Birmingham Children's Hospital NHS
NHS Foundation Trust

Paediatric Clinical Assessment Tools For

Common Children's Conditions Presenting To Urgent / Primary Care

CPADS - 51884/16

Purpose of this Guideline

This Guideline is intended to act as a quick reference guide to some of the most common medical conditions for unscheduled healthcare attendances in children and young people (ages 0-16), which are: respiratory tract infections (croup/ bronchiolitis), asthma, fever, gastroenteritis and abdominal pain. It is aimed to assist primary care professionals when treating children and guide appropriate escalation. Parent / Carer information leaflets are included.

Clinicians are expected to take this guideline 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 or carer.

When you feel a GP review in a specific time period is clinically appropriate, but 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. The patient should also be given the appropriate Parent / Carer information leaflets.

The clinical assessment tools were arrived at after careful consideration of the evidence available including, but not exclusively SIGN, NICE Guidelines, Birmingham Children's Hospital guidelines, existing Birmingham Children's Hospital Information Leaflets, EBM date and NHS Evidence.

With thanks to the team at Gloucestershire CCG who produced the original Big 6 Pathways, on which this guideline is based.

Contents

Please click the section below you would like to view

Normal Values

Normal values at different ages (APLS, Edition 5)

Age of child (years)	Under 1	1–2	2–5	5–12	Over 12
Respiratory rate	30–40	25–35	25–30	20–25	15–20
Heart rate	110–160	100–150	95–140	80–120	60–100
Systolic blood pressure	80–90	85–95	85–100	90–110	100–120

Calculations for commonly used emergency drugs (APLS, Edition 5)

	Formula	Maximum dose
Weight (kg)	**Child 0–12 months** Weight = (0.5 × age in months) + 4	
	Child 1–5 years Weight = (2 × age in years) + 8	
	Child 6–12 years Weight = (3 × age in years) + 7	
Energy (J)	4 J/kg	150–200 J biphasic for first shock 150–360 J biphasic for subsequent shocks
Tube size	**Pre-term babies** 2.5 mm tube **Babies** usually 3 or 3.5 mm tube **Children >1 year** Tube size = (age in years/4) + 4	
Fluid Bolus (IV or IO)	20 mL/kg of 0.9% saline **Exceptions:** Trauma/DKA/cardiac problems use 10 mL/kg of 0.9% saline	500 mL of 0.9% saline in trauma/ DKA/cardiac problems 1000 mL of 0.9% saline
Lorazepam	100 micrograms/kg (IV or IO)	Max single dose 4 mg
Adrenaline (IV or IO)	10 micrograms/kg (0.1 mL/kg of 1:10,000 strength)	Max single dose 1 mg
Glucose 10% (IV or IO)	2–5 mL/kg of 10% dextrose	150–160 mL of 10% dextrose single bolus

UK immunisation schedule

Age of child (months)	Rota virus (oral vaccine)	Diphtheria and tetanus	Pertussus	Polio	Hib	PCV	MenC	MMR	HPV	No. of injections
2 months	✓	✓	✓	✓	✓	✓				2
3 months	✓	✓	✓	✓	✓		✓			2
4 months		✓	✓	✓	✓	✓	✓			3
12 months					✓		✓			1

Neonatal Fluid Requirments

Age	Total volume of fluid required per day (mL/kg)
Day 1	60
Day 2	90
Day 3	120
Day 4 to 28	150

Clinical Assessment Tool

Suspected Bronchiolitis in Babies / Children under 1 year

Baby presenting with Bronchiolitis - assess for signs of severity

Green features and no amber or red

Child can be managed at home with appropriate care and advice. Provide verbal / written information about warning signs and when to seek further advice

Amber features and no red

Is oxygen support required? (sats<92%/high resp rate)

- No → Is feeding sufficient to maintain hydration?
  - Yes → Consider admission according to clinical and social circumstances.
    Provide a safety net for parents/carers by using one or more of the following:
    - Written / verbal information on warning symptoms and accessing further healthcare
    - Arrange appropriate primary care follow up

    If unsure please contact the on-call paediatric registrar at BCH via switchboard **(0121 333 9999)**
  - No → Send child for urgent assessment in hospital setting. Via BCH ED triage on **0121 333 9507** Commence relevant treatment to stabilise baby/child for transfer if appropriate.
- Yes → Send child for urgent assessment in hospital setting. Via BCH ED triage on **0121 333 9507** Commence relevant treatment to stabilise baby/child for transfer if appropriate.

Any red features

Send child for urgent assessment in hospital setting. Via BCH ED triage on **0121 333 9507** Commence relevant treatment to stabilise baby/child for transfer if appropriate.

Be aware of the increased need for hospital admissions in the following infants:

- Pre-existing congenital heart disease, lung disease, neuromuscular disease, immune-deficiency
- Age less than 6 weeks (corrected)
- Prematurity
- Family anxiety
- Re-attendance
- Duration of illness less than 3 days and Amber category – may need to admit as potential to worsen

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 health care professional
Circulation	CRT less than 2 secs	CRT 2-3 secs	CRT over 3 secs
Skin	Normal colour skin,lips & tongue Moist mucous membranes	Pale / mottled Pallor reported by parent/carer Cool peripheries	Pale/mottled/blue Cyanotic lips and tongue
Respiratory rate	Under 12mths: less than 50 Over 12mths: less than 40 No respiratory distress	Under 12mths: 50-60 breaths/minute Over 12mths: 40-60 breaths/minute	All ages over 60 breaths / minute
Sats in air	95% or above	92-94%	less than 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	under 50% fluid intake over 2-3 feeds +/- vomiting Significantly reduced urine output
Apnoeas	Absent	Absent	Present*

Refer to page 1 for normal values CRT - Capillary refill time Sats- Saturations In Air *Apnoea - 10 -15 Sec or shorter if accompanied by drop in SATS / central cyanosis / bradycardia

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Information for Parents / Carers:

Caring for your baby/ child with bronchiolitis

What is bronchiolitis?

Bronchiolitis means inflammation of the bronchioles (tiniest airways in your baby's lungs). Infected bronchioles become swollen and full of mucus. This can make it more difficult for your baby to breathe. It is usually caused by a virus called the Respiratory Syncytial Virus (RSV). Other viruses are sometimes the cause. RSV is a common cause of colds in older children and adults. RSV is spread in tiny water droplets coughed and sneezed into the air.

Who gets bronchiolitis?

Bronchiolitis in the UK usually occurs in the winter months (November to March). It is estimated that as many as 1 in 3 babies in the UK under the age of 12 months develop bronchiolitis at some point. It most commonly occurs in babies aged 3-6 months old. Most babies get better on their own. Some babies (about 3 in 100), especially the very young ones, can have difficulty with breathing or feeding and may need to go to hospital. Babies at higher risk of developing a more serious illness with bronchiolitis include: premature babies, babies with heart conditions, and babies who already have a lung condition.

What are the symptoms of bronchiolitis?

- Cold symptoms: a runny nose, cough and mild fever (less than 39°C) are usual for the first 2-3 days.
- After a few days your baby's cough may get worse.
- Fast breathing and noisy breathing may develop as the infection 'travels' down to the bronchioles. The number of breaths per minute may go as high as 60-80.
- You can often see the muscles between the ribs moving inward during each breath. This is because the baby needs more effort to breathe than normal.
- Sometimes in very young babies, bronchiolitis may cause brief pauses in breathing.
- As breathing becomes more difficult, your baby may have difficulty feeding. Your baby may have fewer wet nappies. Your baby may vomit after feeding.

Bronchiolitis Advice Guide: Babies/Children under 1 year

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

Amber

- Decreasing feeding
- Passing less urine than normal
- Baby / child's health gets worse or you are worried
- If your baby / child is vomiting
- Your baby's 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 non of the above factors are present

Self care
Using the advice in this guide you can provide the care your child needs at home

How can I help my baby?

- If your baby is not feeding as normal, offer feeds little and often.
- If your baby has a fever, you can give them paracetamol at the recommended dose. If your baby is over 3 months you can also give them ibuprofen.
- If your baby is already taking medicines/inhalers, you should continue to use them.
- Bronchiolitis is a 'self-limiting' illness. This means it will normally go as the immune system clears the virus. There is no medicine that will kill the virus. Antibiotics won't help.
- Make sure your baby is **not** exposed to tobacco smoke. Passive smoking can seriously damage your baby's health. It makes breathing problems like bronchiolitis worse.

How long will bronchiolitis last?

- Typically, symptoms peak in severity 3-5 days after starting.
- Most babies get better within 2 weeks.
- An irritating cough can last longer - up to 6 weeks after other symptoms have gone.
- Your baby can go back to nursery/day care as soon as he/she is well enough.

Name of Child .....

Age ..... Date/Time advice given .....

Further advice / Follow up .....

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Name of professional .....

Signature of professional .....

Some Useful Phone Numbers

GP Surgery (make a note of the number here)

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NHS 111 - Dial 111
(available 24hrs - 7 days a week)

GP Out of Hours Service - appointments booked via NHS 111
(Open from 6:30pm - 8:30am, 7 days a week)

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

Urgent Care Centre

Warren Farm Urgent Care Centre
Warren Farm Road, Birmingham, West Midlands, B44 0PU
8.00am-8.00pm

Erdington Health and Wellbeing Walk In Centre
196 High Street, 1st Floor, Erdington, Birmingham, B23 6SJ
8.00am-8.00pm

Washwood Heath Urgent Care Centre
Clodeshall Road, Washwood Heath, Birmingham, West Midlands, B8 3SN
9.00am-9.00pm

The Hill Urgent Care Centre
Sparkhill Primary Care Centre, 856 Stratford Road,
Sparkhill, Birmingham, B11 4BW
8.00am-8.00pm

South Birmingham GP Walk In Centre
0121 415 2095
15 Katie Road, Selly Oak, Birmingham, B29 6JG.
8.00am-8.00pm

Birmingham NHS Walk In Centre
0121 255 4500
Lower Ground Floor, Boots The Chemists Ltd,
66 High Street, Birmingham, West Midlands, B4 7TA

Mon-Fri: 8.00am – 7.00pm (last patient seen at 6:30pm)
Sat: 9.00am – 6.00pm (last patient seen at 5:30pm)
Sun: 1.00am – 4.00pm (last patient seen at 3:30pm)

Solihull UCC
Solihull Hospital, Lode Lane, Solihull, B91 2JL
8.00am-8.00pm

Summerfield GP and Urgent Care Centre
Summerfield Primary Care Centre, 134 Heath Street,
Winson Green, Birmingham, B18 7AL.
8.00am-8.00pm

If you require an interpreter, inform the member of staff you are speaking with.

Data Protection

Looking after and sharing information about your child

We have a duty of care to help patients and families understand how information about them is kept and shared and we include the following information in all our patient leaflets:

Information is collected about your child relevant to their diagnosis, treatment and care. We store it in written records and electronically on computer. As a necessary part of that care and treatment we may have to share some of your information with other people and organisations who are either responsible or directly involved in your child's care. This may involve taking your child's information off site. We may also have to share some of your information for other purposes, such as research etc. Any information that is shared in this way will not identify your child unless we have your consent. If you have any questions and/or do not want us to share that information with others, please talk to the people looking after your child or contact PALS (Patient Advice and Liaison Service) on 0121 333 8403.

Birmingham Children's Hospital NHS Foundation Trust
Steelhouse Lane Birmingham B4 6NH
Telephone 0121 333 9999
Fax: 0121 333 9998
Website: www.bch.nhs.uk

Produced: Oct 2016
Review Date: Oct 2020
Version1.0.0

Clinical Assessment Tool

Suspected Croup in child 3 months - 6 years

Child presenting with barking cough - assess for signs of severity

Green features and no amber or red

- Child can be managed at home with appropriate care and advice.
- Single dose of oral dexamethasone (0.15mg per kg body weight)
- Or oral prednisolone (1-2mg per kg body weight)
- Consider second dose if residual symptoms of stridor are present the following day
- Provide verbal / written information about warning signs and when to seek further advice

Amber features and no red

- Single dose of oral dexamethasone (0.15mg per kg body weight)
- Or oral prednisolone (1-2mg per kg body weight)
- Consider admission according to clinical and social circumstances.

Provide a safety net for parents/carers by using one or more of the following:

- Written / verbal information on warning symptoms and accessing further healthcare
- Arrange appropriate primary care follow up

If unsure please contact the on-call paediatric registrar via BCH switchboard **(0121 333 9999)**

Any red features

Send child for urgent assessment in hospital setting.
Via BCH ED triage on **0121 333 9507**
Commence relevant treatment to stabilise baby/child for transfer if appropriate.
Do not distress the child.

Table 1: Traffic light system for identifying severity of illness

	Green - low risk	Amber - intermediate risk	Red - High Risk
Colour and Activity	• Normal • Child Alert	• Quieter than normal	• Pale • Lethargy • Distress / agitation
Respiratory	Respiratory rate • Under 12 months: less than 50 breaths/minute • Over 12 months: less than 40 breathes/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 • over 60 (all ages) Sats less than 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 less than 2 seconds	CRT 2-4 seconds	CRT more than 4 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	

Refer to page 1 for normal values CRT - Capillary refill time Sats - Saturations In Air

Birmingham Children's Hospital NHS
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Information for Parents / Carers:

Caring for your child with croup

What are the symptoms of Croup?

- Croup starts with a mild fever and runny rose.
- Dry cough often described as 'barking like a seal'.
- Noisy breathing when breathing in (known as stridor).
- Hoarseness of voice
- Restless and irritable
- When breathing in, pulling in of the muscles between ribs and around the neck.
- Difficulty swallowing or drooling (in severe cases)

Symptoms may be worse at night.

How can I help my child?

- Try and stay calm for your child – anxiety could affect your child's breathing. A small child may become distressed with croup, crying can make things worse.
- Allow your child to stay in the position they prefer. Sit your child upright if breathing is noisy or difficult. Do not make your child lie down if they do not want to.
- If your child has a temperature, give them the medicine that you would normally use to lower their temperature, following the instructions on the bottle or as advised by the chemist.
- Your child may be reluctant to eat, so encourage them to have plenty of clear cool drinks. Do not make your child drink if they do not want to.
- A cool environment may help, such as taking your child outside.
- If your child is having difficulty breathing, swallowing or is drooling a doctor should see them immediately.

Croup Advice Guide:

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

Amber

- Not improving with treatment
- Breathing more noisy
- Breathing is more laboured
- Your baby's temperature is above 39°C
- Drooling

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 in this guide you can provide the care your child needs at home

Name of Child .....

Age ..... Date/Time advice given .....

Further advice / Follow up .....

.....

.....

.....

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Clinical Assessment Tool

Acute Asthma in child 2-16 years

Child presenting with suspected acute exacerbation of asthma - assess for signs of severity

Green features and no amber or red

Moderate Exacerbation

- Give 2-10 puffs of ß agonist via a spacer (with a face-mask in younger children)
- Ensure good technique
- Increase ß agonist dose by 2 puffs every 2 minutes upto 10 puffs according to response.
- Consider oral prednisolone 1-2mg/kg (max 40mg)

Assess response

Good response

Deterioration?

Good Response:

- Advise patients to continue using ß agonist via spacer as needed- but not exceeding 4 hourly.
- Give asthma information leaflet
- Give prednisolone for 3 days
- Arrange GP asthma clinic follow up within 48hours.

Amber features and no red

Severe Exacerbation

- Give oxygen via a face-mask/nasal prongs to achieve $Sp0_2$ 94-98%
- Give ß agonist 10 puffs via spacer± facemask or 2.5mg nebulised salbutamol
- Give appropriate dose of oral Prednisolone (1-2mg/kg - max 40mg)

If symptoms are not controlled:

- repeat ß agonist via oxygen driven nebuliser.
- Refer to hospital - ambulance +/- 999
- Discus with paediatric registrar via BCH switchboard **(0121 333 9999)**
- Stay with child until ambulance arrives.

Any red features

Life Threatening

- Give oxygen via a facemask to achieve $Sp0_2$ 94-98%
- Call 999 for an emergency ambulance
- Give Nebulised ß agonist (2.5mg Salbutamol) and Ipratropium: (under 12yrs: 250micrograms, 12-18yrs: 500micrograms) via oxygen driven nebuliser
- Give oral Prednisolone (1-2mg/kg - max 40mg)
- Repeat back to back ß agonists while waiting for ambulance to arrive
- Continually assess the child after each intervention
- Ensure continuous oxygen delivery
- Stay with child until ambulance arrives.

Lower threshold for admission if:

- Attack in late afternoon or at night
- Recent hospital admission or previous severe attack
- Concern over social circumstances or ability to cope at home.

Acute Asthma Table 1: Traffic light system for identifying severity of illness

	Green - low risk	Amber - intermediate risk	Red - High Risk
Behaviour	Normal	Anxious / Agitated	Exhaustion / Confusion
Talking	In sentences / normal	Not able to complete a sentence in one breath	Not able
Respiratory	2-5 years: less than 40 breaths/min 5-12 years: less than 30 breaths /min 12-16 years: less than 25 breaths/min	2-5 years: more than 40 breaths/min Over 5 years: more than 30 breaths/min	As Amber plus: Low respiratory rate Silent chest
Heart Rate	Within normal range*	2-5 years: more than 140 beats/min Over 5 years: more than 125 beats/min (>5 years) *Consider influence of fever &/or Salbutamol	As Amber plus: Hypotension
Sa02	More than 92% in air	Less than 92% in air	As Amber plus: Cyanosis
PEFR	More than 50% of predicted (Refer to Acute Asthma table 2)	33-50% of predicted (Refer to Acute Asthma table 2)	less than 33% of predicted (Refer to Acute Asthma table 2)

*Refer to page 1 for normal values

Outpatient Referral Criteria for Birmingham Children's Hospital

General Paediatrics

- Patients on Step 3 of BTS asthma management guidelines
- Any HDU admissions for asthma
- Repeated ED attendances with asthma/wheeze
- More than 3 admissions in the preceding 12 months
- Poorly controlled asthma including frequent use of bronchodilators and/or oral steroids

Respiratory Medicine

- Uncontrolled asthma at BTS step 3 and above
- Persistent airflow obstruction (FEV1 <70% predicted) despite above therapy
- Recurrent severe exacerbation- one PICU or 2 HDU admissions requiring iv aminophylline/salbutamol
- Alternate day oral Prednisolone
- More than 6 admissions in 12 months
- Where diagnosis of asthma is under question or additional diagnosis (e.g. bronchiectasis) is under consideration or **warning signs** present

Warning signs:

- Symptoms present since birth
- Failure to thrive
- Persisting *wet* cough
- Presence of stridor and wheeze
- Clinical signs of chronic chest e.g. clubbing
- Associated symptoms of choking with feeds/solids in otherwise healthy child

Acute Asthma Table 2 -
Predicted Peak Flow: for use with EU / EN13826 scale PEF metres only

Height (m)	Height (ft)	Predicted PEFR (L/min)	Height (m)	Height (ft)	Predicted 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

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Information for Parents / Carers:

Caring for your child with Asthma / Wheeze

What is asthma?

If you have asthma, the bronchi (the airways in the lungs) will be inflammed 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/ wheeze attack the muscle of the air passages in the lungs go into spasm and the lining of the airways swell. As a result, the airways become narrower 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'. Most children will grow out of it, as they get to school age. Children who have ongoing/recurrent symptoms may be given the diagnosis of asthma.

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 e.g. animals
- Pollens and mould particularly in hay-fever 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 (blue inhaler) 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 feel like they can't get their breath properly
- Young children may complain of a tummy ache.

What to do if your child has an asthma attack:

1. Immediately give your child 2-4 puffs of their reliever inhaler (usually blue). Remember to use a spacer
2. Help your child to sit down and ask them to take slow, steady breaths. Keep them calm and reassure them
3. If they do not start to feel better, give them 2-4 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 start to feel better after taking their inhaler as above, or if you are worried at any time call 999
5. If your child continues to feel unwell while awaiting the ambulance, continue to give a puff a minute until symptoms improve or ambulance arrives

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 an asthma attack 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.

It is an emergency if your child is

- Breathing very fast and using their neck or tummy muscles to breathe.
- Too breathless to talk, eat or drink.
- Tired, pale or blue around the lips.

Action

- **You must seek medical advice immediately – dial 999**

Whilst you are waiting for the ambulance give your child 10 puffs of the blue inhaler using the spacer. You can continue to give 10 puffs every minute until help arrives.

Asthma/Wheeze Advice Guide

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 of consciousness
- Breathless, with heaving of the chest

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

Amber

- Wheezing and breathless
- Not responding to usual reliever treatment
- Needing reliever treatment more than every 4 hours

You need to contact 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 reading

Self care
Using the advice in this guide you can provide the care your child needs at home

Name of Child .....

Age ..... Date/Time advice given .....

Further advice / Follow up .....

.....

Name of professional .....

Signature of professional .....

Asthma/Wheeze Management Plan

Regular treatment

Name of inhaler and strength	Dose	
Preventer (brown/ orange/purple/red)	..... puffs in the morning	..... puffs at bedtime
Reliever (blue)		
Other asthma medications	Give ..... puffs when coughing, wheezing or breathless and 10-15 minutes before exercise	

Remember to use the spacer!

Only 1 puff at a time

Your child's asthma is under control if

- They have very few or no asthma symptoms – wheezing, coughing, shortness of breath.
- They can do all their normal activities without symptoms.

Action

- Continue your child's regular asthma medicines.

What to do when my child is

- Coughing or wheezing more than usual.
- Waking up at night with asthma symptoms.
- Needing their blue inhaler more than usual.
- Has a cold.

Action

- Give 4 puffs of the blue inhaler every 4-6 hours.
- If your child is not better after 1 day see your GP or practice nurse.
- If your child remains unwell see next step.

What do I do when my child is

- Short of breath, wheezing or coughing constantly.
- Needing their blue inhaler every 3-4 hours.
- Unable to do their normal activities.

Action

- Give up to 6-10 puffs of blue inhaler every 4 hours.
- If your doctor has advised oral steroids give – Prednisolone …….mg (…….tablets) once a day each morning for 3-5 days as advised.
- Make an appointment for your child to see your GP or practice nurse today. If it's outside normal opening hours ring the GP emergency number for advice.

Following your child's medical review please give

Day 1

10 puffs of the blue reliever inhaler every 4 hours.

Prednisolone tablets …….mg (…….tablets) in the morning.

If your child needs their inhaler more often get urgent medical advice.

Day 2

4-6 puffs of the blue reliever inhaler every 4-6 hours.

Prednisolone tablets: ……. mg (…….tablets) in the morning.

Get medical advice if your child needs their inhaler more often than this.

Days 3-4

2-4 puffs of the blue inhaler as needed and follow the plan in this leaflet

Some Useful Phone Numbers

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(make a note of the number here)

……..

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Produced: Oct 2016
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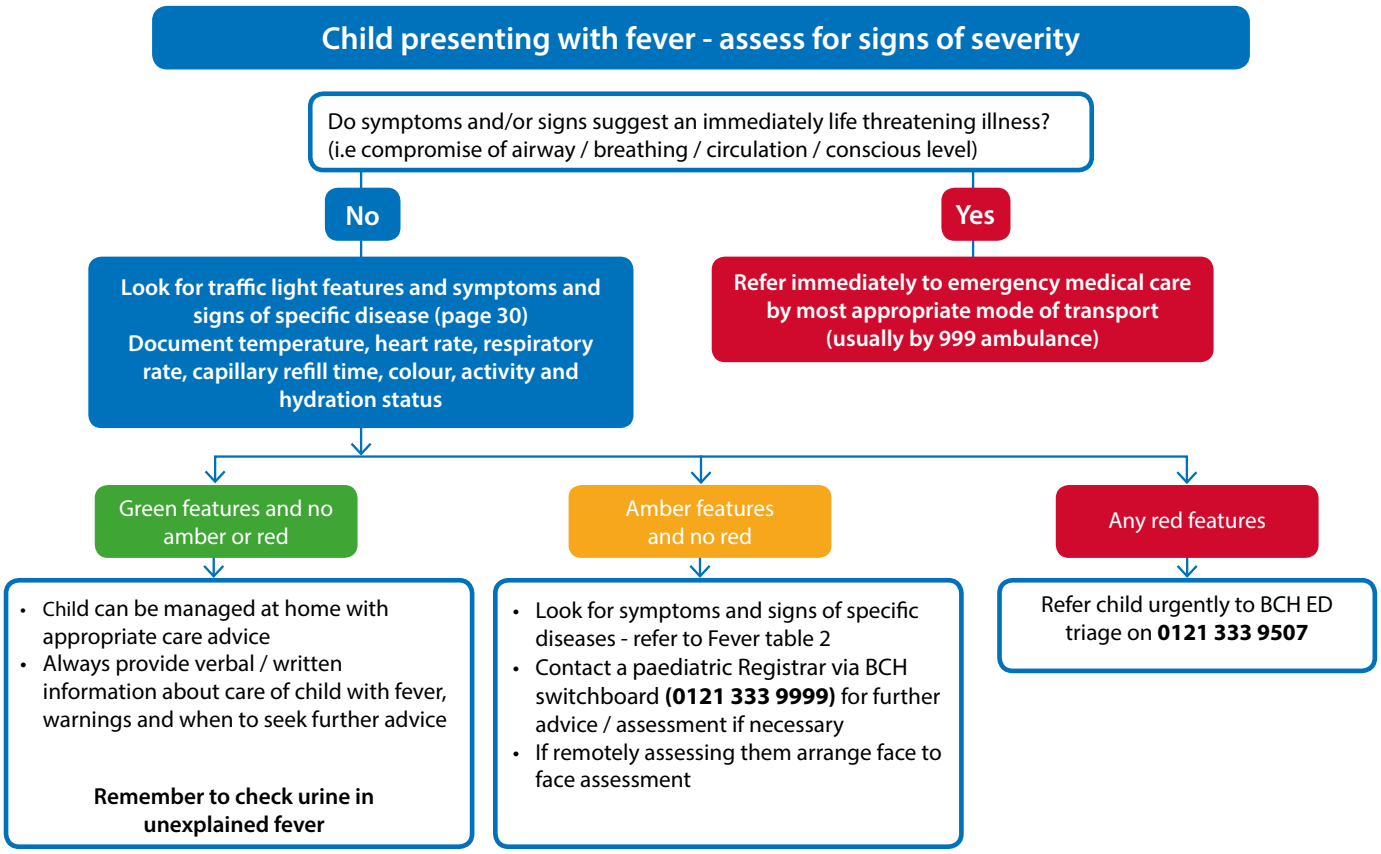
Version1.0.0

Clinical Assessment Tool

Child with fever



Fever Table 1: Traffic light system for identifying severity of 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: Under 12mths - over 50 breaths/minute Over 12mths - over 40 breaths/minute • Oxygen saturation <95% in air • Crackles in the chest	• Grunting • Tachypnoea: over 60 breaths/minute
Circulation and Hydration	• Normal skin and eyes • Moist mucous membranes	• Dry mucus membrane • Poor feeding in infants • CRT over 3 seconds • Tachycardia: Under 1yr - over 160 beats/minute 2-5yrs - over 150 beats/minute • Reduced urine output	Reduced skin turgor
Other	None of the amber or red symptoms or signs	• Fever for more than 5 days • Swelling of a limb or joint • Non-weight bearing/not using an extremity • A new lump more than 2cm • Age 3-6 months, temperature over 39°C • Rigors	• Age 0-3 months, temperature over 38°C • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures

CRT - Capillary refill time

Diagnostic Considerations in Fever

Fever Table 2

Diagnosis to be considered	Symptoms and signs in conjunction with fever
Meningococcal disease	Non- blanching rash, particularly with one or more of the following: • An ill-looking child • Lesions larger than 2mm in diameter (purpura) • Capillary refill time longer than 3 seconds • Neck stiffness • Administer parental antibiotics and refer urgently to hospital
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: Respiratory rate:
	  • 0-5 months - over 60 breaths/minute
	  • 6-12 months - over 50 breaths/minute
	  • Over 12 months - over 40 breaths/minute
	• Crackles in the chest
	• Nasal flaring
	• Chest indrawing
	• Cyanosis
	• Oxygen saturation less than 95%

Urinary tract infection (in children ages 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 following: • Bilateral conjunctival injection • change in upper respiratory tract mucous membranes (for example, injected pharynx, dry cracked lips or straweberry tongue) • change in the perpheral extremitites (for example, oedema, erythema or desquamation • Polymorphous rash • Cervical lymphadenopathy

Refer to normal values page 1

[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 2013)
[3] Note: In rare cases, incomplete/ atypical kawasaki disease may be diagnosed with fewer features.

Birmingham Children's Hospital NHS
NHS Foundation Trust

Information for Parents / Carers:

Caring for your child with fever

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 common. This leaflet provides advice on when to seek help and what you can do to help your child feel better. Often the fever lasts a short duration and many children can be cared for at home if the child continues to drink, remain 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.

What causes fever in children?

Most children with fever can be safety cared for at home. Viral infections are common and cause many childhood problems such as colds, coughs, flu, diarrhoea, rashes etc. Bacterial infections are less common than viral infections but more likely to cause serious illness.

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.

Looking after your feverish child

- Give your child plenty of drinks e.g. water or squash. If you are breastfeeding then continue.
- 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) and 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 clothing they are wearing.
- Physical methods of cooling your child such as fanning them, cold bathing and tepid sponging can cause discomfort and may make fever worse.
- 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 medicine 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 urgently 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.

Fever Advice Guide:

How is your child?

Red

- Has a non-blanching rash using the tumbler test
- Is not responding and very irritable

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

Amber

- The fever does not settle despite paracetamol/ibuprofen
- Looks unwell even when temperature settles
- Has an unusual breathing pattern/is lethargic once temperature settles
- Has reduced fluid intake and dry nappies/ fewer wees

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

Self care
Using the advice in this guide you can provide the care your child needs at home

What should I look out for?

A child with a high temperature may look quite unwell. They may become lethargic, sleepy, flushed and miserable. However, most temperatures are not caused by serious illness, temperature often come down quickly. This is reassuring.

A child with a serious infection may have other symptoms of concern. There include breathing problems, drowsiness or rash.

Talking with your doctor

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 the home or needs to see a healthcare professional face to face.

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 illness and how to get further help if they occur.

Name of Child .....

Age ..... Date/Time advice given .....

Further advice / Follow up .....

.....

.....

.....

.....

.....

.....

Name of professional .....

Signature of professional .....

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Clinical Assessment Tool

Suspected Gastroenteritis in child 0-5 years

Child presenting with diarrhoea and / or vomiting - assess for signs of severity

Green features and no amber or red

No Clinical Dehydration

Preventing dehydration:

- Continue breastfeeding and other milk feeds.
- Encourage fluid intake
- Discourage fruit juice and carbonated drinks
- Offer Oral rehydration Solution (ORS) as supplemental fluid to those at risk of dehydration
- Refer to Box 2 for stool microbiology advice
- Provide parents/carers with advice
- Follow up by arranging a review by an appointment health care professional.

Amber features and no red

Consider if child at increased risk of dehydration

- Younger than 5 years, especially those under 6 months
- Low birth weight infants
- 6+ diarrhoea stools in 24 hours
- 3+ vomits in 24hours
- Children not offered / treated supplementary fluids before presentation
- Infants who have stopped breast feeding during illness
- Pre-existing malnutrition.

Decide if referral to paediatrics is necessary based on

- Risk factors
- Social circumstances

Concerning clinical dehydration

No additional risk factors / concerns

- Home with advice to give oral rehydration without delay - small amounts and often
- Continue breast feeding
- Consider supplementing usual fluids with ORS
- If after 2 hours child is not tolerating ORS/ vomiting parents should be instructed to attend BCH ED
- Give advice sheet

If there is blood or mucus in the stool or if the child is immunocompromised seek further advice or refer to Paediatric registrar via BCH switchboard on **0121 333 9999**

Any red features

Clinical shock suspected or confirmed

Send child for urgent assessment in hospital setting via BCH ED triage **0121 333 9507**

Consider appropriate transport means (dial 999 for an emergency)

Commence relevant treatment to stabilise baby/child for transfer if appropriate.

Parents should be encouraged to give child fluids en-route often and in small amounts

Gastroenteritis Table 1: 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 to normal social cues • Appears ill to a healthcare professional • Unable to rouse or if roused does not stay awake • Weak, high pitch or continuous cry
Skin	Normal skin colour Normal turgour	Normal skin colour Warm extremities	Pale/Mottled/Ashen blue Cold extremities
Respiratory	Normal breathing	Tachypnoea*	Tachycardia*
Hydration	CRT less than 2 seconds Moist mucous membranes (except after a drink) Normal urine output	CRT 2-3 seconds Dry mucous membranes (except after a drink) Reduced urine output	CRT longer than 3 seconds
Pulse/Heart Rate	Heart rate normal Peripheral pulse normal	Tachycardia* Peripheral pulse weak	Tachycardia * Peripheral pulses weak
Blood Pressure	Normal	Normal	Hypotensive
Eyes	Normal Eyes	Sunken Eyes	

*Refer to normal values page 1 CRT - Capillary refill time Sats- Saturations In Air

Gastroenteritis Box 1 Features which may suggest diagnoses other then gastroenteritis:

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

Gastroenteritis Box 2 Stool Microbiology Advice:

Consider performing stool microbiological investigation if any of the following:

- the child has recently been abroad
- the diarrhoea has not improved by day 7
- fever over 5 days

Fluid Rehydration Guidelines

The table below gives the normal maintenance fluid 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.
Parents can use this guideline aiming 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 e.g. dioralyte.

If the child is breast fed continue breastfeeding.
Seek review if the patient:

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

	Child's weight in Kg	Maintenance fluid volume - ml per hour
	2	8
	3	12
	4	16
	5	20
	6	24
6 months	7	28
	8	32
	9	36
1 year	10	40
	11	42
2 years	12	44
	13	46
3 years	14	48
	15	50
4 years	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 / Hospital number .....

NHS Number .....

DOB .....

Weight .....

Please give your child ..... ml of the suggested fluid, measure 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?

Birmingham Children's Hospital NHS
NHS Foundation Trust

Information for Parents / Carers:

Caring for your child with gastroenteritis

About Gastroenteritis

Gastroenteritis is an infection of the gut, which causes diarrhoea and / or vomiting. It can lead to dehydration when the body does not have enough water or the right balance of salts to carry out normal functions.

Children at increased risk of dehydration include:

- Young babies under 1 year (especially under 6 months)
- Those born at a low birth weight,
- Those who have stopped drinking/breastfeeding during the illness
- Children with poor growth.

Gastroenteritis is usually caused by a virus and requires no treatment other than plenty of fluids. Antibiotics do not kill viruses.

Sometimes infected food can cause gastroenteritis (food poisoning). Bacteria can cause food poisoning, for example campylobacter and salmonella.

What are the symptoms of gastroenteritis?

- Diarrhoea, often vomiting as well
- Vomiting can last up to 3 days
- Diarrhoea may continue longer, between 5-7 days after vomiting and can last up to 2 weeks.
- Crampy pains in the abdomen (tummy) are common.
- Dehydration - passing less urine than normal with dry mouth.

Gastroenteritis Advice Guide:

How is your child?

Red

If your child
- Becomes difficult to rouse / unresponsive
- Becomes pale and floppy
- Is finding it difficult to breathe
- Has cold hands and feet
- Has diabetes

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

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 fluid
- Becomes irritable or lethargic
- Their breathing is rapid or deep
- Is under 2months 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 safety managed at home.

Self care
Using the advice in this guide you can provide the care your child needs at home

How can I help my child?

- Continue to offer your child their usual feeds, including breast or other milk feeds (do not dilute milk feeds). This is in addition to extra rehydration fluid if advised.
- Encourage your child to drink plenty of fluids - little and often, even if your child vomits or feels sick. Any drink is better than none. Oral rehydration solutions (ORS) are best. They provide the perfect balance of water salt and sugar. ORS can be purchased from the counters of large supermarkets and pharmacies. Do not use home made salt drinks as the quantity of salt has to be exact.
- Mixing the contents of ORS sachet into squash (not "sugar free") may improve the taste. Ice lollies are a useful extra source of fluid.
- Do not worry if your child is not interested in solid food, but offer food if hungry. Do not "starve" a child with gastroenteritis.
- If your child has other symptoms like high temperature, neck stiffness or rash please ask for advice from your healthcare professional (or call 111).
- If your child has stomach cramps and pain killers do not help, seek advice. Ibuprofen should not be given if your child has not passed urine or has blood in their stools.
- Hand washing is the best way to stop gastroenteritis spreading.

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-diarrhoea medicines (also called Antimotility drugs) should not be given to children.

Preventing the spread of Gastroenteritis

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 48hours after the last episode of diarrhoea and / or vomiting
- Swim in swimming pools until 2 weeks after the diarrhoea has stopped

Name of Child .....

Age ..... Date/Time advice given .....

Further advice / Follow up .....

.....

.....

.....

.....

.....

.....

.....

Name of professional .....

Signature of professional .....

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Information is collected about your child relevant to their diagnosis, treatment and care. We store it in written records and electronically on computer. As a necessary part of that care and treatment we may have to share some of your information with other people and organisations who are either responsible or directly involved in your child's care. This may involve taking your child's information off site. We may also have to share some of your information for other purposes, such as research etc. Any information that is shared in this way will not identify your child unless we have your consent. If you have any questions and/or do not want us to share that information with others, please talk to the people looking after your child or contact PALS (Patient Advice and Liaison Service) on 0121 333 8403.

Birmingham Children's Hospital NHS Foundation Trust
Steelhouse Lane Birmingham B4 6NH
Telephone 0121 333 9999
Fax: 0121 333 9998
Website: www.bch.nhs.uk

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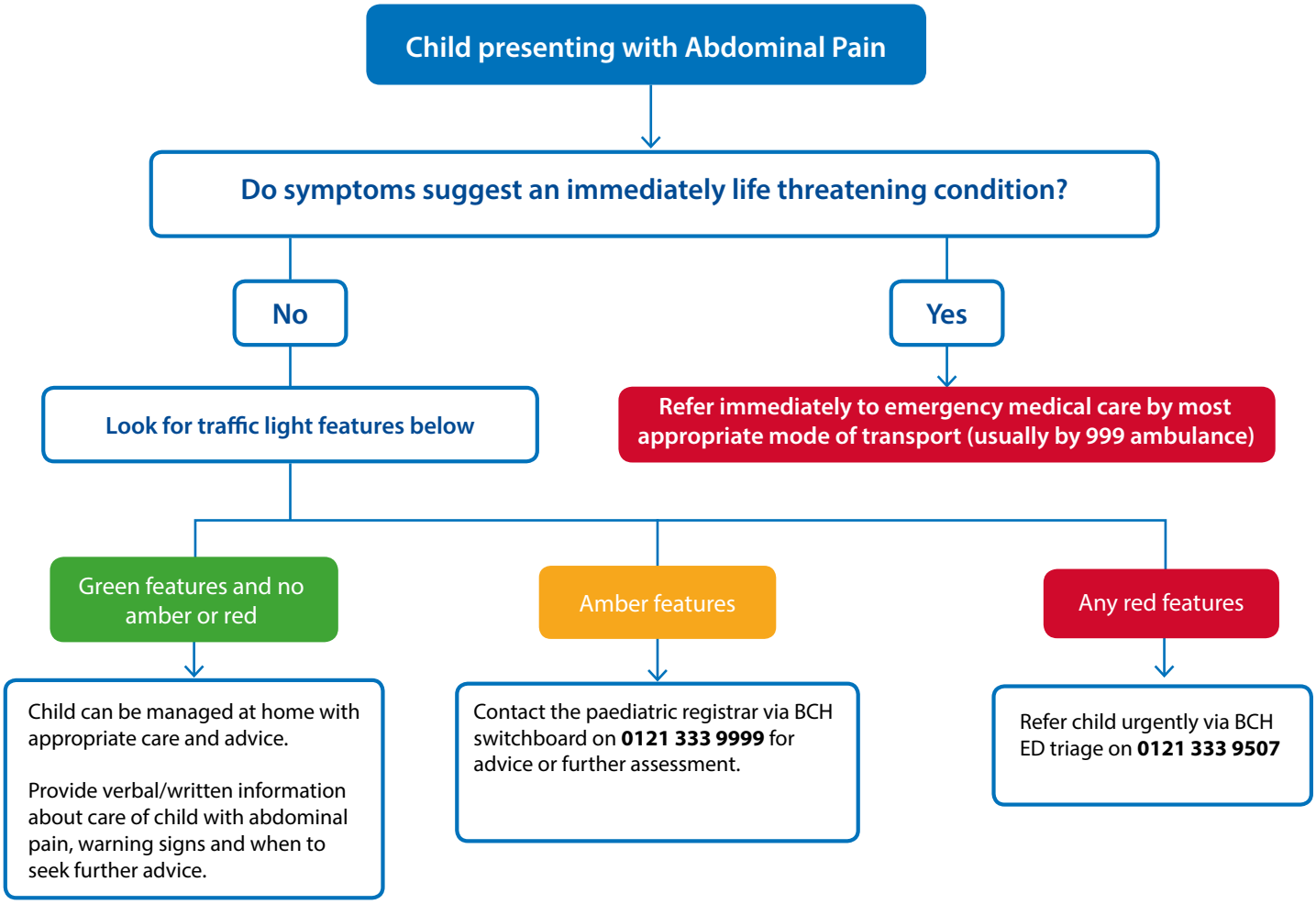
Clinical Assessment Tool

Abdominal Pain in children



Abdominal Pain Table 1: Traffic light system for identifying severity of illness

	Green - low risk	Amber - intermediate risk	Red - High Risk
Activity	Active/ responds normally to social cues		Drowsy/no response to social cues
Respiratory	Respiratory Rate Normal (RR) Infant 30 - 40 Pre-school 25-35 School age 20-25 SATS 95%		Respiratory rate over 60/minute SATS under 92%
Circulation and Hydration	CRT less than 2 seconds Heart rate normal Infant 120-170 Toddler 80-110 Pre-school 70-110 School age 70-110	CRT 2-3 seconds	CRT more than 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 Acute testicular pain Severe/ increasing pain

NB. Broad guidance as differential diagnosis very wide depending on age. Refer to page 1 for normal values CRT - Capillary refill time

Diagnostic Considerations in Abdominal Pain

Common causes of abdominal pain by age

Under 2 years	2 to 12 years	12 to 16 years
Gastroenteritis	Gastroenteritis	Mesenteric adenitis
Constipation	Acute appendicitis	Acute appendicitis
Intussusception	Mesenteric adenitis	Menstruation
Infantile colic	Constipation	Mittelschmerz
UTI	UTI	Ovarian Cyst Torsion
Incarcerated Inguinal Hernia	Pneumonia	UTI
Trauma	Diabetes	Pregnancy
Pneumonia	Testicular torsion	Ectopic Pregnancy
Diabetes	Onset of menstruation	Testicular Torsion
	Functional abdominal pain	Functional abdominal pain
	Trauma	Pneumonia
		Diabetes

Diagnosis to be considered	Symptoms and signs in conjunction with abdominal pain
Gastroenteritis	• Vomiting • Diarrhoea (can also occur in other conditions e.g. intussusception, pelvic appendicitis, pelvis abscess and inflammatory bowel disease)
Intestinal obstruction e.g. Intussusception or volvulus	• Bile stained vomiting • Colicky abdominal pain • Absence of normal stools / flatus • Abdominal distension • Increased bowel sounds • Visible distended loops of bowel • Visible peristalsis • Scars • Swelling 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 stool • Weight loss • Waking at night to open bowels
Midgut volvulus (shocked child)	Blood in stool
Henoch schonlein purpura	• Blood in stool • Purpuric rash
Haemolytic uremic syndrome	Blood in stool
Anorexia nervosa	Loss of appetite

Lower lobe pneaumonia	• Fever • Cough • Tachypnoea • Desaturations
Poisoning	Ask about history of possible ingestions and what drugs and other toxic agent are available at home
Irreducible inguinal hernia	Examine inguinoscrotal region
Tortion of the testis	This is a surgical emergency and if suspected the appropriate paediatric 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
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 overflowing • Abdominal distension • Poor appetite • Lack of energy • Unhappy, angry or irritable mood and general malaise.
If patient is post-pubertal female	• Suggest pregnancy test • Consider ectopic pregnancy, pelvic inflammatory disease or other STD. • Mittelschmerz • Torsion of the ovary • Pelvic inflammatory disease • imperforate hymen with hydrometrocolpos.
Known congenital or pre-exisiting condition	• Previous abdominal surgery (adhesions) • Sickle Cell anaemia • Nephrotic syndrome (primary peritonitis) • Mediterranean background (familial Mediterranean fever) • Hereditary spherocytosis (cholethiasis) • Cystic fibrosis (meconium ileus equivalent) • Cystinuria • Porphyria

Birmingham Children's Hospital NHS
NHS Foundation Trust

Information for Parents / Carers:

Caring for your child with Abdominal (Tummy) Pain

About abdominal (tummy) pain in children

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

- Bowel (gut) problems - constipation, colic or irritable bowel
- Infection - gastroenteritis, infections in other parts of the body like the ear, chest kidney or bladder.
- 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 the pain is low on the right side, your child walks bent over, won't hop or jump, and prefers to lie still.
- Period pain- some girls can have pain before their period starts.
- Poisoning- such as spider bites, eating soap or smoking.
- The most common cause of recurrent tummy ache is stress. Over 10% of children have this. The pain occurs in the pit of the stomach or near the belly button. The pain is mild but real.

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 them aspirin.
- Help your child drink plenty of clear fluid such as cooled boiled water or juice.
- Do not insist that your child should eat, if they feel unwell.
- If your child is hungry, offer 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 causes can be found.
- Sometimes the cause becomes more obvious with time which enables appropriate treatment to be started.
- If pain or other problems persist, see your doctor.

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 urgently 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.

Abdominal pain Advice Guide:

How is your child?

Red

If your child
- Becomes unresponsive
- Has rash that does not disappear using the tumbler test on this page
- Has green or blood stained vomit
- Is increasingly sleepy
- Has severe or increasing pain

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

Amber

If your child has
- 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 active or mobile as usual

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.

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

Name of Child .....

Age ..... Date/Time advice given .....

Further advice / Follow up .....

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Name of professional .....

Signature of professional .....

Some Useful Phone Numbers

GP Surgery (make a note of the number here)

.....

NHS 111 - Dial 111
(available 24hrs - 7 days a week)

GP Out of Hours Service - appointments booked via NHS 111
(Open from 6:30pm - 8:30am, 7 days a week)

For online advice:

NHS Choices www.nhs.uk
(available 24hrs - 7 days a week)

Urgent Care Centre

Warren Farm Urgent Care Centre
Warren Farm Road, Birmingham, West Midlands, B44 0PU
8.00am-8.00pm

Erdington Health and Wellbeing Walk In Centre
196 High Street, 1st Floor, Erdington, Birmingham, B23 6SJ
8.00am-8.00pm

Washwood Heath Urgent Care Centre
Clodeshall Road, Washwood Heath, Birmingham, West Midlands, B8 3SN
9.00am-9.00pm

The Hill Urgent Care Centre
Sparkhill Primary Care Centre, 856 Stratford Road,
Sparkhill, Birmingham, B11 4BW
8.00am-8.00pm

South Birmingham GP Walk In Centre
0121 415 2095
15 Katie Road, Selly Oak, Birmingham, B29 6JG.
8.00am-8.00pm

Birmingham NHS Walk In Centre
0121 255 4500
Lower Ground Floor, Boots The Chemists Ltd,
66 High Street, Birmingham, West Midlands, B4 7TA

Mon-Fri: 8.00am – 7.00pm (last patient seen at 6:30pm)
Sat: 9.00am – 6.00pm (last patient seen at 5:30pm)
Sun: 1.00am – 4.00pm (last patient seen at 3:30pm)

Solihull UCC
Solihull Hospital, Lode Lane, Solihull, B91 2JL
8.00am-8.00pm

Summerfield GP and Urgent Care Centre
Summerfield Primary Care Centre, 134 Heath Street,
Winson Green, Birmingham, B18 7AL.
8.00am-8.00pm

If you require an interpreter, inform the member of staff you are speaking with.

Data Protection

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HELP MAKE A DIFFERENCE

Birmingham Children's Hospital Charity

There are many ways in which you can support Birmingham Children's Hospital Charity and help make a huge difference to our patients and families.

For more info on how to get involved:

0121 333 8506

@ fundraising@bch.org.uk

Text **LOVEBCH** to **70020** and donate £3 a month to show your love for tomorrow's children

WWW.BCH.ORG.UK

This is a subscription service. You will be charged £3 plus a message at your standard network rate in the first month & £3 thereafter. Birmingham Children's Hospital Charities will receive 100% of the donation regardless of your network. To unsubscribe text STOP to 70020 or call 0121 333 8506. To find out how we manage your money please visit: www.bch.org.uk/money. Registered Charity Number: 1160875.

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