Out of Hours

Registrar Induction

Dr Robin Hollands

Programme

- Do we still have to do OOH?
- Cases in groups..
- Organising registration and OOH Sessions.
- How to demonstrate your OOH training competences
- How OOH is Organised
- Tea
- Cases to discuss in groups

Programme

- Do we still have to do OOH?

See http://www.primarycare.severndeanery.nhs.uk/training/trainees/urgent-and-unscheduled-care-uusc/

What are the key changes to OOH training?

- A move away from counting the number of hours worked OOH, to an approach that looks at the number of competencies trainees have reached whilst working in a variety of OOH locations

There are six UUSC competencies that need to be demonstrated with satisfactor evidence to your ES to achieve this by end of ST3;

- Ability to manage common medical, surgical and psychiatric emergencies
- Understanding the organisational aspects of NHS out of hours care, nationally and at local level
- The ability to make appropriate referral to hospitals and other professionals
- The demonstration of communication and consultation skills required for out of hours care
- Individual personal time and stress management
- Maintenance of personal security, and awareness and management of security risks to others

Do I still need to do OOH training to achieve this?

- Absolutely. All trainees still have to complete OOH training.
- Trainees still need to use the OOH setting to sign off appropriate competencies and all trainees must have the opportunity to experience delivery of OOH primary care in settings away from their usual place of practice.

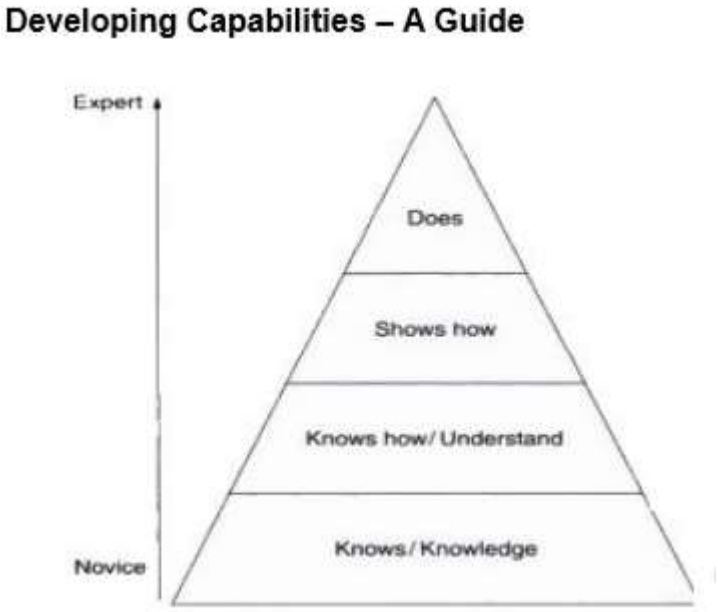
Some evidence could be demonstrated during unscheduled work ‘in hours’.

- **How many hours of UUSC do ST3 trainees now need to complete during their training?**
- There is no longer a minimum required number of hours
- The emphasis in the new guidance is on achieving competence with quality evidence

- There is clear national guidance that Deanery cannot stipulate a minimum number of hours worked outside the practice setting
- We do know that it used to take most trainees around 72 hours in ST3 to achieve competence in all aspects of UUSC.

- Principals of showing quality competence

Eg Millar's Pyramid - BP



COT

CBD

Reflection

Lecture

OOH example

- Knows where Paediatics is based (Lecture in Log)
- Knows how to refer a 1 month old with temp 39C to Paeds.(reflection of case in Log).
- Shows how you referred a child to Paeds (CBD).
- Does by referring a child to Paeds (COT)

Do ST1/2s need to do UUSC work?

- The new guidance does not make a formal stipulation as to what should happen over each of the three years of training but expects all trainees to have achieved competence by the end of ST3.

- In order to achieve this we would suggest trainees start to familiarise themselves with the breadth of USC in their area during their GP placements in ST1 or 2.
- This could include observation of others (which will count towards weekly educational time - see next slide) or experience working in urgent care providers (which may count towards weekly clinical time).

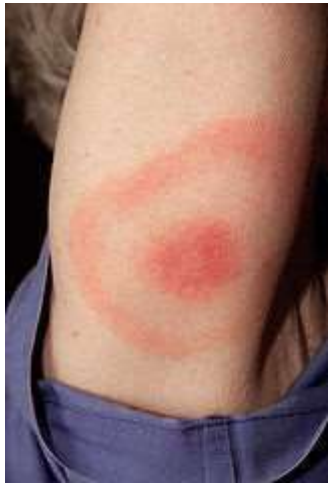
Additional Approved OOH experiences as educational time

- Walk in Centre – with an approved clinical supervisor
- Ambulance-1 shift with para-medic crew
- NHS Direct – 1 shift observing
- Mental Health Crisis Team – 1 shift
- Telephone Triage Course – 1 session
- As provision and services continue to evolve trainees can apply to their local OOH Deanery Lead for prospective approval for specific OOH opportunities that might arise

- By the end of ST1/2 you should be able to turn up to OOH, log in, know how to use OOH computer, telephone recording and be confident to start seeing patients at a level of supervision to be agreed with your supervisors

Triage Example

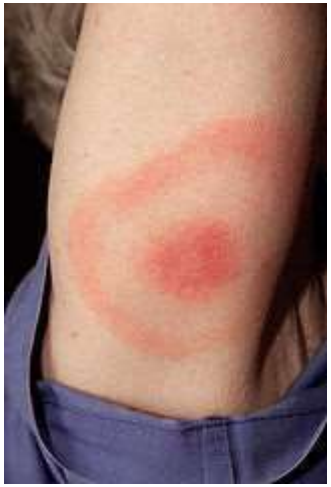
- MIIU at Cirencester phoned for advice concerning a 9 year old child with Erythema Migrans after walking with dad and dog in woods a few days earlier? The nurse wanted to know what to prescribe as the age was outside her PGD.



Triage Example

- In groups try searching patient uk and Nice CKS to find out what to prescribe?
- Would you be happy to trust the nurse and fax a prescription to a pharmacy for her?.

Telephone Triage issues



Preparation.

Children's BNF "In most cases the antibiotic used is either doxycycline or amoxicillin. The course of treatment is usually two or three weeks" !!!

Patient UK

People with a typical rash of erythema migrans should be treated with antibiotics and not tested. This is because the antibody test has very low sensitivity at this stage as the antibody response takes some time to develop. False negatives in the acute phase are as high as 50%, even in those with disseminated disease.

- Blood tests are NOT necessary; the diagnosis can be made clinically.
- Treat with an oral antibiotic for 2-3 weeks:
- Doxycycline 100 mg bd or amoxicillin 500 mg tds.
- For children aged under 12, use amoxicillin in age-dependent doses as per the British National Formulary (BNF) or cefuroxime 5 mg/kg twice per day (

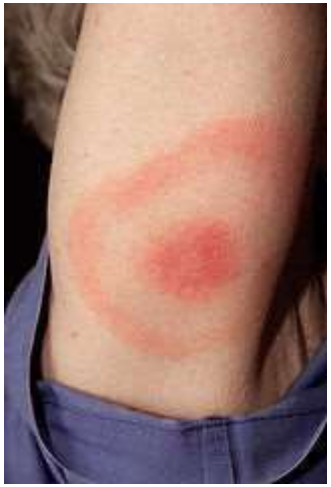
Nice CKS

Table 2 Antibiotic treatment for Lyme disease in children (under 12) according to symptoms [a, b, c]

Symptoms	Age	Treatment	First alternative	Second alternative
Lyme disease without focal symptoms				
Erythema migrans **and/or** Non-focal symptoms	9–12 years	Oral doxycycline[a] for children under 45 kg: 5 mg/kg in 2 divided doses on day 1 followed by 2.5 mg/kg daily in 1 or 2 divided doses for a total of 21 days For severe infections, up to 5 mg/kg daily for 21 days	Oral amoxicillin for children 33 kg and under: 30 mg/kg 3 times per day for 21 days	Oral azithromycin[d, e] for children 50 kg and under: 10 mg/kg daily for 17 days
	Under 9	Oral amoxicillin for children 33 kg and under: 30 mg/kg 3 times per day for 21 days	Oral azithromycin[d, e] for children 50 kg and under: 10 mg/kg daily for 17 days	–

Telephone Triage issues

Nice CKS
Lyme disease without focal symptoms



Antibiotic treatment for Lyme disease in adults and young people (aged 12 and over) according to symptoms [a]

At the time of publication (April 2018), doxycycline did not have a UK marketing authorisation for this indication in children under 12 years and is contraindicated. The use of doxycycline for children aged 9 years and above in infections where doxycycline is considered first line in adult practice is accepted specialist practice.
The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

Good medical practice: The ‘musts’

- You must recognise and work within the limits of your competence.
- You must provide a good standard of practice and care

- You are responsible for the prescriptions you sign and your decisions and actions when you supply and administer medicines and devices or authorise or instruct others to do so.
- You must be prepared to explain and justify your decisions and actions when prescribing, administering and managing medicines.

Organising CARE UK Registration and OOH Sessions.

Care UK has the OOH contract

England's largest independent provider of NHS services, delivering more than 70 different healthcare services throughout the UK.

Primary Care services...

- GP services
- Health in justice - **prisons, sexual assault referral centres and youth offender establishments.**
- NHS 111
- Out-of-hours
- Urgent care
- Integrated urgent care

Secondary care services...

- Hospitals
- Clinical Assessment and Treatment Services (CATS)
- Diagnostics

- You need to be good with IT.
- Know which Guidelines you can follow.
- Recognise guidelines differ
- Guidelines don’t have to be followed.
- Ensure you store useful for future use.
- Know how do use establish the competence of nurse practitioners, ECPs and Paramedics and understand the PGDs that they follow.?

Telephone Triage issues Examples

- Wards asking for drug charts to be written up and for advice concerning unwell patients.
- Paramedic Examples:
  - What PGDs do they have?
  - Giving nebulisers to patients and then phoning for advice
  - Giving analgesia to patients and then phoning for adivce
- DN asking for EOL medications and drug charts to be completed.

Organising CARE UK Registration and OOH Sessions.

- You have the option of linking with Care UK or BrisDoc for
- Severn GP School would normally expect a majority of this work to be undertaken in the patch that the trainee is based for their training.

This talk is going to be about working for Care UK but the principals should be the same for Brisdoc work.

Organising CARE UK Registration and OOH Sessions.

- The details you have completed today have been forwarded to CARE UK and are being processed; this takes 2 weeks.
- You should receive an email confirming your Care UK login/password and your Adastra login/password. You should be able to login into Adastra with these or your SMART Card.
- CARE UK will also send you a login/password to access the GP online rota which is how you choose shifts
- If there are any problems then email ryan.hancox@careuk.com

- If a registrar is not sent the three logins and passwords by 2 weeks then registrars should email the local Gloucestershire team via ryan.hancox@careuk.com. copy in the email in Jeevan.kulkarni@CareUK.com.

- With the Rotamaster website https://careuk.rotamasterweb.co.uk you can choose and request additional shifts up to 2 months in advance with an Educational Supervisors (ES) . However you need to wait for an email to confirm you chosen shifts.
- You will also be able to check on booked shifts.
- Rotamaster does provide a direct way of cancelling shifts.
- If problems eg no reply to a request or if you want to cancel a shift then email gloucestershire.RotaTeam@Careuk.com

Reminder to Trainees and Trainers about Trainee Contract and EWTR

- When organising OOH shifts trainees are reminded about the European Working Time Regulations and the new Junior Doctors Contract and need to be compliant with these. The main features are:
  - a minimum of 11 hours continuous rest in 24 hours
  - You need to claim back the OOH time from your GP surgery.
- So if you work one evening to 2300 then shouldn't start seeing patients next working day until 1000. You will need to claim back 4.5 hours from the surgery.

Reminder to Trainees and Trainers about OOH work and EWTR

- It is the responsibility of trainees to let their practices know if they need to adjust their daytime practice working hours to be compliant eg if finishing an OOH shift at 11pm should not start work the following day until 10am. However trainees still need to do their usual 40 hour working week so if starting late will need to make up the time elsewhere in the week or at a later date.
- Trainees need to remember that practices usually need at least a months notice and ideally 6 weeks or more to re-organise surgeries as most will have surgeries open for booking at least a month in advance so re-organising surgeries at short notice is very time consuming.
- If it is not possible or trainees do not wish to organise a late start then an evening OOH shift could start last at 1900 or at 10pm as an alternative.
- If trainees plan to work an overnight shift these should only be booked for a Friday or Saturday night unless the trainee has arranged to take the following day off and if working on a Friday night they should ensure an adequate break between daytime work and starting an overnight shift.

- In Groups list as many Childhood rashes as you can think of and the main pathognomonic features

- Measles (1nd Disease) koplic spots Notify
- Scarlet Fever (2rd Disease) sandpaper Notify
- Rubella (3rd Disease)
- Slapped Cheek Syndrome/Erythema Infectiosum (5th Disease)/Parvo virus B19 – pregnancy?
- Roseolar Infantum (6^{th} Disease)
- Chickenpox 14-21 Treat adults if in time. – pregnancy?
- Shingles >50yrs treat
- Eczema Herpeticum- beware

- Scalded Skin Syndrome v erythema Toxicum neonatorum v impetigo.
- Cellulitis v Erysipilis
- Urticaria – physical v viral v mycoplasma (1/3)
- Erythema Multiform v HSV
- Henoch-schönlein purpura
- ‘Straining’ petechiae
- Meningococcal Meningitis N
- Pityriasis Rosea/Versicolor
- Erythema Nodosum

- How to demonstrate your OOH training

•**How does a supervisor and their trainee decide what level of supervision they should be working at on each shift?**

•At the start of each shift the supervisor and trainee should sit down to discuss the supervision level they both feel is appropriate.

•It is expected that the trainee will provide the supervisor with an updated copy of their training passport preferably before but at the latest at the start of each shift to support this conversation.

- How to demonstrate your OOH training

Following discussion, the supervisor and trainee will agree on a level of supervision. If there is any discrepancy between their wishes it would generally be expected that they would start the shift at the highest level of supervision requested, but then consider progressing to less supervision if both parties were happy following further discussions.

- How to demonstrate your OOH training

Factors to take into account are previous UUSC experience, level of supervision at in hours work at that time, familiarity with the provider set up/shift type/IT etc. The workload on the shift should not directly impact on the decision regarding supervision level given to the trainee i.e. if it is busy this is NOT a reason to relax supervision if it would not otherwise have been felt to be appropriate for that trainee.

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- Example of passport which you should maintain and maybe save in an email

Competency	1. Ability to manage common medical, surgical and psychiatric emergencies in urgent or unscheduled care setting (At least three items of evidence required - one for each category)		2. Understanding the organisational aspects of NHS out of hours care, nationally and at local level		3. The ability to make appropriate referral to hospitals and other professionals	
Evidence	Type	Date	Type	Date	Type	Date
1	CBD	6/2/2016	Learning Log - Urgent/Unscheduled Care Log	7/2/2017	Learning Log - Urgent/Unscheduled Care Log	5/3/2017
2	Learning Log - Urgent/Unscheduled Care Log	4/5/2017	Learning Log - Significant Event	6/2/2018	Learning Log - Urgent/Unscheduled Care Log	8/25/2018
3	Learning Log - Urgent/Unscheduled Care Log	6/14/2017	Learning Log - Urgent/Unscheduled Care Log	10/2/2018	Learning Log - Urgent/Unscheduled Care Log	9/1/2018

- How to demonstrate your OOH training

4. The demonstration of communication and consultation skills required for urgent, unscheduled or out of hours care		5. Individual personal time and stress management		6. Maintenance of personal security, and awareness and management of security risk to others	
Type	Date	Type	Date	Type	Date
Learning Log - Urgent/Unscheduled Care Log	5/1/2017	Learning Log - Urgent/Unscheduled Care Log	5/1/2017	CSR	4/1/2016
Learning Log - Urgent/Unscheduled Care Log	6/1/2017	Learning Log - Urgent/Unscheduled Care Log	9/1/2018	Learning Log - Professional Conversation	7/3/2016
CSR	6/3/2019	Learning Log - Urgent/Unscheduled Care Log	10/3/2018	Learning Log - Urgent/Unscheduled Care Log	5/3/2019

- How to demonstrate your OOH training

If a trainee did not have a passport to share with their supervisor before or at the start of the shift it is possible that this could lead to a compromise in the quality and level of training provided. In the absence of an updated passport the supervisor/provider reserves the right to alter the shift to enable them to feel comfortable with the trainee and their capabilities.

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- How to demonstrate your OOH training

•GPSTs should demonstrate **competency** in the provision of OOH care and record their experience and reflection in the OOH log entry section of the e-portfolio. the portfolio and then link these to the passport above.

Can CBDs, COTs and audio COTs be completed during an UUSC shift?

Work place based assessments should reflect the full scope of training. As a result, we would encourage trainees to complete a proportion of these assessment in the UUSC setting.

Car Face to Face

- In Gloucestershire it is difficult to get a large number of Car sessions. On a typical 5 hours session you may only see 4 patients
- You should try and attend at least one by doing one
- Jeevan Kulkarni is the Medical Lead for OOH and does frequent sessions at the weekend. Choose sessions via Rotamaster.

Practical Tips

- The UUSC log sheet http://www.primarycare.severndeanery.nhs.uk/assets/Primary-Care/UUSC/Urgent-and-Unsheduled-Care-Guidance-Document.pdf should still be completed by a trainee at the end of each UUSC shift.
- This form should then be signed by the UUSC clinical supervisor. The completed form should then be uploaded to the eportfolio as an OOH log entry.

- Reflections can be written on this form or in the e-portfolio entry.

Type of session (e.g. base doctor (including walk-in centre), visiting doctor, telephone triage, minor injuries centre) PCC 12/8/2019 0800 - 1300
Type of cases seen and significant events
Admitted 55 yrs patient with chest pain Gave advice to nurse practitioner who asked about a patient with a rash Spoke to cancer patient with Special Patient notes
This session provides evidence for which UUSC competencies. (please refer to the competency record for competencies and circle all that are relevant making brief, anonymous, notes to support this)1, 2, 3, 4, 5, 6.
Use of IT (general Competency); Working with Colleagues (OOH competency); Ability to make appropriate referrals to hospitals and other professionals in the out-of-hours setting (OOH Competency_
Learning areas and needs identified (to be discussed with trainer)
Look up NICE guidelines on chest pain; Please see e-portfolio for further evidence of completion.
Debriefing notes from Clinical Supervisor. Good use of Adastra. I think now competent to work face to face without direct supervision. I agree with competences shown
Signature of Clinical Supervisor R Hollands **Date** 12/8/2019

Paper Copy Example

The six generic competencies, embedded within the RCGP Curriculum Statement on ‘Care of acutely ill people’, are defined as the:

- Understanding of the organisational aspects of NHS out of hours care.
- Ability to manage common medical, surgical and psychiatric emergencies in the out-of-hours setting.
- Ability to make appropriate referrals to hospitals and other professionals in the out-of-hours setting.
- Demonstration of communication skills required for out-of-hours care.
- Individual personal time and stress management.
- Maintenance of personal security and awareness and management of the security risks to others

EXAMPLE OF OOH WORKBOOK

1.Recognised blood in stool could be potentially harmful but when seeing the child communicated effectively that not ill. Arranged appropriate follow up with own GP by asking to take sample in and wrote this in the summary. Made use of time and resources appropriately. Ref
2.Recognised child green on the NICE fever child protocol. Offered empathy and understanding to mum. Explained why safe to be at home and safety netted. Comm
3.Made appropriate diagnosis of fungal rash. Acted professionally by supporting the patient's own GP's actions which had been very appropriate. Communicated well the plan and suggestions for skin scraping and continuing fungal cream after rash gone.
4.Made appropriate assessment of the ear. Made an appropriate referral to ENT for follow up via sho on call. Communicated plan to patient.
5.Recognised that the patient was after reassurance rather than a review. Communicated empathically over the phone why the breast lump should be seen by own GP.
6.Recognised the symptom of chest infection in a patient with co morbidities is potentially serious. Recognised that adequate communication and info gathering not possible on the phone due to learning difficulties. Made use of home visit appropriately. Made the decision in a timely fashion and met the patient's expectations.

Out Of Hours session

Add/Edit Comment | Validate evidence | Mark as Unread |

Current Selections

- **Professional Competences** 1 Communication and consultation skills
- **Professional Competences** 3 Data gathering and interpretation
- **Professional Competences** 4 Making a diagnosis/decisions
- **Professional Competences** 5 Clinical management
- **Professional Competences** 8 Working with colleagues and in teams
- **Curriculum Statement Headings** 3.2 Patient Safety
- **Curriculum Statement Headings** 4.2 Information Management and Technology
- **Curriculum Statement Headings** 8 Care of Children and Young People
- **Curriculum Statement Headings** 15.2 Digestive problems
- **Curriculum Statement Headings** 15.4 ENT and facial problems
- **Curriculum Statement Headings** 15.10 Skin problems

EXAMPLE OF E-Portfolio OOH log

GREEN

Date	20/01/2011
Type of OOH session	5 hours Dilk memorial hospital
Name of Supervisor	Dr T lench
What did you learn?	See attachment
What will you do differently in future?	see attachment
What further learning needs did you identify	see attachment
How will you address these in future	see attachment
Shared? :	Yes
Record created	24/01/2011 22:44:22
Comments	Dr Jonathan Layzell (GP Trainer) [31/01/2011 21:58:20] Good

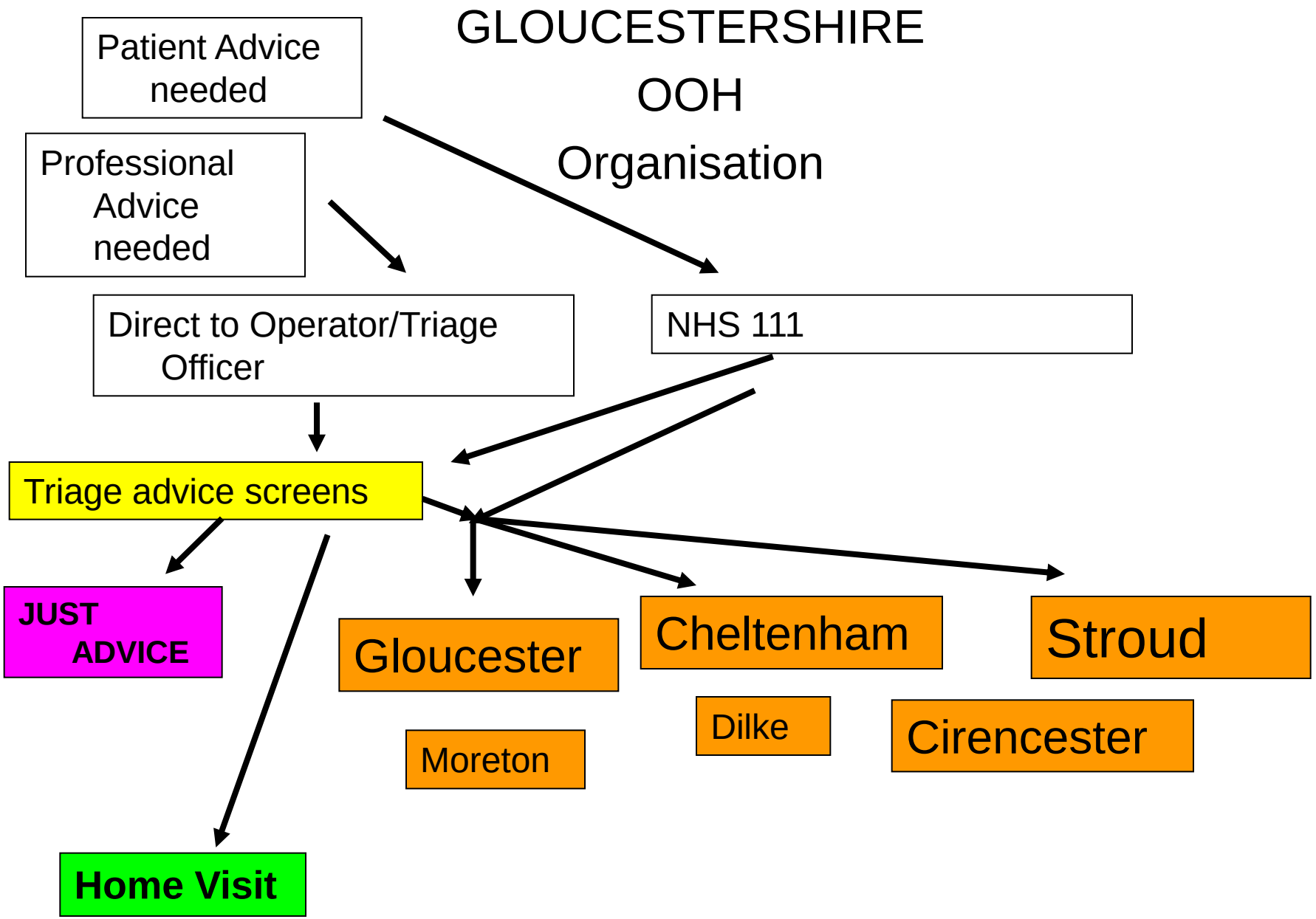
Using Adastra

- You will be shown how to use Adastra at your first shift
- The important thing to do is type quickly and accurately.
- The next slide shows an example of how text might look in Adastra after a patient has spoke to a call operator, failed to answer telephone calls, has been triaged and finially assessed by a triage GP

CONSULTATION EXAMPLE

“PATIENT HAS MANAGED TO GET HIS NORMAL PHONE SO PLEASE RING ON THE LISTED NUMBER - THANK YOU
patient unable to get to his land line, has called on his mobile but cannot remember the number
currently lying on the bed, unable to
has been vomiting
has taken an 'ace' drug with nurofen and thinks this has caused him to feel so unwell
is a physiotherapist and would like to discuss pharmacology with GP please
triage by **XYZ**
been on ramipril 3m for bp, 2.5mg. felt dizzy when taken earlier than at night. was on nsaid -nurofen. had nsaid, beer on saturday. felt dizzy since.stopped ramipril saturday. today took nurofen again. started spinning-vertigo like symptoms along with urti like symptoms. worried it may be medication related
symptoms sound like viral labyrinthitis, not medication
adv otc buccastem.when able to restart ramipril do so at night as 1st dose effect may cause probs.”

How OOH is Organised


GLOUCESTERSHIRE
OOH
Organisation
Patient Advice needed
Professional Advice needed
Direct to Operator/Triage Officer
NHS 111
Triage advice screens
JUST ADVICE
Gloucester
Moreton
Cheltenham
Dilke
Stroud
Cirencester
Home Visit

TARGETS

There are some 30-40 national targets to achieve but the main ones for us are:

1. All paramedic calls where they are waiting at patient's house are black in Adastra have to be assessed by clinician in 20 mins.
2. Palliative Care patients have to be assessed in 20 mins.
3. All NHS 111 calls have to be assessed within 1/2/6/12/24 hours and are red to white in colour.
4. Walk-ins have to be assessed within 20 mins- send to ED.
5. All routine patients have to have face to face consultations eg visits started within six hours and urgents within 2 hours.

TARGETS

You should be bare below the elbows and if working on wards then do not wear a watch

If a patient vomits you need to know how to help clear this up as receptionists are not allowed to do this. Spill-kit- nurses.

Ensure that anything that touches a patient goes into an orange bag; sandwiches etc into a black page. Patient notes and damaged scripts to reception to be shredded. THIS IS AUDITED FREQUENTLY!

Cases to discuss in groups

ACTUAL PATIENTS (ANONYMISED)

Would you manage the patients differently?

Compare your triaging of actual clinical and management problems with other colleagues from around the county

‘flu’ illnesses

25 years Telephone Triage

Unwell for the last 3 days hot and cold; flu symptoms; coughing ++ .no chest pains Vomited x2 2 days ago; no diarrhoea. feels hot; no rashes; no contact with illness no travel PMH nil DH Cold an flu tablets only. AR nil

viral illness

given general advice

- **Extra questions?**
- Would you manage this differently?
- When would you see a flu illness in children and adults?

D&V

73yrs

ELDERLY PATIENT HAS HAD DIARRHOEA FOR 4 DAYS PASSING LESS URINE FEELS LIGHTHEADED AND DIZZY

Diarrhoea for the last few days; variable in frequency; orange colour; no blood; no vomiting; occasional stomach pains but not severe. PMH nil DH Regulan. Lives alone. drinking water. Passing urine not eating; occasional dizziness.
Diarrhoea ? cause
suggest drinks Dioralyte juices etc; friend will get and Ribena. will contact us again if diarrhoea worsens.

- Extra questions?
- Would you have organised a visit to check for dehydration?
- Which patients generally (young and old) would you give advice to and which would you want to see?
- ? SAFETY NET MORE WITH FRIEND

Otalgia

23 months

High temp 101. - been unwell 2 days - not eating - pulling at ears - not sleeping PMH nil DH Ibuprofen. given ibuprofen would like to be seen. to attend pcc

- **How much history to take if you have decided that a patient can come to a primary care centre?**

Which children with otalgia would you advise over the phone to continue with analgesia and which would you just see?

- What sort of things do you say to parents if you are not going to give antibiotics?
- How does 10.30 on a Sunday morning compare to 10.30 in the evening effect your decision?

? See rashes

65 years male

pain in joints for a month > diagnosed arthritis prescribed medication no improvement.

Today developed rash wants to take Paracetamol to relieve pain and stop taking arthritis meds ; arthritis effects shoulders back right wrist/thumb both groins and right knee. ? diagnosis

Rx Naproxen last week and today has woken up with a rash; on the torso; like several small pimples 1-2 cm apart, like a heat rash; not itchy. PMH nil DH Naproxen AR nil.

rash ? allergic

stop NSAID for the weekend and review by GP next week. can use paracetamol

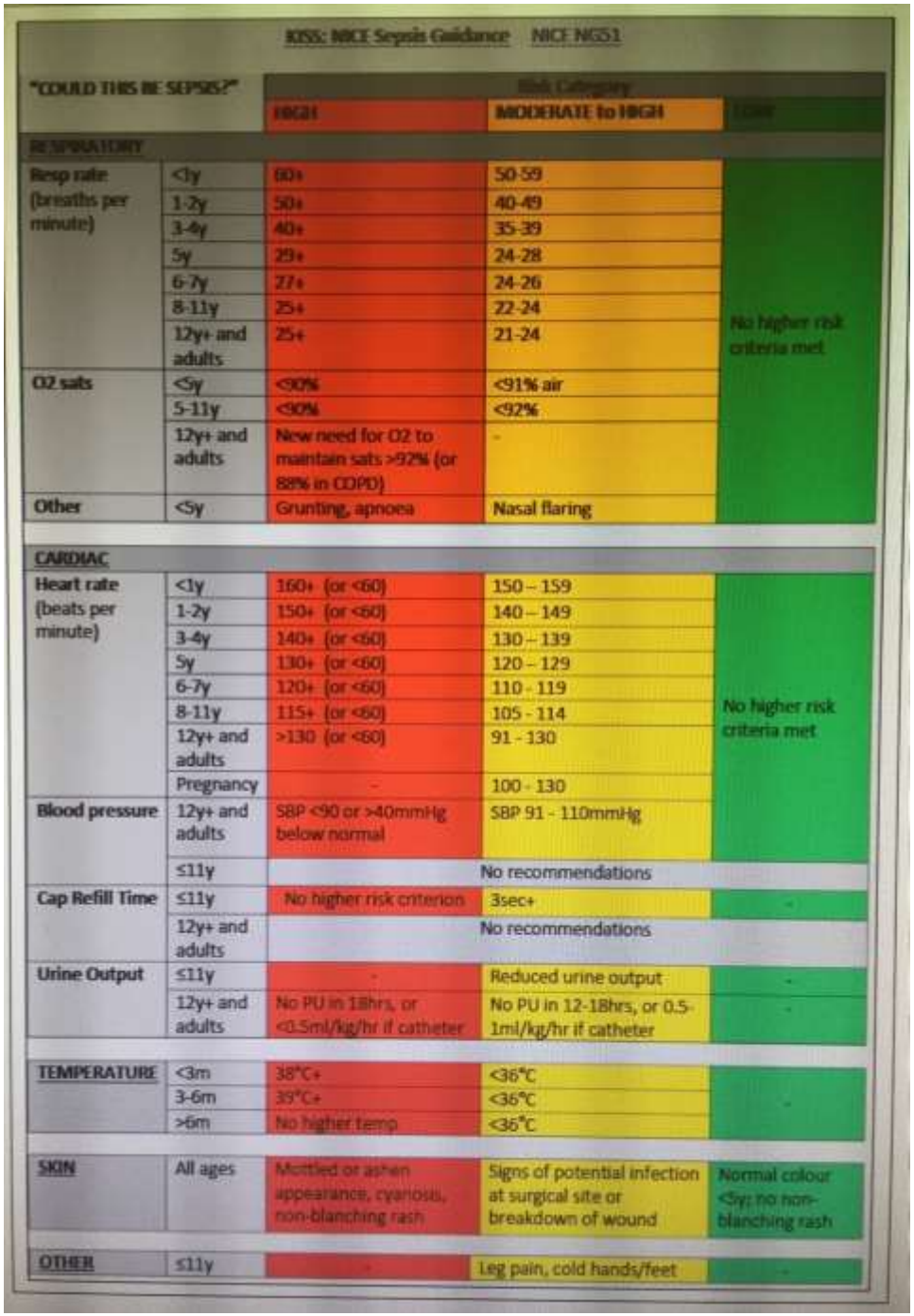
•**Extra questions?**

Would you manage this differently?

•When do you see rashes and when to you ask them to come in?

•How would you manage a rash that you thought (but only slightly) might be meningitis 112/999 vs ask to come down vs urgent car.

Store Useful photos in your mobile phone



KISS: NICE Sepsis Guidance NICE NG51

"COULD THIS BE SEPSIS?"		Risk Category: HIGH	MODERATE to HIGH	LOW
RESPIRATORY				
Resp rate (breaths per minute)	<1y	60+	50-59	No higher risk criteria met
	1-2y	50+	40-49	
	3-4y	40+	35-39	
	5y	29+	24-28	
	6-7y	27+	24-26	
	8-11y	25+	22-24	
	12y+ and adults	25+	21-24	
O2 sats	<5y	<90%	<91% air	
	5-11y	<90%	<92%	
	12y+ and adults	New need for O2 to maintain sats >92% (or 88% in COPD)	-	
Other	<5y	Grunting, apnoea	Nasal flaring	
CARDIAC				
Heart rate (beats per minute)	<1y	160+ (or <60)	150 – 159	No higher risk criteria met
	1-2y	150+ (or <60)	140 – 149	
	3-4y	140+ (or <60)	130 – 139	
	5y	130+ (or <60)	120 – 129	
	6-7y	120+ (or <60)	110 - 119	
	8-11y	115+ (or <60)	105 - 114	
	12y+ and adults	>130 (or <60)	91 - 130	
	Pregnancy	-	100 - 130	
Blood pressure	12y+ and adults	SBP <90 or >40mmHg below normal	SBP 91 - 110mmHg	
	≤11y	No recommendations		
Cap Refill Time	≤11y	No higher risk criterion	3sec+	-
	12y+ and adults	No recommendations		
Urine Output	≤11y	-	Reduced urine output	-
	12y+ and adults	No PU in 18hrs, or <0.5ml/kg/hr if catheter	No PU in 12-18hrs, or 0.5-1ml/kg/hr if catheter	-
TEMPERATURE	<3m	38°C+	<36°C	-
	3-6m	39°C+	<36°C	
	>6m	No higher temp	<36°C	
SKIN	All ages	Mottled or ashen appearance, cyanosis, non-blanching rash	Signs of potential infection at surgical site or breakdown of wound	Normal colour <5y; no non-blanching rash
OTHER	≤11y	-	Leg pain, cold hands/feet	-

Store Useful links in your mobile phone

Upper Respiratory Tract
Lower Respiratory Tract
Urinary Tract
Meningitis
Gastrointestinal Tract
Genital Tract
Skin & Soft Tissue
Eye
Dental

Local bronchiolitis advice

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 a healthcare professional
Circulation	CRT < 2 secs	CRT 2 - 3 secs	CRT over 3 secs
Skin	Nermal colour skin, lips & tongue moist mucous membranes	Pale/mottled Pallor colour reported by parent/carer cool peripheries	Pale/Mottled/Ashen blue Cyanotic lips and tongue
Respiratory Rate	Under 12mths <50 breaths/ minute Over 12 mths <40 breaths/ minute No respiratory distress	<12 mths 50-60 breaths/minute >12 months 40-60 breaths/minute	All ages > 60 breaths/minute
SATS in air	95% or above	92 - 94%	<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	<50% fluid intake over 2-3 feeds +/- vomiting. Significantly reduced urine output.
Apnoeas	Absent	Absent	Present*

CRT: Capillary refill time *Apnoea – for 10-15 secs or shorter if accompanied by a sudden decrease in saturations/central cyanosis or bradycardia
SATS: Saturation in air

Local advice Diarrhoea and vomiting

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 normally to or 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
Skin	• Normal skin colour • Normal turgour	• Normal skin colour • Warm extremeties	• Pale/Mottled/Ashen blue • Cold extremeties
Respiratory	• Normal breathing	• Tachypnoea (ref to normal values table 3)	• Tachycardic (ref to normal values table 3)
Hydration	• CRT≤ 2 secs • Moist mucous membranes (except after a drink) • Normal urine	• CRT 2–3 secs • Dry mucous membrances (except after a drink) • Reduced urine output	• CRT >3 seconds
Pulses/ Heart Rate	• Heart rate normal • Peripheral pulses normal	• Tachycardic (ref to normal values table 3) • Peripheral pulses weak	• Tachycardic (ref to normal values table 3) • Peripheral pulses weak
Blood Pressure	• Normal (ref to normal values table 3)	• Normal (ref to normal values table 3)	• Hypotensive (ref to normal values table 3)
Eyes	• Normal Eyes	• Sunken Eyes	

CRT:capillary refill time RR: respiration rate

Local advice- Asthma

Table 1: Traffic Light system for identifying signs and symptoms of clinical dehdration and shock

	Green – Moderate	Amber – Severe	Red – Life Threatening
Behaviour	Normal	Anxious/Agitated	Exhaustion/Confusion
Talking	In sentences	Not able to complete a sentence in one breath	Not able
Respiratory	<40 breaths/min 2-5 years <30 breaths/min 5-12 years <25 breaths/min 12-16 years	>140 beats p/min (2-5 years) >125 beats p/min (>5 years) *Consider influence of fever &/or Salbutamol	
Heart Rate	Within normal range (Ref to table 2)	Rate>40 Breaths/min 2-5 years Rate>30 Breaths/min >5 years Silent Chest	
Sa02	≥92% in air		<92% in air
PEFR	>50% of predicted (Ref to table 3)	33-50% of predicted (Ref to table 3)	<33% of predicted (Ref to table 3)

CRT: capillary refill time RR: respiration rate