

CONSULTATION SKILLS · ACUTE & URGENT CARE

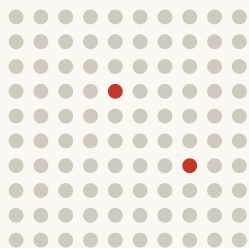
Decision-Making & Safety-Netting in Acute Presentations

Recognising serious illness — and keeping the patient safe — when the diagnosis is uncertain

1 The core challenge

Acute illness is the commonest reason people contact primary care. The overwhelming majority — feverish children above all — have a **self-limiting viral illness** that will settle by itself. A very small number have a **serious infection** that can kill or leave lasting harm.

The hard part is timing. The serious few often present **early**, when the danger signs are still subtle and look identical to the harmless many.



A needle in a haystack

Of roughly 100 acutely unwell children a GP sees, only a handful have a serious infection. Your task is not to diagnose everyone — it is to **separate the few who are, or are becoming, seriously unwell** from the many who are not, and to build a safety net for everyone in between.

● Self-limiting illness ● Serious infection

◆ FRAMING

Diagnostic uncertainty is normal in primary care. Most consultations end without a firm diagnostic label. The skill is not to eliminate uncertainty — that is impossible — but to **manage it safely**.

2 Four ways to handle uncertainty

When you cannot be certain, you still have a small, reliable set of moves. Heneghan and colleagues, and Buntinx and colleagues, described these strategies for managing diagnostic uncertainty. Combined, they give one clean toolkit.

🎯 1 • Investigate

Order a test to raise or lower your suspicion — but only when the result will change what you do.

▶ 2 • Trial of treatment

Treat, then watch for the response you expect. A clear improvement — or its absence — is itself diagnostic information.

◆ 3 • Watch & wait

Use **time as a diagnostic tool**. Review at a set point so the picture can declare itself.

✓ 4 • Safety-net

Agree a contingency plan so the patient is caught if the illness behaves in a way you did not predict.

Two things support every move: your **gut feeling** — a validated warning sign that you must take seriously — and **diagnostic algorithms** such as the NICE traffic light system. When one strategy is not enough, combine them, and **share the uncertainty openly** with the patient or parent.

◆ CONCEPT

These are not consolation prizes for a "failed" consultation. Acting wisely under uncertainty **is** the core craft of primary care.

3 Safety-netting: your safety net

Roger Neighbour introduced *safety-netting* as an essential part of every good consultation. A safety net is a **contingency plan** — it keeps the patient safe if the illness does something you did not expect.

Neighbour framed it as three questions you must answer **out loud**, for every patient:

1 If I am right, what do I expect to happen?

e.g. the fever settles within about three days.

2 How will I know if I am wrong?

e.g. the fever persists beyond three days, or the child becomes more unwell.

3 What will I — and the parent — do then?

e.g. re-attend for review, by a clearly agreed route back in.

Modern research gives us a sharper definition. Safety-netting is a consultation technique that does three jobs: it **communicates uncertainty**, it tells the patient which **red-flag symptoms** to watch for, and it **plans timely re-assessment** (Jones et al., *BJGP* 2019).

✓ KEY PRINCIPLE

A safety net is only safe if the patient understands it. You **must** confirm they know **what** to look for, **when** to act, and exactly **how** to get back to you.

4 How to safety-net well

Good safety-netting is **specific**. "Come back if you're worried" is not a safety net. Every net needs three answers the patient can repeat back to you:

LOOK FOR

What

The specific worrying symptoms and red flags for *this* illness — named, not vague.

ACT

When

The expected time course, and the point at which "normal" becomes "worrying."

GET HELP

How

The exact route back — same-day appointment, 111, or 999 — tailored to the time of day.

Behind the scenes, safety-netting also means **following up your own tests and referrals**, and arranging review wherever real risk remains.

► IN PRACTICE

- Give **written AND verbal** advice. Combining both improves recall and, in children, reduces antibiotic use and re-attendance (Burvenich et al., *BJGP* 2024). Verbal advice alone is no longer sufficient where deterioration is a real risk.
- **Tailor it.** Use plain language, avoid jargon, and allow for first-time parents, language barriers, and health literacy.
- **Document it.** Record the specific advice you gave — it is a medicolegal expectation and it supports continuity of care.

5 Worked example: the feverish child

The clearest worked example is the child under 5 with fever. **NICE NG143** provides a traffic light system to stratify the risk of serious illness.

▲ ALWAYS FIRST

Before anything else, look for immediately life-threatening problems — airway, breathing, circulation, consciousness — and think "**Could this be sepsis?**" If sepsis is possible, act now using **NICE NG254** (suspected sepsis in under 16s).

Assessment	GREEN — low risk	AMBER — intermediate risk	RED — high risk
Colour (skin, lips, tongue)	Normal colour	Pallor reported by parent or carer	Pale, mottled, ashen or blue
Activity	Responds normally to social cues · content or smiles · stays awake or wakes quickly · strong or normal cry, or not crying	Not responding normally to social cues · no smile · wakes only with prolonged stimulation · decreased activity	No response to social cues · appears ill to a professional · will not wake, or if roused will not stay awake · weak, high-pitched or continuous cry
Respiratory	—	Nasal flaring · tachypnoea (RR >50 if 6–12 mo; >40 if >12 mo) · O ₂ sats ≤95% in air · crackles in the chest	Grunting · tachypnoea RR >60 · moderate or severe chest indrawing
Circulation & hydration	Normal skin and eyes · moist mucous membranes	Tachycardia (>160 if <12 mo; >150 if 12–24 mo; >140 if 2–5 yr) · capillary refill ≥3 s · dry mucous membranes · poor feeding in infants · reduced urine output	Reduced skin turgor
Other	None of the amber or red features	Age 3–6 mo, temp ≥39°C · fever ≥5 days · rigors · swelling of a limb or joint · non-weight-bearing / not using a limb	Age <3 mo, temp ≥38°C · non-blanching rash · bulging fontanelle · neck stiffness · status epilepticus · focal neurological signs · focal seizures

Adapted from NICE NG143 (2019, updated 2021), Table 2 — Traffic light system for identifying risk of serious illness in under-5s. Manage by the highest-risk feature present.

What to do — action by colour (NICE NG143)

● RED

Refer **urgently** to a paediatric specialist for same-day assessment. If any feature is **immediately life-threatening**, call **999 now**.

● AMBER

Arrange **face-to-face assessment**. If no clear diagnosis is reached, provide a **safety net** or refer for specialist paediatric assessment.

● GREEN

Care **at home** with clear, specific **safety-net advice** on when and how to seek further help.

► THE ONE RULE THAT TIES IT TOGETHER

Score by the **worst feature present**. A single **red** feature makes the child high-risk, however reassuring everything else looks. And the table never overrides you: immediately life-threatening signs — or your own, or the parent's, serious concern — mean you **escalate at once**.

Safety-net advice for parents (NICE NG143)

Tell parents to **seek further help urgently** if the child:

- ✗ has a fit
- ✗ develops a **non-blanching rash**
- ✗ looks more unwell than before
- ✗ the parent is more worried, or cannot cope
- ✗ has a fever lasting **5 days or longer**
- ✗ shows signs of dehydration

Also show parents how to spot a non-blanching rash — it is harder to see on darker skin, so check the **palms, soles and conjunctivae** — and how to recognise dehydration. Offer regular fluids (breast milk if breastfed) and check the child overnight.

▲ DO NOT — COMMON ERRORS TO AVOID

- ✗ **Do NOT** use paracetamol or ibuprofen with the sole aim of lowering temperature — treat *distress*, not the thermometer reading.
- ✗ **Do NOT** give paracetamol and ibuprofen together routinely (consider alternating only if distress persists before the next dose is due).
- ✗ **Do NOT** prescribe oral antibiotics to a child with fever and **no identified source**.
- ✗ **Do NOT** use tepid sponging, and **do NOT** under-dress or over-wrap the child.

Antipyretic and antibiotic guidance: NICE NG143, sections 1.5–1.6. Doses must be checked against the BNF for Children before prescribing.

6 What's changed from older teaching

▲ UPDATED GUIDANCE — READ BEFORE YOU TEACH

- **"Think sepsis" now points to NICE NG254** (suspected sepsis in under 16s), which has superseded the earlier sepsis guidance.
- **The traffic light system is an aid, not a rule-out.** Recent primary-care studies show it does not reliably separate serious from self-limiting illness on its own (Clark et al.). Use it *alongside* your clinical judgement and gut feeling — never instead of them.
- **Written PLUS verbal safety-netting is now the standard.** Verbal advice alone is not enough where deterioration is a real risk.
- **Fever + non-blanching rash:** since MenB/MenC vaccination, the chance of meningococcal disease has fallen to around 1% (PIC study, 2020) — but every such child **still needs same-day assessment**.
- **Antipyretics are for comfort, not for the number** on the thermometer.

7 Pitfalls & the medicolegal net

- ▶ A **worried parent** and your own **gut feeling** are red flags in their own right — act on them, do not explain them away.
- ▶ The **height and duration of fever alone do not predict serious illness** — but a fever lasting **5 days or longer** means you must assess for Kawasaki disease.
- ▶ The commonest failure is a **vague net**. Always specify the **what**, the **when**, and the **how**.
- ▶ If it is not written down, it did not happen. **Document the net** — the specific advice, not just "safety-netted."

8 One-page recap

The problem

Rare serious illness hides among common self-limiting illness — and often presents **early**, before the signs are obvious.

The mindset

You cannot remove uncertainty. **Manage it** — don't chase a label you may not reach.

The toolkit

Investigate · **Trial of treatment** · **Watch & wait** · **Safety-net** — supported by gut feeling and algorithms.

The net (Neighbour's three questions)

If I'm right, what happens? · How will I know if I'm wrong? · What will we do then?

Make it specific

WHAT to watch for · **WHEN** to act · **HOW** to get help — given **written** + **verbal**.

Fever, step by step

Think sepsis first → traffic-light stratify → **Red** refer urgently / 999 · **Amber** face-to-face + net · **Green** home + net.

Always

Document the advice you gave.

Sources & further reading

NICE NG143 — Fever in under 5s: assessment and initial management (2019, updated 2021). · **NICE NG254** — Suspected sepsis: recognition, diagnosis and early management (under 16s). · **NICE NG240** — Meningitis (bacterial) and meningococcal disease. · **NICE QS64** — Fever in under 5s (safety-net quality statement).

Jones D, et al. Safety netting for primary care: evidence from a literature review. *Br J Gen Pract* 2019;69:e70–79. · **Burvenich R, et al.** Effectiveness of safety-netting approaches for acutely ill children: a network meta-analysis. *Br J Gen Pract* 2024. · **Neighbour R.** *The Inner Consultation* (safety-netting). · Conceptual frameworks after **Heneghan et al.** and **Buntinx et al.**

Acknowledgement: modernised from a Bradford VTS teaching note on decision-making and safety-netting in acute presentations. Clinical content verified against NICE guidance (primary source) in July 2026.

◆ DISCLAIMER

This document is provided exclusively for education and training as a teaching aid. It does not constitute formal clinical guidance. Clinicians must independently verify all medical information, prescribing guidance, procedural protocols, and legal requirements against current national guidance, the BNF, local policies, and the relevant regulatory bodies before applying anything in practice.