PAEDIATRICS · PRIMARY & URGENT CARE

Top tips for paediatric care in general practice

A fast, plain-English field guide for GP trainees and international medical graduates. How to **read a sick child**, the emergencies you **must not miss**, and the everyday problems you will see every week — rebuilt against current UK guidance.

Original teaching aid by Dr Jenny Wright (August 2021). Clinically updated & redesigned by Bradford VTS, July 2026.

◆ THE ONE IDEA TO HOLD ONTO

In children, **how a child looks beats any single number.** A well-looking child with a high fever is usually safer than a quiet, floppy, "just not right" child with a normal temperature. Assess the **whole child**, listen to the parent's instinct, and use the traffic-light system to decide who is safe to go home.

What's inside

◎ HOW TO USE THIS GUIDE

Every emergency is laid out the same way — **Recognise** → **Act** → **Refer** — so the pattern becomes automatic under pressure. All doses are drawn from the **BNF for Children** and named national guidance and are cited on the page. Verify against your local pathway before acting.

Five rules that keep children safe

1. Look at the child, **not the number.**
2. Trust the **parent's instinct.**
3. In anaphylaxis, give **adrenaline first.**
4. For the meningococcal child, **don't delay transfer.**
5. When in doubt, **phone paediatrics today.**

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1 Reading the child in front of you

A structured history and examination catches most serious illness before any test does.

Start with the people who know the child best

- **Trust the parent's instinct.** Parents and carers know their child best; "he's just not himself" is a red flag until proven otherwise. **Listen** to their concern — it outperforms most examination findings.
- **Read the background.** Birth and past history give away risk: prematurity or atopy points to chronic respiratory problems; recurrent ear infections may explain speech delay. One glance at the notes reframes the whole consultation.
- **Look at the child, not just the numbers.** Are they **alert, active and interested** in their surroundings, or floppy, glazed and too quiet? A child who resists examination is usually reassuring; one who lets you do anything may be seriously unwell.

The four things you must always check and record

▶ MEASURE AND WRITE DOWN — EVERY CHILD, EVERY TIME

Temperature, heart rate, respiratory rate and capillary refill time. Compare against age-appropriate values (see the traffic-light table overleaf). You cannot call a child low-risk without them. **[NICE NG143]**

Hydration — ask specifically: feeding and fluid intake, and wet nappies. Babies dehydrate fast. **Red flag:** no urine / dry nappy for more than **12 hours**.

See the child in context

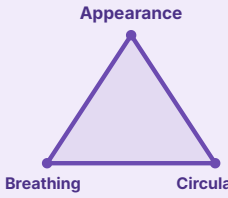
- For behavioural or chronic problems, weigh the **psychological, social and environmental picture** — safeguarding concerns, parental mental health, neglect, poverty and poor housing all shape a child's health and development.
- Name the parents' **expectations and worries** out loud, then give clear **safety-net advice** so they know exactly when to come back.

✓ THE GOLDEN RULE

If you are unsure whether a child needs admission or observation, **you must discuss with paediatrics the same day.** Trusting your instinct and picking up the phone is never the wrong call. It is always better to be safely wrong than confidently late.

The 5-second look from the doorway

◆ THE PAEDIATRIC ASSESSMENT TRIANGLE — BEFORE YOU TOUCH THE CHILD



Appearance	Alert, engaging, good tone and cry? Or floppy, glazed, inconsolable, too quiet?
Work of breathing	Recession, nasal flaring, grunting, head-bobbing, abnormal sounds?
Circulation to skin	Colour: pink, or pale / mottled / blue? Capillary refill?

Any side abnormal from across the room = a potentially seriously unwell child. This first impression shapes everything that follows.

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2 The sick child at a glance

The NICE traffic-light system for under-5s — the fastest way to sort low, intermediate and high risk. **[NICE NG143]**

	Green · low risk	Amber · intermediate	Red · high risk
Colour (skin/lips/tongue)	Normal colour	Pallor reported by parent/carer	Pale / mottled / ashen / blue
Activity	– Responds normally to social cues – Content / smiles – Stays or wakes quickly; strong cry	– Not responding normally; no smile – Wakes only with prolonged stimulation – Decreased activity	– No response to social cues – Appears ill to a professional – Won't wake / won't stay awake – Weak, high-pitched or continuous cry
Respiratory	Normal breathing	– Nasal flaring – Tachypnoea: RR >50 (6–12 mo), RR >40 (>12 mo) – O_2 sats ≤95% in air; crackles	– Grunting – Tachypnoea: RR >60 – Moderate/severe chest indrawing
Circulation & hydration	Normal skin & eyes; moist mucous membranes	– Tachycardia: >160 (<1 yr), >150 (1–2 yr), >140 (2–5 yr) – CRT ≥3 s; dry mucous membranes – Poor feeding; 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/joint – Non-weight-bearing / not using a limb	– Age <3 mo, temp ≥38°C – Non-blanching rash; bulging fontanelle; neck stiffness – Status epilepticus; focal seizures / focal neurology

GREEN
- Home with clear safety-net advice.

AMBER
- Face-to-face assessment; if no diagnosis, safety-net or refer for specialist assessment.

RED
- Urgent, same-day face-to-face assessment / admission.

▲ **WHAT'S CHANGED FROM OLDER TEACHING — TREAT THE CHILD, NOT THE THERMOMETER**

Do not rely on how high the fever is, or on whether it falls after paracetamol, to decide how serious the illness is. In children over 6 months, height of temperature **alone** does not identify serious illness. Give antipyretics to **relieve distress**, not to "treat the number" — and they do **not** prevent febrile convulsions. **[NICE NG143]**

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3 Emergencies you must not miss

Same layout every time: **Recognise** the pattern → **Act** now → **Refer** / escalate.

Meningococcal sepsis & meningitis

~90% OCCUR UNDER 5 YEARS

A **non-blanching rash in an unwell child is sepsis until proven otherwise.**

RECOGNISE

- Non-blanching petechiae/purpura (lesions >2 mm)
- Fever, irritability, poor feeding, mottled skin
- Neck stiffness, photophobia, bulging fontanelle, altered consciousness, seizures
- **No rash does not exclude it**

ACT

- **Call 999** and transfer — transfer must not be delayed
- If meningococcal disease is strongly suspected (esp. non-blanching rash), give **IM/IV benzylpenicillin** (or ceftriaxone) as soon as possible **unless it delays transfer**
- Give IM if a vein cannot be found

REFER

- Blue-light admission, every case
- Communicate the dose given to the receiving team
- Notify & involve health protection for contact prophylaxis

Pre-hospital benzylpenicillin — single STAT dose (IV or IM)	Dose
Adult & child 10 years or over	1.2 g
Child 1–9 years	600 mg
Child under 1 year	300 mg

*Withhold pre-hospital antibiotics **only** if there is a clear history of **severe allergy / anaphylaxis** to penicillin or ceftriaxone. A simple rash after penicillin is **not** a contraindication. Source: NICE NG240 (2024); BNFc.*

Anaphylaxis

ADRENALINE IS THE ONLY FIRST-LINE DRUG

Sudden onset + **Airway, Breathing or Circulation** problem, usually with skin/mucosal change.

RECOGNISE

- Rapid onset after a likely trigger
- **A:** stridor, hoarse voice, swelling
- **B:** wheeze, respiratory distress, low sats
- **C:** pale, clammy, hypotension, collapse

ACT

- **IM adrenaline into the anterolateral thigh — give it early**
- Call 999; give high-flow oxygen
- Lie flat and **raise the legs** (sit up only if breathing is easier; never stand suddenly)
- **Repeat IM adrenaline after 5 min** if no better; give an IV fluid bolus

REFER

- No response after **2 IM doses = refractory** → IV adrenaline by specialists only
- Admit & observe; discharge with **2 adrenaline auto-injectors** + training + allergy referral

IM adrenaline 1:1000 — repeat after 5 min if no improvement	Dose
Adult & child over 12 years	500 mcg (0.5 mL)
Child 6–12 years	300 mcg (0.3 mL)
Child 6 months–6 years	150 mcg (0.15 mL)
Child under 6 months	100–150 mcg (0.1–0.15 mL)

▲ WHAT'S CHANGED — DROP THE ANTIHISTAMINE AND STEROID REFLEX

In the current algorithm, **you must NOT delay adrenaline** to give anything else. Chlorphenamine and hydrocortisone are **no longer part of the emergency treatment** of anaphylaxis — adrenaline, oxygen and fluids are what save the patient. Source: Resuscitation Council UK (2021).

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Acute asthma / wheeze CHILD AGED 1 YEAR AND OVER

Sats and effort of breathing sort the moderate attack from the emergency.

RECOGNISE — SEVERE / LIFE-THREATENING

- SpO_2 <92%; silent chest, poor effort, exhaustion
- Too breathless to talk or feed
- RR >40 (1–5 yr) or >30 (>5 yr); using accessory muscles
- PEF <50% of best

ACT

- **Severe:** call 999. If SpO_2 <92% give high-flow oxygen + nebulised salbutamol 2.5–5 mg (± ipratropium, esp. under 2s)
- **Mild–moderate, sats >94%:** up to **10 puffs** salbutamol via spacer, every 3–4 h
- Give **oral prednisolone early** (see table)

REFER

- Admit if SpO_2 <94%, exhausted, or not settling on 10 puffs
- Tell parents: if symptoms not controlled by 10 puffs at home, **seek urgent help**
- Review within 48 hours after any attack

Oral prednisolone — give early, usually 3–5 days (roughly 1–2 mg/kg)	Dose
Child under 2 years	**10 mg**
Child 2–5 years	**20 mg**
Child over 5 years	**30–40 mg**

*Source: BTS/SIGN acute asthma algorithm; BNFc. Note: the 2024 BTS/NICE/SIGN guideline (NG245) changed **chronic** asthma diagnosis and treatment but **does not cover acute attacks** — acute management still follows the BTS/SIGN algorithm.*

New type 1 diabetes & DKA DO NOT SEND HOME TO "SEE HOW THEY GO"

The classic story is easy to miss when you are thinking "just a virus".

RECOGNISE

- Subacute weight loss, thirst, **polyuria / new bed-wetting**, fatigue
- **DKA:** vomiting, abdominal pain, ketotic (pear-drop) breath, deep sighing breathing, drowsiness, shock

ACT

- Check **finger-prick glucose** and blood/urine ketones the same day
- Confirmed diabetes → **same-day referral** to the paediatric diabetes team

REFER

- Any suspicion of **DKA** or a shocked child → **admit via 999**

Source: NICE NG18 (diabetes in children & young people).

Decode the noisy breathing

The sound	Where the problem is	Think of
Stridor (harsh, on breathing in)	Upper airway / larynx	Croup; inhaled foreign body; (rarely) epiglottitis
Wheeze (musical, on breathing out)	Lower airway / bronchi	Asthma (over 1 yr); bronchiolitis / viral wheeze (under 1 yr)
Grunting	Lung / a child fighting to breathe	**A red flag — sepsis, pneumonia, severe distress**

◆ **MEMORY HOOK — THE "3 A'S" OF THE WELL VS UNWELL CHILD**

For any acutely unwell child, glance for the **3 A's**: **Alert** (engaging, making eye contact), **Active** (moving, playing, resisting you), **Amber/red-free** (no traffic-light flags). Lose any one, and your threshold to discuss with paediatrics drops sharply.

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4 Refer or discuss the same day

Conditions where the safe default is admission or a same-day paediatric conversation. Spot the giveaway clue, then act.

Condition	The giveaway clue	Action
Kawasaki disease	Fever **≥5 days** + red cracked lips, bilateral conjunctivitis, rash, swollen/peeling hands & feet, cervical node	**Admit — risk of coronary artery aneurysm**
Non-accidental injury	**Bruising in a non-mobile baby**; injury inconsistent with the story or with development	**Admit & follow local safeguarding pathway**
First / febrile seizure	First-ever seizure, or any focal, prolonged (>5 min) or repeated seizure, or child still unwell	**Admit for assessment (give O_2, call 999 if fitting)**
Head injury	LOC, repeated vomiting, confusion, focal neurology, or dangerous mechanism	**Send to ED. Do not arrange CT from the community [NG232]**
Bronchiolitis (<1 yr)	Coryza then wheeze/crackles; **poor feeding, apnoea, recession, grunting**	**Admit if feeding poorly or working hard [NG9]**
Dehydration (D&V)	Dry nappies >12 h, no tears, sunken fontanelle, prolonged CRT, lethargy	**Admit if shock or unable to tolerate oral fluids [NG84]**
Fever without source	Baby **<3 months**, fever ≥5 days, or an unwell infant — often occult **UTI**	**Admit / same-day assessment; send urine [NG143, NG224]**
Irritable hip	Atraumatic limp or **refusal to weight-bear** (transient synovitis / Perthes; must exclude septic arthritis)	**Same-day assessment**
Henoch–Schönlein purpura	Palpable purpura on legs/buttocks + joint or abdominal pain	**Check BP, U&E & urine dip; arrange follow-up urine monitoring**
ENT — quinsy / mastoiditis	Trismus & drooling; or a tender, pushed-forward ear with unwell otitis media	**Same-day ENT / admission**

Surgical causes — the "can't-wait" abdomen & groin

▲ **REFER FOR URGENT SURGICAL ASSESSMENT**

- ▲ **Appendicitis** — ask the child to **jump or cough**: pain in the right iliac fossa on doing so is a useful pointer. If they can't, admit.
- ▲ **Testicular torsion** — a **high, swollen, exquisitely tender testis** is torsion until proven otherwise. This is time-critical — refer immediately.
- ▲ **Pyloric stenosis** — **projectile non-bilious vomiting** in a hungry 2–6 week-old, with weight loss / dehydration.
- ▲ **Incarcerated inguinal hernia** in a neonate or infant — a tender, irreducible groin/scrotal lump.

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5 The problems you'll see every week

High-volume primary-care presentations where getting the basics right prevents most referrals.

Croup

Barking (seal-like) cough, hoarse voice and stridor, usually worse at night in a 6-month to 3-year-old.

Give a single oral dose of dexamethasone 150 mcg/kg for **all** severities — it works within hours and cuts re-attendance. Use nebulised budesonide 2 mg only if oral is not tolerated.

Admit if there is stridor at rest, marked recession, agitation or drowsiness — give steroid and nebulised adrenaline before transfer.

Source: BNFc; NICE CKS croup.

Constipation

Common, and often under-treated. Diagnose it **clinically** — no investigations needed in typical cases.

First-line is an oral macrogol (e.g. polyethylene glycol 3350 + electrolytes), using an **escalating disimpaction regimen**, then a maintenance dose. Add a stimulant laxative if macrogol alone is not enough. Dose by weight/age — check the BNFc.

Reassure that this is **not** long-term harm and continue treatment for weeks after regular soft stools return.

Source: NICE CG99; BNFc.

▲ **CONSTIPATION RED FLAGS — DO NOT JUST PRESCRIBE A LAXATIVE**

Refer / investigate rather than treat blindly if there is: failure to pass meconium in the **first 48 hours** of life, constipation from **birth or the first few weeks**, **ribbon stools**, leg weakness or abnormal lower-limb neurology, abdominal distension with vomiting, or any safeguarding concern. These suggest an organic cause (e.g. Hirschsprung's disease, spinal or anorectal problems). **[NICE CG99]**

◎ **FEVER MYTH-BUSTING — WHAT TO TELL EVERY PARENT**

- Use paracetamol **or** ibuprofen to relieve distress — **do not routinely give both together.** Consider switching to the other agent only if distress persists.
- **Do not** tepid-sponge, over-wrap or under-dress a febrile child.
- Antipyretics **do not** prevent febrile convulsions — never prescribe them for that reason.
- Keep the child hydrated; check on them overnight; and know the warning signs below.

Source: NICE NG143.

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6 Safety-netting & safeguarding

The last two minutes of the consultation are the ones that keep a child safe after they leave you.

Give every parent a clear safety net

✓ SPELL OUT EXACTLY WHEN TO SEEK HELP — VERBALLY AND IN WRITING

Tell parents to seek urgent advice if the child: **develops a non-blanching rash**, has a **fit**, becomes **drowsy or difficult to wake**, shows **fast or laboured breathing**, **stops feeding or passing urine** (dry for >12 h), or if the **fever lasts 5 days or more**. Say **how** to get help (out-of-hours, 111, 999) and **when** to come back for review. **[NICE NG143]**

◎ THE "WAS NOT BROUGHT" PRINCIPLE

When a child misses an appointment, record it as **"was not brought"** rather than "did not attend" — the responsibility sits with the adult, not the child. Repeated missed appointments in an unwell or vulnerable child is itself a **safeguarding flag**. Always know how to reach your named safeguarding lead and local pathway.

◆ THE WHOLE GUIDE IN ONE BREATH

Look at the child, not the number. Trust the parent's instinct. Give adrenaline first in anaphylaxis. Don't delay transfer for the meningococcal child. When in doubt, phone paediatrics the same day. Get these five right and you will keep children safe.

Acknowledgements. Adapted and modernised from the original teaching aid *"Top Tips for Paediatric Care in General Practice"* by **Dr Jenny Wright (August 2021)**. Clinical content reviewed and updated against current UK guidance by Bradford VTS, July 2026. The NICE traffic-light content has been reproduced as a clean rebuild of the original screenshot for legibility.

Sources (verify against the live version before acting). NICE NG143 — Fever in under 5s (2019, updated 2021). NICE NG240 — Meningitis (bacterial) and meningococcal disease (2024). Resuscitation Council UK — Emergency treatment of anaphylaxis (2021). BTS/SIGN — acute asthma in children algorithm; NICE/BTS/SIGN NG245 (2024, chronic/diagnosis only). NICE NG18 — Diabetes (type 1 & 2) in children & young people. NICE NG232 — Head injury (2023). NICE NG9 — Bronchiolitis in children. NICE NG84 — Diarrhoea & vomiting / gastroenteritis in under 5s. NICE NG224 — Urinary tract infection in under 16s (2022). NICE CG99 — Constipation in children & young people. NICE CKS — Croup. BNF for Children (BNFc) for all doses.

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