

Document Title:	FEVERISH ILLNESS IN CHILDREN: ASSESSMENT AND INITIAL MANAGEMENT IN CHILDREN YOUNGER THAN 5 YEARS		
Document Reference/Register no:	10043	Version Number:	3.0
Document type: (Policy/ Guideline/ SOP)	Guideline	To be followed by: (Target Staff)	Nurses, Junior Doctors and Consultant Paediatricians
Ratification Issue Date: (Date document is uploaded onto the intranet)	8 th April 2019	Review Date:	7 th April 2022
Developed in response to:	Update and improve practice NICE guidance 47		
Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) CQC Fundamental Standards of Quality and Safety:			12
Issuing Division/Directorate:	Women's and Children's		
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Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	<input checked="" type="checkbox"/> MEHT <input type="checkbox"/> BTUH <input type="checkbox"/> SUH		
Consultation:	(Refer to page 2)		
Approval Group / Committee(s):	n/a	Date:	n/a
Professionally Approved by: (Asset Owner)	Dr Datta, Clinical Lead Paediatrics	Date:	4 th April 2019
Ratification Group(s):	DRAG Chairman's Action	Date:	5 th April 2019
Executive and Clinical Directors (Communication of minutes from Document Ratification Group)	Date: April 2019	Distribution Method:	Trust Intranet/ Internet

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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 08038 Aseptic ANTT Antibiotic Prescribing Policy 11046 Child and Young Person Observation Policy 10042 Urinary Tract Infection- Children
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Document Review History:			
Version No:	Authored/Reviewer:	Summary of amendments/ Record documents superseded by:	Issue Date:
1.0			2010
1.1	Carol Newman	(extended period of currency)	3 May 2013
2.0	Victoria Machell, Clinical Governance Facilitator		31 May 2016
3.0	Lucy Bouckley	Full Review	8 th April 2019

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1.0 Purpose

- 1.1 There is a need to improve the recognition, assessment and immediate treatment of feverish illnesses in children. This guideline is designed to assist healthcare professionals in the initial assessment and immediate treatment of young children with fever presenting to secondary care.

2.0 Equality Impact Assessment

- 2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals. (Refer to Appendix 3)

3.0 Scope

- 3.1 This guideline is to be used by all nursing staff and medical staff caring for children aged 5 years or less.

4.0 Background

- 4.1 Feverish illness in young children usually indicates an underlying infection and is a cause of concern for parents and carers. Feverish illness is very common in young children, with between 20 and 40% of parents reporting such an illness each year. As a result, fever is probably the commonest reason for a child to be taken to the doctor. Feverish illness is also the second most common reason for a child being admitted to hospital. Despite advances in healthcare, infections remain the leading cause of death in children under the age of 5 years.
- 4.2 Fever in young children can be a diagnostic challenge for healthcare professionals because it is often difficult to identify the cause. In most cases, the illness is due to a self-limiting viral infection. However, fever may also be the presenting feature of serious bacterial infections such as meningitis or pneumonia. A significant number of children have no obvious cause of fever despite careful assessment. These children with fever without apparent source are of particular concern to healthcare professionals because it is especially difficult to distinguish between simple viral illnesses and life-threatening bacterial infections in this group.

5.0 Thermometers and Detection of Fever

- 5.1 The oral and rectal routes should not routinely be used to measure the body temperature of children aged 0–5 years.
- 5.2 In infants under the age of 4 weeks, body temperature should be measured with an electronic thermometer in the axilla.
- 5.3 In children aged 4 weeks to 5 years, healthcare professionals should measure body temperature by one of the following methods:
 - Electronic thermometer in the axilla;
 - Chemical dot thermometer in the axilla;
 - Infra-red tympanic thermometer.
- 5.4 Disposable chemical dot thermometers should not be routinely used for multiple temperature measurements.
- 5.5 Forehead chemical thermometers are unreliable and should not be used by healthcare professionals.
- 5.6 Parental reporting of fever should be considered valid and taken seriously by healthcare professionals.

6.0 Assessment of Risk of Serious illness

- 6.1. Healthcare professionals should identify any immediately life- threatening features, including compromise of the airway, breathing or circulation, and decreased level of consciousness.
- 6.2 Think ‘could this be sepsis?’ if a child presents with fever and symptoms or signs that indicate possible sepsis.
- 6.3 Healthcare professionals should refer to and follow the Paediatric Sepsis 6 protocol in assessing and treating a child at risk of severe sepsis, septic shock or red flag sepsis.
- 6.4 Children with feverish illness should be assessed for the presence or absence of symptoms and signs that can be used to predict the risk of serious illness using the traffic light system (Refer to Appendix 1).
- 6.5 When assessing children with learning difficulties, take the individual child’s learning disability into account when interpreting the traffic light table

6.6 Children with the following symptoms or signs should be recognised as being in a high-risk group for serious illness:

- Unable to rouse or if roused does not stay awake;
- Weak, high-pitched or continuous cry;
- Pale/mottled/blue/ashen;
- Reduced skin turgor;
- No response to social cues;
- Moderate or severe chest in-drawing;
- Respiratory rate greater than 60 breaths per minute;
- Grunting;
- Bulging fontanelle;
- Appearing ill to a healthcare professional.

6.7 Children with any of the following symptoms should be recognised as being in at least an intermediate-risk group for serious illness:

- Wakes only with prolonged stimulation;
- Decreased activity;
- Poor feeding in infants;
- Not responding normally to social cues/no smile;
- Dry mucous membranes;
- Reduced urine output ;
- Rigors;
- Pallor reported by parent or carer;
- Nasal flaring.

6.8 Children who have all of the following features, and none of the high or intermediate risk features, should be recognised as being in a low-risk group for serious illness:

- Strong cry or not crying;
- Content/smiles;
- Stays awake;
- Normal colour of skin, lips and tongue;
- Normal skin and eyes;
- Moist mucous membranes;
- Normal response to social cues.

6.9 Healthcare professionals should measure and record temperature, heart rate, respiratory rate and capillary refill time and a score using the Children's Early Warning Tool (CEWT) as part of the routine assessment of a child with fever.

6.10 Healthcare professionals examining children with fever should be aware that a raised heart rate can be a sign of serious illness, particularly septic shock.

- 6.11 A capillary refill time of 3 seconds or longer should be recognised as an intermediate-risk group marker for serious illness (amber sign; refer to Appendix 1).
- 6.12 Healthcare professionals should measure the blood pressure of children with fever if the heart rate or capillary refill time is abnormal and the facilities to measure blood pressure are available.
- 6.13 Body temperature alone should not be used to identify children with serious illness, but recognise that;
- Children younger than 3 months of age with a temperature of 38°C or higher should be considered high risk;
 - Children aged 3–6 months with a temperature of 39°C or higher should be considered intermediate risk.
- 6.14 Duration of fever should not be used to predict the likelihood of serious illness, but children presenting with a fever lasting five days or more should be assessed for Kawasaki Disease.
- 6.15 Healthcare professionals should recognise that tachycardia indicates at least an intermediate risk. Advance Paediatric Life Support (APLS) guidelines should be followed to assess tachycardia, with consideration being given to;
- Tachycardia of greater than 160bpm in children under 12 months;
 - Tachycardia of greater than 150bpm in children 12- 24 months;
 - Tachycardia of greater than 140bpm in children 2-5 years.
- 6.16 Children with fever should be assessed for signs of dehydration. Healthcare professionals should look for:
- Prolonged capillary refill time;
 - Abnormal skin turgor;
 - Abnormal respiratory pattern;
 - Weak pulse;
 - Cool extremities.

7.0 Symptoms and Signs of Specific illnesses

- 7.1 Healthcare professionals should look for a source of fever and check for the presence of symptoms and signs that are associated with specific diseases. (Refer to Appendix 2)
- 7.2 Meningococcal disease should be considered in any child with fever and a non-blanching rash, particularly if any of the following features are present:
- An ill-looking child;

- Lesions larger than 2 mm in diameter (purpura);
 - A capillary refill time of 3 seconds or longer;
 - Neck stiffness.
- 7.3 Meningitis should be considered in a child with fever and any of the following features:
- Neck stiffness;
 - Bulging fontanelle;
 - Decreased level of consciousness;
 - Convulsive status epilepticus.
- 7.4 Healthcare professionals should be aware that classical signs of meningitis (neck stiffness, bulging fontanelle, high-pitched cry) are often absent in infants with bacterial meningitis.
- 7.5 Herpes simplex encephalitis should be considered in children with fever and any of the following features:
- Focal neurological signs;
 - Focal seizures;
 - Decreased level of consciousness.
- 7.6 Pneumonia should be considered in children with fever and any of the following signs:
- Tachypnoea (respiratory rate greater than 60 breaths per minute, age 5 months; greater than 50 breaths per minute, age 6–12 months; greater than 40 breaths per minute, age older than 12 months);
 - Crackles in the chest;
 - Nasal flaring;
 - Chest in-drawing;
 - Cyanosis;
 - Oxygen saturation of 95% or less when breathing air.
- 7.7 Urinary tract infection should be considered in any child younger than 3 months with fever.
- 7.8 Urinary tract infection should be considered in a child aged 3 months and older with fever and one or more of the following:
- Vomiting;
 - Poor feeding;
 - Lethargy;
 - Irritability;
 - Abdominal pain or tenderness;
 - Urinary frequency or dysuria.

7.9 Septic arthritis/osteomyelitis should be considered in children with fever and any of the following signs:

- Swelling of a limb or joint;
- Not using an extremity;
- Non-weight bearing.

7.10 **Kawasaki disease**

7.10.1 Should be considered in children with fever that has lasted longer than 5 days and who have four of the following five features:

- Bilateral conjunctival injection;
- Change in mucous membranes in the upper respiratory tract (for example, injected pharynx, dry cracked lips or strawberry tongue);
- Change in the extremities (for example, oedema, erythema or desquamation);
- Polymorphous rash;
- Cervical lymphadenopathy.

7.10.2 Healthcare professionals should be aware that, in rare cases, in complete/atypical Kawasaki disease may be diagnosed with fewer features.

7.11 **Imported infections**

When assessing a child with feverish illness, healthcare professionals should enquire about recent travel abroad and should consider the possibility of imported infections according to the region visited.

8.0 **Management by the Paediatrician**

8.1 In this guideline, the term paediatrician refers to a healthcare professional who has had specific training or has recognised expertise in the management of children and their illnesses. Examples include paediatricians, or healthcare professionals working in children's emergency departments.

8.2 **Children older than 5 years**

8.2.1 Management by the paediatric specialist should start with a clinical assessment. The healthcare professional should attempt to identify symptoms and signs of serious illness and specific diseases as summarised in appendix 1&2.

8.3 Children younger than 3 months

8.3.1 Infants younger than 3 months with fever should be observed and have the following vital signs measured and recorded:

- Temperature;
- Heart rate;
- Respiratory rate.

8.3.2 Infants younger than 3 months with fever should have the following investigations performed:

- Full blood count;
- Blood culture;
- C-reactive protein;
- Urine testing for urinary tract infection;
- Chest X-ray only if respiratory signs are present;
- Stool culture, if diarrhoea is present.

8.3.3 Lumbar puncture should be performed on the following children (unless contraindicated):

- Infants younger than 1 month;
- All infants aged 1–3 months who appear unwell;
- Infants aged 1–3 months with a white blood cell count (WBC) less than 5×10^9 or greater than 15×10^9 /litre.

8.3.4 When indicated, a lumbar puncture should be performed without delay and, whenever possible, before the administration of antibiotics.

8.3.5 Parenteral antibiotics should be given to:

- Infants younger than 1 month with fever;
- All infants aged 1–3 months with fever who appear unwell;
- Infants aged 1–3 months with WBC less than 5×10^9 or greater than 15×10^9 /litre.

8.3.6 When parenteral antibiotics are indicated for infants less than 3 months of age (refer to recommendation 8.3.5), a third-generation cephalosporin (for example, cefotaxime or ceftriaxone) should be given plus an antibiotic active against *Listeria* (for example, amoxicillin).

8.4 Children aged 3 months to 5 years

8.4.1 Children with fever without apparent source presenting to paediatric specialists with one or more 'red' features (appendix 1) should have the following investigations performed:

- Full blood count;
- Blood culture;
- C-reactive protein;
- Urine testing for urinary tract infection.

8.4.2 The following investigations should also be considered in children with 'red' features, as guided by the clinical assessment:

- Lumbar puncture in children of all ages (if not contraindicated)
- Chest X-ray irrespective of body temperature and WBC
- Serum electrolytes and blood gas

8.4.3 Children with fever without apparent source presenting to paediatric specialists who have one or more 'amber' features (appendix 1) should have the following investigations performed unless deemed unnecessary by an experienced paediatrician:

- Urine should be collected and tested for urinary tract infection;
- Blood tests: full blood count, C-reactive protein and blood cultures;
- Lumbar puncture should be considered for children younger than 1 year;
- Chest X-ray in a child with a fever greater than 39°C and WBC greater than 20×10^9 /litre.

8.4.4 Children who have been referred to a paediatrician with fever without apparent source and who have no features of serious illness (that is, the green group appendix 1), should have urine tested for urinary tract infection and be assessed for symptoms and signs of pneumonia (refer to appendix 2).

8.4.5 Routine blood tests and chest X-rays should not be performed on children with fever who have no features of serious illness (that is, the green group).

8.4.6 Febrile children with proven respiratory syncytial virus or influenza infection should be assessed for features of serious illness. Consideration should be given to urine testing for urinary tract infection.

8.4.7 In children aged 3 months or older with fever without apparent source, a period of observation in hospital (with or without investigations) should be considered as part of the assessment to help differentiate non-serious from serious illness.

8.4.8 When a child has been given antipyretics:

- Healthcare professionals should not rely on a decrease or lack of decrease in temperature after 1–2 hours to differentiate between serious and non-serious illness;
- Children in hospital with 'amber' or 'red' features should be re-assessed after 1–2 hours.

8.5 **Immediate treatment by the paediatric specialist** (this should be used in conjunction with the Paediatric Sepsis 6 Protocol):

8.5.1 Children with fever and shock presenting to specialist paediatric care or an emergency department should be:

- Given an immediate intravenous fluid bolus of 20 ml/kg. The initial fluid should normally be 0.9% sodium chloride;
- Actively monitored and given further fluid boluses as necessary.

8.5.2 Children with fever presenting to specialist paediatric care or an emergency department should be given immediate parenteral antibiotics if they are:

- Shocked;
- Unroutable;
- Showing signs of meningococcal disease.
(Refer to Appendix 2)

8.5.3 Immediate parenteral antibiotics should be considered for children with fever and reduced levels of consciousness. In these cases symptoms and signs of meningitis and herpes simplex encephalitis should be sought. (Refer to table 2; Appendix 2).

8.5.4 When parenteral antibiotics are indicated, a third-generation cephalosporin (for example, cefotaxime or ceftriaxone) should be given, until culture results are available. For children younger than 3 months, an antibiotic active against *Listeria* (for example, amoxicillin) should also be given.

8.5.5 Children with fever and symptoms and signs suggestive of herpes simplex encephalitis should be given intravenous Aciclovir.

8.5.6 Oxygen should be given to children with fever who have signs of shock or oxygen saturation (SpO₂) of less than 92% when breathing air. Treatment with oxygen should also be considered for children with an SpO₂ of greater than 92%, as clinically indicated.

8.6 Treatment of suspected serious bacterial infection

8.6.1 In a child presenting to hospital with a fever and suspected serious bacterial infection, requiring immediate treatment, antibiotics should be directed against *Neisseria meningitidis*, *Streptococcus pneumoniae*, *Escherichia coli*, *Staphylococcus aureus* and *Haemophilus influenzae* type b. A third-generation cephalosporin (for example, cefotaxime or ceftriaxone) is appropriate, until culture results are available. For infants younger than 3 months of age, an antibiotic active against *Listeria* (for example, amoxicillin) should be added.

8.6.2 Healthcare professionals should refer to local treatment guidelines when rates of bacterial antibiotic resistance are significant.

8.7 Admission to and discharge from hospital

8.7.1 The following factors should be considered when deciding whether to admit a child with a fever to hospital, alongside their clinical condition:

- Social and family circumstances;
- Other illnesses that affect the child or other family members;
- Parental anxiety and instinct;
- Previous contact with other people who have serious infectious diseases;
- Recent travel abroad to tropical/subtropical areas or any areas with a high risk of endemic infectious disease;
- When the extent of the parental concern has caused them to seek repeated healthcare advice for this illness;
- Where the family has experienced a previous serious illness or death due to feverish illness;
- When a feverish illness has no obvious cause but the child remains ill longer than expected.

8.7.2 Where a decision has been made to discharge a feverish child but no diagnosis has been reached, provide a safety net for parents and carers if any 'red' or 'amber' features are present. This should consist of one or more of the following:

- Providing the parents or carer with verbal and/or written information on warning symptoms and how further healthcare can be accessed;
- Arranging further follow-up at a specific time and place;
- Liaising with other healthcare professionals as required to offer direct access for the child if further assessment is required.

8.7.3 Children with only 'green' features can be cared for at home with appropriate advice for parents and carers, including on when to seek further attention and help from the healthcare service.

8.7.4 Children requiring admission will need to be observed and monitored in accordance with the child and young person observation policy.

8.7.5 Paediatric intensive care:

- Children with fever who are shocked, unrousable or showing signs of meningococcal disease should be referred and urgently reviewed by an experienced paediatrician, with consideration for referral to a paediatric intensive care unit;
- Parental antibiotics should be given to children with suspected meningococcal disease at the earliest opportunity;
- Children admitted to hospital with meningococcal disease should be under the care of a paediatric team and consultant, where their needs for inotropes can be assessed.

8.8 Antipyretic interventions

8.8.1 Tepid sponging is not recommended for the treatment of fever.

8.8.2 Children with fever should not be under dressed or over wrapped.

8.8.3 The use of antipyretic agents should be considered in children with fever who appear distressed or unwell. Antipyretic agents should not routinely be used with the sole aim of reducing body temperature in children with fever who are otherwise well. The views and wishes of parents and carers should be taken into consideration.

8.8.4 Either paracetamol or ibuprofen can be used to reduce temperature in children with fever.

8.8.5 Paracetamol and ibuprofen should not be administered at the same time to children with fever.

8.8.6 When using paracetamol and ibuprofen in children with fever;

- Continue using only as long as distress is present;
- Only consider using the other antipyretic agent if distress is not resolving;
- Only consider alternating these if distress persists or reoccurs before next dose is due.

8.8.7 Antipyretic agents do not prevent febrile convulsions and should not be used specifically for this purpose.

9.0 Advice for Home Care

9.1 Parents or carers should be advised to manage their child's temperature as described in section 8.8.

9.2 Parents or carers looking after a feverish child at home should be advised:

9.2.1 Offer the child regular fluids (where a baby or child is breastfed the most appropriate fluid is breast milk).

9.2.2 Detect signs of dehydration by looking for the following features:

- Sunken fontanelle;
- Dry mouth;
- Sunken eyes;
- Absence of tears;
- Poor overall appearance.

9.2.3 Encourage their child to drink more fluids and consider seeking further advice if they detect signs of dehydration.

9.2.4 How to identify a non-blanching rash.

9.2.5 To check their child during the night .

9.2.6 To keep their child away from nursery or school while the child's fever persists but to notify the school or nursery of the illness.

9.3 When to seek further help

9.3.1 Following contact with a healthcare professional, parents and carers who are looking after their feverish child at home should be informed of who and where they should seek further advice from if:

- The child has a fit;
- The child develops a non-blanching rash;
- The parent or carer feels that the child is less well than when they previously sought advice.

10.0 Staff Training

10.1 All medical and nursing staff are to ensure that their knowledge, competencies and skills are up-to-date in order to complete their portfolio for appraisal.

10.2 During induction process junior medical staff will receive instruction on current policies and guidelines.

- 10.3 At case presentation and junior doctor teaching will discuss serious cases relating to high fever, and learn from the outcomes.
- 10.4 Where a patient's notes have demonstrated that the appropriate action has not been taken a 'risk event form' is to be completed. This will address any further training needs for staff that requires updating.

11.0 Infection Prevention

- 11.1 All staff should follow Trust guidelines on infection prevention ensuring that they effectively 'decontaminate their hands' before and after each procedure.
- 11.2 All staff should ensure that they follow Trust guidelines on infection prevention using Aseptic Non-Touch Technique (ANTT) when carrying out procedures.

12.0 Audit and Monitoring

- 12.1 Where a child's notes have demonstrated that the appropriate action has not been taken a 'risk event form' is to be completed. This will address any further training needs for staff that require updating.
- 12.2 Laboratories should monitor resistance patterns of urinary pathogens and make this information routinely available to prescribers.
- 12.3 Annual audit of children admitted with Urinary Tract Infections against this guideline.

13.0 Communication

- 13.1 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.
- 13.2 Approved guidelines will be disseminated to appropriate staff via email after ratification of guideline.

14.0 References

NICE, 2013, Clinical Guideline 47, Feverish illness in children: Assessment and initial management in children younger than 5 years.

Advanced Life Support Group (2016). Advanced paediatric life support: a practical approach to emergencies (6th ed). Wiley-Blackwell

Table 1 Traffic light system for identifying risk of serious illness**Appendix 1**

Children with fever and **any** of the symptoms or signs in the red column should be recognised as being at high risk. Similarly, children with fever and any of the symptoms or signs in the amber column and none in the red column should be recognised as being at intermediate risk. Children with symptoms and signs in the green column and none in the amber or red column are at low risk. The management of children with fever should be

	Green – low risk	Amber – intermediate risk	Red – high risk
Colour	<ul style="list-style-type: none"> • Normal colour of skin, lips and tongue 	<ul style="list-style-type: none"> • Pallor reported by parent/carer 	<ul style="list-style-type: none"> • Pale/mottled/ashen/blue
Activity	<ul style="list-style-type: none"> • Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying 	<ul style="list-style-type: none"> • Not responding normally to social cues • Wakes only with prolonged stimulation • Decreased activity • No smile 	<ul style="list-style-type: none"> • 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
Respiratory		<ul style="list-style-type: none"> • Nasal flaring • Tachypnoea: RR > 50 breaths/minute age 6–12 months RR > 40 breaths /minute age > 12 months • Oxygen saturation ≤ 95% in air • Crackles 	<ul style="list-style-type: none"> • Grunting • Tachypnoea: RR > 60 breaths/minute • Moderate or severe chest indrawing
Hydration	<ul style="list-style-type: none"> • Normal skin and eyes • Moist mucous membranes 	<ul style="list-style-type: none"> • Dry mucous membrane • Poor feeding in infants • CRT ≥ 3 seconds • Reduced urine output 	<ul style="list-style-type: none"> • Reduced skin turgor
Other	<ul style="list-style-type: none"> • None of the amber or red symptoms or signs 	<ul style="list-style-type: none"> • Fever for ≥ 5 days 	<ul style="list-style-type: none"> • Age 0–3 months, temperature ≥ 38°C • Age 3–6 months, temperature ≥ 39°C
		<ul style="list-style-type: none"> • Swelling of a limb or joint • Non-weight bearing/not using an extremity 	<ul style="list-style-type: none"> • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures
		<ul style="list-style-type: none"> • A new lump > 2 cm 	<ul style="list-style-type: none"> • Bile-stained vomiting
CRT, capillary refill time; RR, respiratory rate.			

Appendix 2

Table 2 Summary table for symptoms and signs suggestive of specific diseases

Diagnosis to be considered	Symptoms and signs <u>in conjunction with fever</u>
Meningococcal disease	Non-blanching rash, particularly with one or more of the following: <ul style="list-style-type: none"> • an ill-looking child • lesions larger than 2 mm in diameter (purpura) • a capillary refill time of ≥ 3 seconds • neck stiffness
Meningitis	Neck stiffness Bulging fontanelle Decreased level of consciousness Convulsive status epilepticus
Herpes simplex encephalitis	Focal neurological signs Focal seizures Decreased level of consciousness
Pneumonia	Tachypnoea (RR > 60 breaths per minute age 0–5 months, RR > 50 breaths per minute age 6–12 months; RR > 40 breaths per minute age > 12 months) Crackles Nasal flaring Chest indrawing Cyanosis Oxygen saturation $\leq 95\%$
Urinary tract infection	Vomiting Poor feeding Lethargy Irritability Abdominal pain or tenderness Urinary frequency or dysuria
Septic arthritis	Swelling of a limb or joint Not using an extremity Non-weight bearing
Kawasaki disease	Fever for more than 5 days and at least four of the following: <ul style="list-style-type: none"> • bilateral conjunctival injection • change in mucous membranes • change in the extremities • polymorphous rash • cervical lymphadenopathy

Appendix 3: Preliminary Equality Analysis

This assessment relates to: Feverish Illness In Children: Assessment And Initial Management In Children Younger Than 5 Years/ 10043

A change in a service to patients		A change to an existing policy	X	A change to the way staff work	
A new policy		Something else (please give details)			
Questions			Answers		
1. What are you proposing to change?			Full Review		
2. Why are you making this change? (What will the change achieve?)			3 year review		
3. Who benefits from this change and how?			Patients and clinicians		
4. Is anyone likely to suffer any negative impact as a result of this change? If no, please record reasons here and sign and date this assessment. If yes, please complete a full EIA.			No		
5. a) Will you be undertaking any consultation as part of this change? b) If so, with whom?			Refer to pages 1 and 2		

Preliminary analysis completed by:

Name	Lucy Bouckley	Job Title	Staff Nurse	Date	March 2019
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