Pre-school 31 School age 27 Sats 95%		Respiratory rate > 60/minute Sats < 92%
Circulation and hydration	CRT < 2 seconds Heart rate normal Infant 120-170 Toddler 80-110 Pre-school 70-110 School age 70-110	CRT 2-3 seconds	CRT > 3 seconds
Other		Fever (see separate guide) Abdominal distension Sexually active/missed period Palpable abdominal mass Localised pain Jaundice	Abdominal guarding/rigidity Bile (green) stained vomit Blood stained vomit "Red currant jelly" stool Trauma associated Acute testicular pain Severe/increasing pain

NB. Broad guidance as differential diagnosis very wide depending on age.

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 use BTS Guidelines 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.

Signs and Symptoms of Specific Illnesses

Common causes of Abdominal Pain by Age

<2yr	2 to 12yr	12 to 16 years
Gastroenteritis	Gastroenteritis	Non specific abdominal
Constipation	Mesenteric adenitis	pain/ "Mesenteric
Intussusception	Constipation	Adenitis."
Infantile colic	UTI	Acute appendicitis
UTI	Onset of menstruation	Menstruation
Incarcerated Inguinal Hernia	Trauma	Mittelschmerz
Trauma	Pneumonia	Ovarian problems
Pneumonia	Diabetes	UTI
	Appendicitis	Pregnancy
	(uncommon	Ectopic Pregnancy
	in <3yrs)	Testicular Torsion
	Psychogenic	Psychogenic
		Diabetes

Diagnosis to be considered	Symptoms and signs in conjunction with abdominal pain
Gastroenteritis	Vomiting Diarrhoea (does not exclude other conditions eg intussusception, pelvic appendicitis, pelvic abscess and inflammatory bowel disease)
Intestinal obstruction eg Intussusception or volvulus	Bile stained vomiting Colicky abdominal pain Absence of normal stooling/flatus Abdominal distension Increased bowel sounds Visible distended loops of bowel Visible peristalsis Scars Swellings at the site of hernial orifices and of the external genitalia Stool containing blood mixed with mucus
Infective diarrhoea	Blood mixed with stools – ask about travel history and recent antibiotic therapy
Inflammatory bowel disease	Blood in stools
Midgut volvulus (shocked child)	Blood in stools
Henoch schonlein purpura	May have joint swelling and purpuric rash
Haemolytic uremic syndrome	Bloody diarrhoea followed one to two weeks later with systemic illness including renal failure (decreased urine output) and bruising
Lower lobe pneumonia	Fever Cough Tachypnoea Desaturation
Poisoning	Ask about history of possible ingestions and what drugs and other toxic agents are available at home
Irreducible inguinal hernia	Examine inguinoscrotal region

Torsion of the testis	This is a surgical emergency and if suspected the appropriate surgeon should be consulted immediately
Jaundice	Hepatitis may present with pain due to liver swelling
Urinary Tract Infection	Routine urine analysis for children presenting with abdominal pain
Bites and stings	Ask about possibly bites and stings. Adder envenomation can result in abdominal pain and vomiting.
Peritonitis	refusal/inability to walk slow walk/stooped forward pain on coughing or jolting lying motionless decreased/absent abdominal wall movements with respiration abdominal distention abdominal tenderness – localised/generalised abdominal guarding/rigidity percussion tenderness palpable abdominal mass bowel sounds – absent/decreased (peritonitis) associated non-specific signs – tachycardia, fever
Constipation	infrequent bowel activity Foul smelling wind and stools Excessive flatulence Irregular stool texture Passing occasional enormous stools or frequent small pellets Withholding or straining to stop passage of stools Soiling or overflow Abdominal distension Poor appetite Lack of energy Unhappy, angry or irritable mood and general malaise.
If patient is post-menarchal female	Suggest pregnancy test Consider ectopic pregnancy, pelvic inflammatory disease or other STD. Other gynaecological problems Mittelschmerz torsion of the ovary pelvic inflammatory disease imperforate hymen with hydrometrocolpos.
Known congenital or pre-existing condition	Previous abdominal surgery (adhesions) Nephrotic syndrome (primary peritonitis)

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 the surgery to be connected to the out of hours service (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.

Abdominal Pain 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

- Unresponsive
- Green or blood stained vomit
- Increasing sleepiness
- Severe or increasing pain

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

Amber

- Increased thirstiness
- Weeing more or less than normal
- Pain not controlled by regular painkillers
- Swollen tummy
- Yellow skin or eyes
- Blood in their poo or wee
- Not being as active or mobile as usual

You need to see or speak to a nurse or doctor today. Please ring your GP surgery or call NHS 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)

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

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For more copies of this document, please email:

Abdominal Pain Advice Sheet

About abdominal pain in children

There are many health problems that can cause stomach pain for children, including:

- Bowel (gut) problems – constipation, colic or irritable bowel
- Infections – gastroenteritis, kidney or bladder infections, or infections in other parts of the body like the ear or chest
- Food-related problems – too much food, food poisoning or food allergies
- Problems outside the abdomen – muscle strain or migraine
- Surgical problems – appendicitis, bowel obstruction or intussusception (telescoping of part of the gut). Suspect appendicitis if pain low on the right side, walks bent over, won't hop or jump, and prefers to lie still.
- Period pain – some girls can have pain before their periods start
- Poisoning – such as spider bites, eating soap or smoking.
- Much of childhood recurrent abdominal pain is unexplained although the pain is genuine and real. Stress and anxiety can contribute to this.

How can I look after my child?

- Reassure the child and try to help them rest.
- If they are not being sick, try giving them paediatric paracetamol oral suspension. Avoid giving Ibuprofen.
- Help your child drink plenty of clear fluids such as clear fluids or juice.
- Do not push your child to eat if they feel unwell.
- If your child is hungry, offer bland food such as crackers, rice, bananas or toast.
- Place a gently heated wheat bag on your child's tummy or run a warm bath for them.

Things to remember

- Many children with stomach pain get better in hours or days without special treatment and often no cause can be found.
- Sometimes the cause becomes more obvious with time and treatment can be started.
- If pain or other problems persist, see your doctor.


The Big 6
Adapted with kind permission from NHS Gloucestershire Clinical Commissioning Group 2014

3. Monitoring compliance and effectiveness

Element to be monitored	Compliance with document
Lead	Author and medical staff- audit and guidelines lead
Tool	Review of referrals and primary care
Frequency	annually
Reporting arrangements	Audit and guidelines
Acting on recommendations and Lead(s)	Medical lead
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 6 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	The Big Six. Common conditions children present with for urgent care Clinical Guideline V3.0		
Date Issued/Approved:	18 July 2019		
Date Valid From:	July 2019		
Date Valid To:	July 2022		
Directorate / Department responsible (author/owner):	Dr Matthew Thorpe Child Health		
Contact details:	01872252716		
Brief summary of contents	This Guideline is aimed to assist primary care settings when treating children and includes parental information and escalation advice.		
Suggested Keywords:	Children Paediatrics Primary care Common conditions Big 6		
Target Audience	RCHT	CFT	KCCG
	✓		
Executive Director responsible for Policy:	Medical Director		
Date revised:	May 2019		
This document replaces (exact title of previous version):	The Big Six . Common conditions children present with for urgent care Clinical Guideline V2.0		
Approval route (names of committees)/consultation:	Consultant paediatricians Audit and guidelines		
Care Group General Manager confirming approval processes	Debra Shields		
Name and Post Title of additional signatories	Not Required		
Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings	{Original Copy Signed}		
	Name: Caroline Amukusana		

Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Paediatrics			
Links to key external standards	none			
Related Documents:	NHS Gloucestershire clinical commissioning group 2014			
Training Need Identified?	No			

Version Control Table

Date	**Version No**	**Summary of Changes**	**Changes Made by** *(Name and Job Title)*
05/11/15	V1.0	Initial Issue	Dr.M.Thorpe consultant
10/05/16	V2.0	Change to advice line telephone number only	Dr.M.Thorpe consultant
01/05/2019	V3.0	Full review – no changes	Dr.M.Thorpe consultant

Appendix 2. Initial Equality Impact Assessment Form

<table>
<tr><td colspan="6">Name of the strategy / policy /proposal / service function to be assessed

The Big Six. Common conditions children present with for urgent care Clinical Guideline V3.0</td></tr>
<tr><td colspan="3">Directorate and service area:
Child health</td><td colspan="3">New or existing document:
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:

Child Health Guidelines Group</td><td colspan="3">Telephone:
01872252716</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">Document to assist primary care with escalation and parental information.</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">To assist primary care with escalation and parental information.</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">Standardised practice</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">review</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">Children and primary care staff</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>x</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups
Consultant paediatricians
Audit and guidelines group</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="5">Guideline approved</td></tr>
</table>

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		X		
Sex (male, female, trans-gender / gender reassignment)		X		
Race / Ethnic communities /groups		X		Any information provided should be in an accessible format for the parent/carer/patient's needs – i.e. available in different languages if required/access to an interpreter if required
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		X		Those parent/carer/patients with any identified additional needs will be referred for additional support as appropriate - i.e to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g. easy read, audio etc
Religion / other beliefs		X		All staff should be aware of any beliefs that may impact on treatment decisions, and respond accordingly
Marriage and Civil partnership		X		
Pregnancy and maternity		X		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		X		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**X**

9. If you are **not** recommending a Full Impact assessment please explain why.

No areas indicated

Date of completion and submission	18/07/2019	Members approving screening assessment	Policy Review Group (PRG) APPROVED

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust's web site.