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Acute paediatric clinical features generally considered as indicators of high risk clinical situations (i.e. Sepsis/ serious health conditions/ health escalations) and may need consideration for referral to hospital (LCH/ PHB) same day/ Emergency/ urgently.

- Fever in less than 3 month old infant
- Fever with rapidly spreading non blanching rash especially in non SVC distribution
- Fever, inconsolable irritability, vomiting, bulging fontanelle, parents report that child is stiff to handle, poor feeding
- Fever, altered behaviour, irritability, neck pain, light hurting eyes
- Fever, child not usual self, abnormal posture or movements
- Child with Complex medical needs with fever: especially with indwelling vascular line/ urinary catheter, tracheostomy, shunts (in heart/ Cranium)
- Fever, unable to weight bear with or without joint swelling, not in their usual self
- Fever in immunocompromised clinical situations (e.g. oncology)
- Non-vaccinated unwell child with fever
- Febrile, grunting, cold extremities and pale- dusky, passing less urine, dry
- Fever, flank pain, unwell, urinary symptoms
- Children with significant failing to thrive with new symptoms of acute ill health.
- Neurological clinical context with acute neurological signs
- Fever, abdominal pain, adbominal distension, vomiting, refuses to mobilise, not letting touch tummy (referral to surgical team for children age > 5 years)
- Child with viral wheeze or asthma exacerbation not responding to appropriate action plan management steps in community
- Palpitations/ chest pain/ fainting with features of haemodynamic compromise
- T1DM/ DKA
- Vulnerable child with unreliable history (safeguarding concerns/ on child protection register/ local authority care)
- Suspicion of Non-accidental injury:
    - Medically unstable--- ED by ambulance
    - Medically stable: *Safeguarding concerns should be first escalated to children social services for consideration for Multiagency Strategy Discussion.*

- This is not an exhaustive list but covers most commonly encountered sepsis-prone/ other high risk clinical situations.
- It is important to remember that there could be a cross over with different permutation combinations of above features in given serious health condition in a child.
- Also, disease process and symptomatology may be evolving over variable period of time during the disease process.
- Stratification re severity of symptoms is age dependent in children.
- Information gathering from EPR (System One) is important.
- Listening to parent and CYP re their views and reflections is important

- There is no substitute to use a balanced combination of clinical acumen and common sense in making management decisions.
- Also, if in doubt consider.....

1. Consult with GP colleague in surgery
2. In borderline clinical situations: Consider risk assessing, safety-netting and follow up phone call to parents
3. You can contact paediatric hot week team (on call middle grade/ consultant) for advise

General paediatric situations needing consideration for the same day/ emergency review

Sepsis:

- Fever or cold/ clammy
- Blue, grey, pale or blotchy skin, lips or tongue – on brown or black skin, this may be easier to see on the palms of the hands or soles of the feet
- Non- blanching Rash
- Breathlessness, grunting
- Weak, high-pitched cry that's not like their normal cry
- Not responding like they normally do, or not interested in feeding or normal activities
- Being sleepier than normal or difficult to wake
- Reduced urine output

Bronchiolitis: (Prodromal Viral Coryzal symptoms, ronchi and crepts in infant/ toddler with respiratory distress)

- Significant work of breathing: Grunting, apnoeic episodes
- Reducing feeding to less than 50% of usual amount, infant not passed urine in 12 hours
- Poor oxygenation: poor colour, cold clammy, irritable (in these children Sats are likely to be below 92%)
- Abnormal mentation: poor tone, inconsolable, pauses in breathing
- High risk patients: Chronic lung disease, Congenital heart disease, CF, immunodeficient patients,
- Safeguarding concerns impacting on community based care and monitoring
- Be vary of Diphtheria as differential where cough is an overarching worrying symptom (especially non-vaccinated/ inadequately vaccinated children)

Asthma/ Viral Wheeze:

- ❖ No symptomatic improvement on appropriately followed asthma/ acute wheeze action plan
- ❖ Previous HDU/ITU care for asthma/ acute wheeze
- ❖ Unusually irritable/listless/ limp child with asthma exacerbation
- ❖ Child not able to speak in full sentences
- ❖ Safeguarding concerns impacting on community based care and monitoring

Community acquired pneumonia:

- ❖ Grunting
- ❖ Poor hydration, tachycardia disproportionate to fever and respiratory distress
- ❖ Unusually irritable/listless/ limp child
- ❖ Not getting better despite nearing 48 hours of PO antibiotics
- ❖ Background health conditions with poor overall reserves (respiratory, neuromuscular, nutritional)
- ❖ Safeguarding concerns impacting on community based care and monitoring
- ❖ Non- vaccinated/ inadequately vaccinated children

Croup:

- ❖ Background upper airway problems (e.g. in extreme prematurity)
- ❖ Unusually irritable/listless/ limp child
- ❖ Drooling, Temp >39, Pale, mottled
- ❖ Recurrence of symptoms following recent treatment for croup
- ❖ Background health conditions with poor overall reserves (respiratory, neuromuscular, nutritional)
- ❖ Safeguarding concerns impacting on community based care and monitoring
- ❖ Non- vaccinated/ inadequately vaccinated children

Possibility of meningitis:

- ❖ Temp >39, non-blanching rash, pale, cold , mottled
- ❖ Budging anterior fontanelle
- ❖ Unusually irritable- shrill cry/ listless/ limp/ abnormal posture in child
- ❖ Parents concerned something not right with their child

- Reduced feeding reduced urine output
- Situation of partially treated Meningitis (Children already on PO antibiotics)
- Background health conditions (Immunocompromised, medical devises/ plastic in situ, nutritionally compromised)
- Non- vaccinated/ inadequately vaccinated children

Urinary tract infections:

- Temp >39, Flank pain,
- Background structural urinary tract problem
- Urinary catheters/ stents in situ
- No response in 48 hours to reasonable antibiotic Rx
- Reduced feeding reduced urine output
- Unusually irritable/listless/ limp child
- Unusual urinary culture growth (atypical bacteria)

Exotic, unusual infectious/ non infectious diseases:

- Ongoing cough, night sweats, low grade fever, poor appetite , weight loss, from TB endemic country
- Pale, jaundice, high grade fever with chills, HS megally, petechial rash, poor urine output- Malaria/ acute hepatitis
- Acute gastroenteritis with blood in stools, fever, pale, poor urine output (Haemolytic uremic syndrome)
- High grade fever with maculopapular rash spreading from face to body, buccal mucosa lesions (Koplic spots) : Measles
- Fever ongoing > 5 days, irritable, rash, conjunctivitis, oral mucosal lesions, lymphnodes, oedema: Kawasaki

Non-blanching rash/ bruises:

- ITP: widely distributed petechial rashes, bruises- usually not an unwell child
- Leukaemia: widely distributed petechial rashes, bruises, unwell, joint symptoms, aches and pain, pallor, lymph node enlargement, Hepatosplenomegaly
- Henoch–Schönlein purpura: Non blanching palpable rashes mainly legs and buttocks, joint symptoms, abdominal pain
- Be aware of any safeguarding concerns

Children presenting with palpitations:

- Sudden onset or offset of palpitations
- Cardiac family history
- Abnormal ECG (especially QTc) or cardiac examination
- Palpitations are associated with collapse or pre-syncope
- Unwell/haemodynamic compromise
- Suspension of substance misuse or self-harm
- Abnormal thyroid status assessment

General Surgical problems:

- Abdominal pain +/- vomiting , loose motions with abnormal abdominal signs (appendicitis)
- Bilious vomiting may indicate problems with small bowel obstruction (e.g. malrotation)
- Torsion testis (this can just present with lower abdominal pain- important to examine testicles in such situations)
- Recurrent projectile Milky vomits in early infancy, with failing to thrive and dehydrated child- Pyloric stenosis

Acute Limp and Joint paints:

Risk factors increase likely hood of septic orthopaedic situations: Fever, Age < 3 Years, background health problems, intercurrent skin soft tissue infections, other features of sepsis

Renal:

Reduced urine output, oedema, sudden weight gain, haematuria, proteinuria (excess of 2+), high BP

First afebrile seizure in community:

- Check blood sugar, BP and ECG QTc
- Longer than 5 mins duration
- Intercurrent ill health symptoms
- Focal seizure
- postictal focal weakness, long postictal phase (> 1 hour),
- background of developmental delay, background health issues, strong family history of epilepsy
- Safeguarding concerns

Atypical Febrile seizure in community:

- ❖ Check blood sugar, BP and ECG QTc
- ❖ Longer than 15 mins duration,
- ❖ No obvious cause for fever could be ascertained
- ❖ Focal seizure
- ❖ postictal focal weakness, long postictal phase,
- ❖ Any clinical features of meningitis
- ❖ background of developmental delay, background health issues, strong family history of epilepsy
- ❖ Safeguarding concerns impacting on community based care and monitoring

Patients in following clinical situations may have open access to paediatrics and may have CCN and rapid response physiotherapy support in the community

- Patients with Chronic Lung Disease of prematurity on home oxygen
- Patients with Cystic Fibrosis
- Patients on continuous/ daily home oxygen
- Patients with tracheostomy
- Patients on long term Home Ventilation
- Patients with brittle/ difficult to treat asthma (history of PICU/ HDU care)
- Patients with bronchiectasis
- Patients with haemodynamically unstable congenital heart disease
- Patients with clinical conditions or treatments causing immune deficiency
- Patients with stoma/ mucus fistulae
- Patients with chronic neuromuscular conditions
- Patients who are wheel chair bound, special educational needs and on regular community physiotherapy support
- Patients at risk for febrile neutropenia (Oncology patients on immunosuppressive treatments)

For Safeguarding children issues, please follow recommendations in your PCN guidance.

For logistical advice regarding same day assessment paediatric referral process:

Please refer to recommendations in System Integrated Paediatric Pathway for UTCs and EDs in ULHT 2025 document.

Disclaimer:

This document is produced by Dr Amol A Chingale clinical lead Acute Paediatrics ULHT

- At the request of GP and UEC services in Lincolnshire ICB
- It is intended to be a general Top-Tips advice for more common paediatric conditions that get discussed by primary and secondary care for urgent/ emergency/ same day review.

- This is not intended to be exhaustive clinical information but communicated in the spirit of common general paediatric information sharing with a GP colleague.

Related references:

https://remedy.bnssg.icb.nhs.uk/media/6694/tips-and-tripwires-in-urgent-paediatric-primary-care-digital.pdf

https://www.selondonics.org/wp-content/uploads/GP-Referral-Guidance-for-General-Paediatrics-V2.pdf