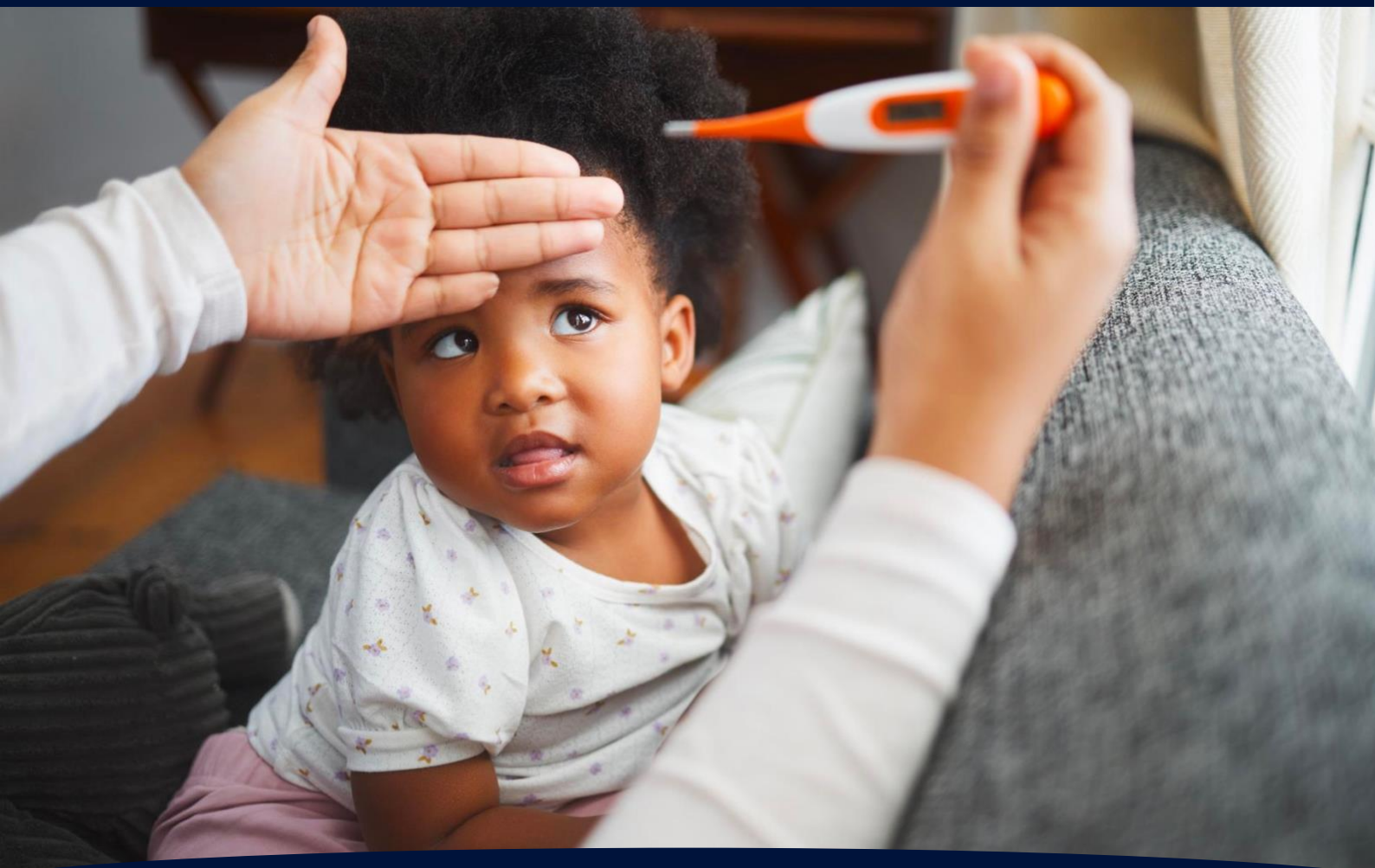
Tips and Tripwires in Urgent Paediatric Primary Care

Increase your knowledge and confidence in managing urgent problems in children and young people



BrisDoc Development Academy

Endorsed by Paediatric Emergency Consultants from the Bristol Children's Emergency Department and the Urgent Care Network of the GPCB

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Tips and Tripwires in Urgent Paediatric Primary Care

Introduction:

SevernSide IUC has previously distilled Tips and Tripwires in Urgent Primary Care, taking an all-ages lens:

- **Get the basics right - listen to the patient (or parent/carer**) - the clinical detail, the level of concern, the background picture, anything unusual, the time of day or night etc – 'Go to where the patient – or parent - is'. What are their ideas, concerns and expectations (ICE)?
- Beware assumptions
- Pay attention to detail – especially if prescribing
- Share uncertainty and share decision-making
- Beware the last patient
- Know your fears and be courageous
- "That's a bit odd" - pause and think, probably discuss
- Keep good (enough) records – capture all salient points, who is in the room/on the call, allow golden minute(s), document if 'nil similar before', eating/drinking/PUing, 'looks well, fully mobile', relevant obs, 'happy with plan', safety-netting, 'stressed' (emphasis to ring back), name advice sources, write more if the case is borderline or contentious or there are safeguarding concerns.

Tips and Tripwires in Urgent Paediatric Primary Care

This document shifts the lens to children and young people (CYP) and builds on the above. Within urgent paediatric primary care, there is a large breadth of clinical scenarios, from an unsettled 3w-old to a depressed 14yr-old, and all in-between. There is also substantial variation in clinical confidence. In general, the younger the patient, the more clinicians feel twitchy. So, take a moment to consider your own confidence in working with CYP.

Do certain age groups and/or clinical presentations cause particular unease? What resources might help? What support can you draw on 'in the moment'? An almost-universal trigger for fear-based medicine is that of missing serious illness in a child - and the child coming to avoidable harm. Another is missing a serious safeguarding concern. We have compiled these Tips and Tripwires to help you manage urgent paediatric cases with greater confidence.

Most children in primary care are not, in fact, seriously ill; many are not even unwell. Hence reassurance is a big part of our role. However, we must be able to recognise the sick child. See: *Home | Spotting the Sick Child* . Safeguarding CYP in urgent primary care is a big and thorny area. Child abuse, ranging from borderline neglect to catastrophic harm, is actually fairly common. However, individual clinicians see serious safeguarding cases rarely and hence often miss the signs. As well as all the training and usual advice, our straplines must be "eternal vigilance" and "if in doubt, act". *See links to Safeguarding resources in the Useful Resources section at the end.*

Our initial assessment these days is usually by telephone, with or without video or photo. The key question to answer in all cases is, **"What is the best next step?"** This is influenced by several factors, including the clinical picture, the diagnostic possibilities, the time of day (or night), the level of parental concern, the age of the patient, other recent consultations for the same issue, and so on.

We set out below a suggested format for both a remote and a face-to-face consultation. They are deliberately laid out separately, because there is a key decision in a telephone consultation which sets it apart from a face-to-face encounter. That is, whether to see the child face-to-face or not. Much of the telephone conversation leads to that decision.

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Remote Consultations:

GENERAL:

- Be conscious of your own levels of energy and confidence
- Use usual skill around history taking
- **Listen** to the CYP and their primary carer(s)
- Try to get to the ICE (ideas, concerns and expectations)
- Keep an open mind as long as possible and **think as the story unfolds**

PHONE consultation specifics:

- What exactly prompted the call? What are they most worried about?
- Find out what has been tried already and/or what services have been accessed already
- Ask about the activity level/behaviour of the child; what are they doing at the moment?

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- Are there any unusual features that merit bespoke probing? Eg. “mottled”, “vacant”, “floppy”, “unresponsive” etc
- Intake and output – bottles/nappies or general eating/drinking - relative to normal (≥50% of usual fluid intake and two urines in 24hrs is reassuring)
- Overall, how is the child compared to normal?
- How worried does the parent *sound*? Parental concern that their child is ‘just not right’ should always be taken seriously
- What is the social set-up?
- Consider the time of day or night – what is the child and family’s usual routine/bedtime etc?
- Remember the ‘extra bits’ for infants: perinatal, neonatal history, birth weight, risk factors for sepsis, prematurity, immunisation status
- Weight can help guide adjustment of dosing/fluids (NOTE: Paracetamol 15mg/kg/dose q4-6hourly, MAX 4 doses in 24 hours and Ibuprofen 10mg/kg/dose q6-8hourly, MAX 3 doses in 24 hours)
- Review Safeguarding history – check EMIS, Connecting Care, CPIS on Adastra

‘EXAMINATION’ on the phone:

- Can you hear the CYP in the background? What do they sound like? What are they doing during the call?
- Depending on the age, consider asking to speak to the CYP and use appropriate questioning. If needed because of a sensitive issue, check that they are in a safe and/or private environment
- Consider whether seeing the CYP (and their primary carer) on video will add value: assessing a child remotely in their home environment can provide useful additional information, but is generally not advised if a physical f2f is a likely outcome anyway
- Consider whether a photo will be useful – often helpful for rashes, swellings etc – especially in a well child. See Dermatology links in the Useful Resources section
- Refer to Paediatrics Reference Card for normal observation ranges - https://brisdoc.co.uk/wp-content/uploads/2017/08/PAEDIATRICS-REF-CARD-V2016.pdf
- Consider using remote further consultation guidelines to assist your decision making – see Clinical pathways - remote assessment :: Healthier Together (what0-18.nhs.uk) (these guidelines specifically cover remote assessment in CYP of abdo pain, cough

and SOB in <1yr and >1yr, D&V, earache, fever, limp, rash, sore throat and unsettled baby).

- If a worried parent really wants their child to be seen, arrange a face-to-face

ASK YOURSELF before finishing:

- Am I satisfied with my planned next step? Listen to 'your gut' and take a moment to reflect
- What is the level of uncertainty or concern here? Do I need to sense-check with a colleague (options include discussion with the Clinical Co-ordinator/another senior colleague on shift/colleague in the next room/CED advice line)

SUMMARISE and make a plan:

- Summarise key points out loud (and record them)
- Allow both the CYP (if appropriate) and their primary carer to ask questions
- It can be helpful to offer a range of options, to 'think out loud', especially late at night, e.g. "I am not concerned by this picture - we could see him tonight if you're worried - or you could see how he is in the morning – you can call us back if things change before then" (often, once heard and reassured, parents will opt to wait and see)
- Invest time in educating, reassuring and providing clear safety-netting advice to CYP and their carer
- More detailed, emphatic safety-netting advice is required where there is more clinical uncertainty – document specifics about time-frames and whom to call if things change, e.g. "If she's not picking up, or she's worse in the next 24hrs then you *must* call us back – here's the number"
- As a rule, safety-net back to Severnside (usually via the patient line) and not to ED or 999
- Consider providing written safety-netting advice too e.g., a factsheet via text
- If using the patient line, explain its use
- In general, empower parents to make informed decisions and escalate evolving concerns
- Where appropriate, recommend that parents download the HandiAPP (created by BNSSG and covers D&V, fever, chesty baby (bronchiolitis), chesty child (wheeze and asthma), abdo pain, common newborn problems, head injury)
- Know that the time you are investing here works towards improving the primary carer's health literacy, which can impact on future care episodes

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Face to Face Consultations:

GENERAL advice SAME as for remote consultation:

- Be conscious of your own energy levels and confidence
- Recap the telephone history and fill in any gaps; try to avoid repetition
- **Listen** to the CYP and their primary carer(s)
- Try to get to the ICE (ideas, concerns and expectations)
- Keep an open mind as long as possible

EXAMINATION:

- OBSERVATION - Behaviour/interactions with caregiver/interactions with you as the clinician -? age and developmentally appropriate, are they paying attention to the surroundings? How are they moving in the consulting room?
- Inspection - what is their general condition – well or unwell? Does the child appear well cared for? clean? appropriate weight for age? What is their colour? Children with high fevers can appear quite unwell; getting the temp down and then review (if feasible) will often reveal a different picture
- Remember that WELL children PLAY – is there a 'window of happiness' in your assessment of the child or not? Distraction techniques may need to be used in an unsettled or uncooperative CYP

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- Move from least invasive parts of structured assessment e.g. observations of behaviour, colour, movements from a distance, to more invasive e.g. ENT examination and pulse-oximetry
- Check baseline observations and vital signs – HR, RR, temp, sats (record if possible, and use size appropriate sats probe to avoid inaccurate reading). NOTE BP is rarely indicated in primary care – acute shifts in BP in paediatrics are a late sign
- Beware an *unexplained* tachycardia – it can be an early sign of sepsis (CED uses correct 10 beats per minute for each degree of raised temp)
- *Refer to Paediatrics Reference Card for normal observation ranges* - **HERE**
- The following acronym (used in APLS) can help to assist a structured approach to the examination (we recognise that there are other approaches to performing a structured assessment). The most important thing is that clinicians perform an appropriately thorough assessment in the circumstances:
    - Airway –? patent/stridor/stertor
    - Breathing – work of breathing/recession, chest wall movement, respiratory rate, oxygen saturations, auscultation of chest
    - Circulation – skin colour? ask parents for comparison to normal skin colour, capillary return, heart rate - interpret this in the context of fever, heart sounds
    - Disability – alert/activity state, behaviour? age and developmentally appropriate for individual, seizure, new focal neurology
    - Exposure – temperature (NOTE definition of fever is $\geq 38°$, $note\ low\ temp \leq 36°\ esp.\ in\ neonates\ can\ be\ a\ sign\ of\ sepsis$), head to toe check for rash (NOTE fever $\geq 38°$ under 3 months of age is a RED flag)
    - Fluids – input/output, hydration status,?<50% normal intake, fewer than 2 wet nappies in 24 hours
    - Glucose – consider doing a BM if dehydration concerns/ diabetic emergency is within your differential diagnosis
    - Complete systemic or focused examination – e.g. abdo/ENT/joints

SUMMARISE and make a PLAN:

- Summarise key points out loud (and record them)
- Allow both the CYP and their primary carer to ask questions
- Often the plan is clearcut, but, if not, as above, it can be helpful to offer a range of options, to 'think out loud'
- Consider whether an interval review would help ("We will ring you in a few hrs to see how she's doing" sort of thing)
- Invest time in educating, reassuring and providing clear safety-netting advice to CYP and their carer

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- Consider providing written safety-netting advice too e.g. a factsheet via text
- Where appropriate, offer the patient line and explain its use
- As above, safety-netting should be more detailed and emphatic if the case is borderline
- As a rule, safety-net back to Severnside and not to ED or 999
- Empower parents to make informed decisions and escalate evolving concerns
- Where appropriate, encourage use of the HANDi Paediatric App (created by BNSSG and covers D&V, fever, chesty baby (bronchiolitis), chesty child (wheeze and asthma), abdo pain, common newborn problems, head injury)
- Know that the time you are investing here works towards improving the primary carer's health literacy, which can impact on future care episodes

In *all* cases, seek to share decision-making and agree the decision. If agreement cannot be reached, then explore further, tread very carefully and take advice.

Reminder: some general RED or AMBER flags:

- Fever ≥ 38° under 3m
- Fever ≥ 39° 3-6m
- Unexplained tachycardia
- Fever for ≥ 5 days
- Vomiting without diarrhoea
- Pain waking a child from sleep

Fuller list for the feverish child: HERE

Summary

Providing urgent care to children and young people – and their parents – can be interesting, fun and rewarding. Children do not stand on ceremony. There is little clinical complexity and the simplest of interventions – empathy and reassurance – can be invaluable to a worried parent and fulfilling for the clinician. There can also be moments of fear, uncertainty, and perplexity, but the team at Severnside IUC is there to offer support and guidance. We strongly stress the importance of getting the basics right, and we hope that these "Tips and Tripwires" will increase your knowledge and confidence to practise courage-based medicine. We cannot be soothsayers, but we can do all that is reasonable, with a warm smile (or an engaging tone), an attentive ear, and a kind heart.

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Additional input from: Dr Charlie Kenward, BrisDoc Lead GP, Renuka Suriyaarachchi, Head of Severnside IUC Nursing and AHPs, Dr Vicky Donkin, GP, BrisDoc

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Useful Resources:

Clinical Guidelines

- Remote assessment guidelines covering abdo pain, cough & SOB, D&V, earache, fever, limp, rash, sore throat and unsettled baby: CLICK HERE
- Medicines for Children factsheets listing advice for individual drugs, FAQs, when to give, possible side-effects etc: CLICK HERE
- Refer to local BNSSG clinical guidelines available through REMEDY – CLICK HERE
- RCH guidelines CLICK HERE (these are generally user friendly and most would be applicable to patients in BNSSG)
- Dermatology: https://dermnetnz.org/ or https://dftbskindeep.com/

Safety-netting advice & parent factsheets

- 'Healthier Together' Parent fact sheets: Please note that these are RCPCH-endorsed and cover a wide range of conditions. These factsheets are accessible in both written and spoken format and can be translated into multiple languages by simply clicking a button in the header bar on the healthier together website. Factsheets can be directly SMS texted to parents from the website: CLICK HERE
- HANDi Paediatric app – for parents to download CLICK HERE
- UHBW parent factsheets https://foi.avon.nhs.uk/
- Information for children with complex needs, including training videos and guides e.g. online CPR training https://www.wellchild.org.uk/
- Mental health, behaviour, and wellbeing resource https://happymaps.co.uk/

SAFEGUARDING

- Referrals & Procedures (Remedy BNSSG ICB)
- Non-Mobile Babies Injuries – BrisDoc Clinical ToolKit
- Crying baby resource which has been shown to reduce abusive head trauma ('shaken baby') https://iconcope.org/

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