BEST Education Sessions, Spring 2016

Diarmuid Kerrin
Consultant Paediatrician
Barnsley Hospital

Who am I?

- Consultant in Barnsley since 2001
  - committed to the community
- Acute paediatrician, with a variety of responsibilities / interests, including education
  - part of a team
  - allergy, safeguarding, CF
- Keen on two-way communication with primary care; clinical supervisor for VTS trainees
  - conscious of differences in settings / resources

What do I / we hope to achieve?

- Enjoyable, interactive and useful sessions
- Increased and shared understanding of conditions, roles and interface
- Key practice points (both ways)
- Clarification and development

The Sick Child

with

Vicky Caddick, Sister

Amy Whitworth, HCA

Who here gets scared by the thought of a sick child?

- We all want the same safe outcomes
- We all find it a challenge

Children…

- Are not small versions of adults
- Different diseases, physiology, development and psychology
- Cannot always tell you what's wrong
- Can get very sick very quickly
- (usually don't)
- Can get better very quickly
- Have been defined as 'noise covered in dirt'

What are our tools for dealing with the sick child?

- Time
- Acknowledging uncertainty
- Acknowledging parents' observations
- (especially returns)
- Gut feeling / 'gestalt'
- Safety netting

- Guidelines

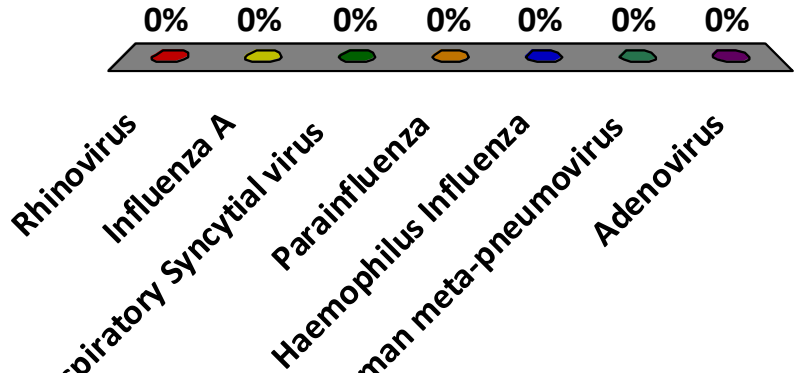
NICE Feverish child – red flags

Common acute conditions

Case A

What is the most common organism in bronchiolitis?

A. Rhinovirus
B. Influenza A
C. Respiratory Syncytial virus ✓
D. Parainfluenza
E. Haemophilus Influenza
F. Human meta-pneumovirus
G. Adenovirus



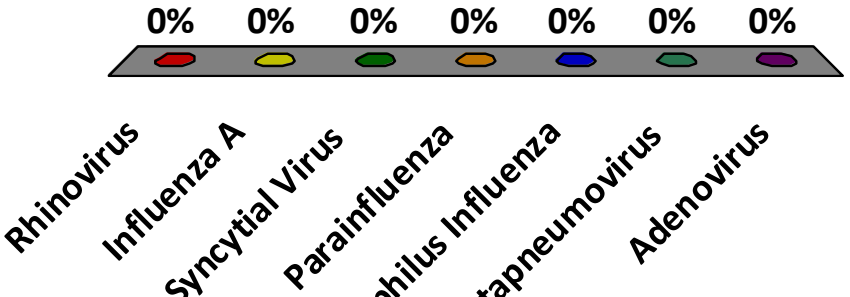
Bronchiolitis – key points

- Age
- Apneoas
- NICE guidelines - saturations
- Supportive treatment
- 5 day peak
- Post bronchiolitis

Case B

What is the most common organism in croup?

A. Rhinovirus
B. Influenza A
C. Respiratory Syncytial Virus
✓ D. Parainfluenza
E. Haemophilus Influenza
F. Human Metapneumovirus
G. Adenovirus



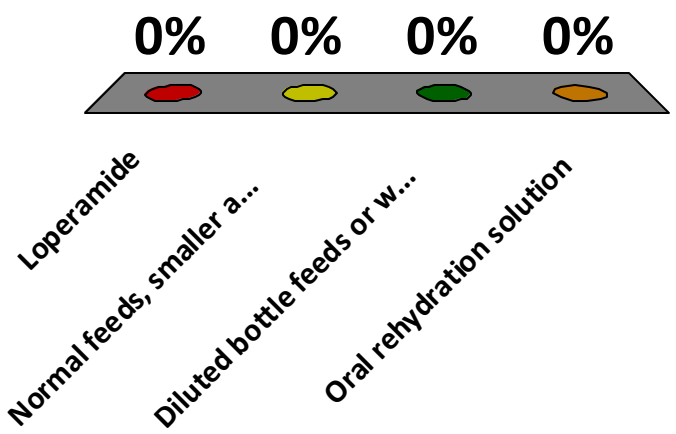
Croup – key points

- Timing / time
- Saturations
- Dexamethasone
- Adrenaline
- Differentials

Case C

For gastroenteritis in a 6 month old child, common management is?...

A. Loperamide
B. Normal feeds, smaller amounts more frequently
C. Diluted bottle feeds or water if tolerated
D. Oral rehydration solution

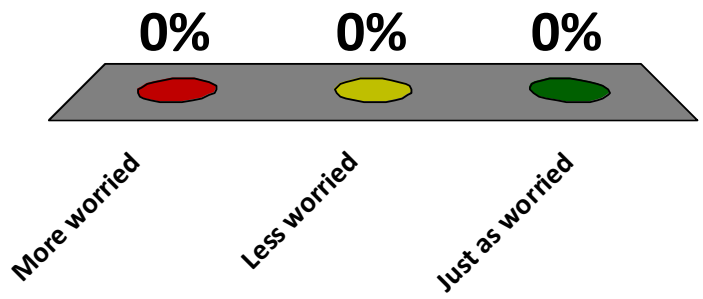


Gastroenteritis in children – key points

- Assessment of dehydration; beware hypoglycaemia in babies
- Avoid hyponatraemia
- Back to usual feeds soon
- Discussion re secondary lactase deficiency

Case D – 3 year old child very unwell with a spreading purpuric rash. The child has meningism. This observation leads you to be:

A. More worried
✓ B. Less worried
C. Just as worried



Petechial rash / Sepsis – key points

- NICE guidelines – child with fever; meningococcal disease
- Petechiae are a common presentation and usually do not represent meningococcal disease
- Composite assessment
- Time may be diagnostic
- If in doubt, treat

Case E – Bruising in babies
What percentage of babes under 6 months old have bruises?

A. 75%

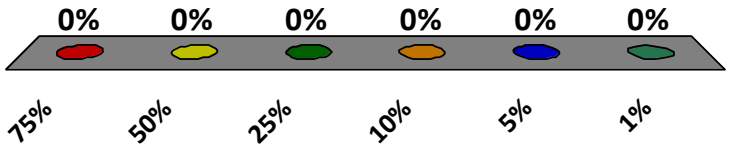
B. 50%

C. 25%

D. 10%

✓ E. 5%

✓ F. 1%



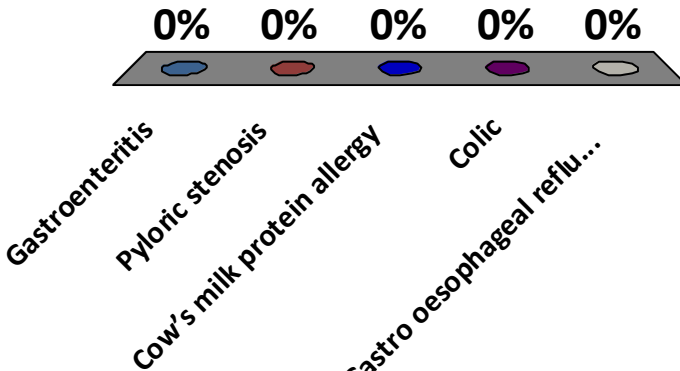
Bruising in non-mobile children – protocol: handout

- Immediate referral

- Both paediatric consultant and children's social care
- https://www.safeguardingchildrenbarnsley.com/media/21067/safeguarding_children_guidelines_for_primary_care.pdf

Case F - 12 weeks old, vomits every bottle feed since 3 weeks, lots of crying at night, back arching. Mild eczema but otherwise well. Most likely diagnosis is?

A. Gastroenteritis
B. Pyloric stenosis
C. Cow's milk protein allergy
D. Colic
E. Gastro oesophageal reflux disease GORD ✓



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- Colic
- Gastro oesophageal reflux disease ✓

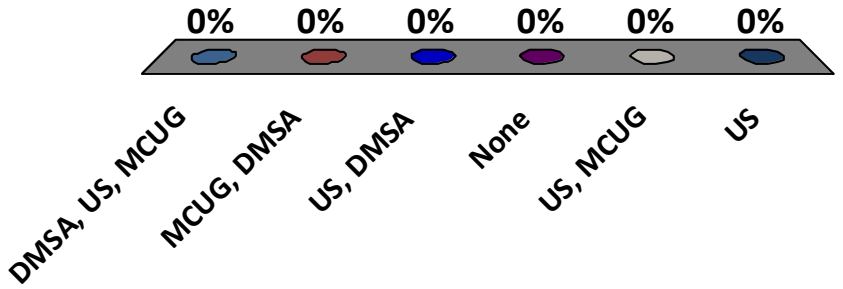
GORD – key points

- Diagnosis / interpretation
- CMPA
- N= 1
- Domperidone / PPI etc
- Feed aversion

Case G

Question: 1 year old boy, E coli in urine, responds to oral antibiotics – what investigations are needed?

A. DMSA, US, MCUG
B. MCUG, DMSA
C. US, DMSA
✓ D. None
E. US, MCUG
F. US



UTI – Key points

- Is it easy to collect urine samples in a child?
- NICE guidelines
  - a little controversial
  - emphasis on better diagnosis, less investigations
- Investigations
- Prophylaxis

Other common conditions

- Diabetes
- Asthma
- Jaundice
- etc..

Tools to help assess the potentially sick child…

Equipment

- Saturation monitors
- Blood glucose monitoring
- Blood pressure cuffs

Other top tips from nursing colleagues…

Leg Stretch Break!

Where to refer and what timescale?

ED

CAU (Children's Assessment Unit)

Routine OPD

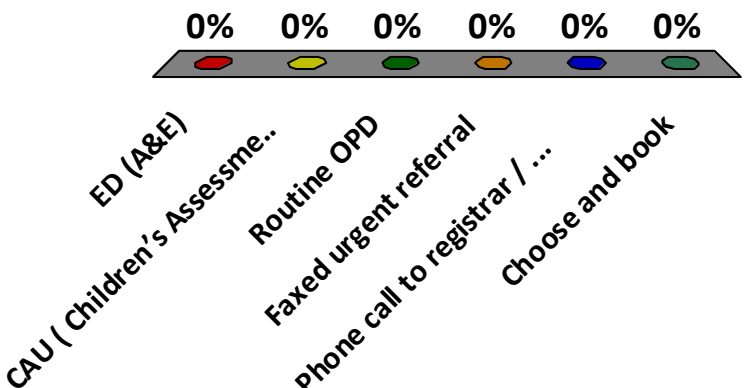
Faxed urgent referral

Phone call to registrar / consultant for discussion / advice

Choose and book

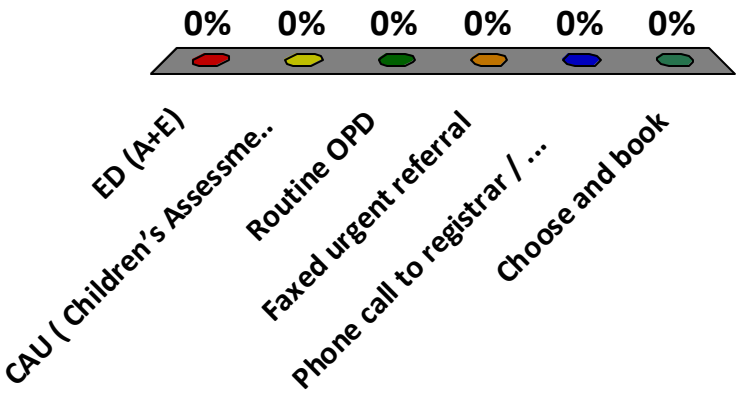
Case 1 – 6 month old with gastroenteritis and drinking less than 50% of usual intake

A. ED (A&E)
B. CAU (Children's Assessment Unit)
C. Routine OPD
D. Faxed urgent referral
E. Phone call to registrar / consultant for discussion / advice
F. Choose and book



Case 2 – 6 week old with pallor and breathing difficulties

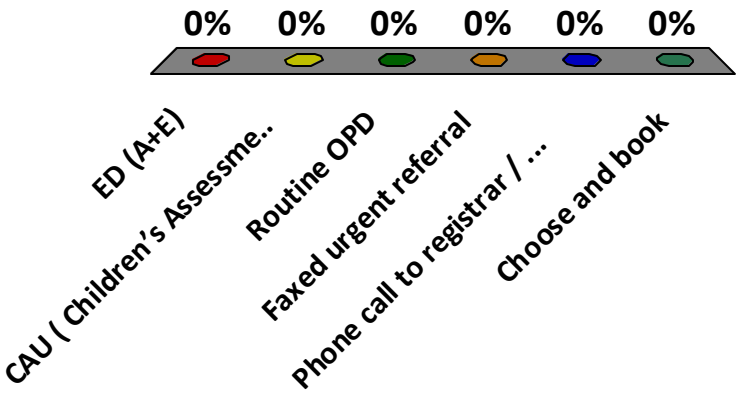
A. ED (A+E)
B. CAU (Children's Assessment Unit)
C. Routine OPD
D. Faxed urgent referral
E. Phone call to registrar / consultant for discussion / advice
F. Choose and book



Case 3

7 year old with nocturnal enuresis

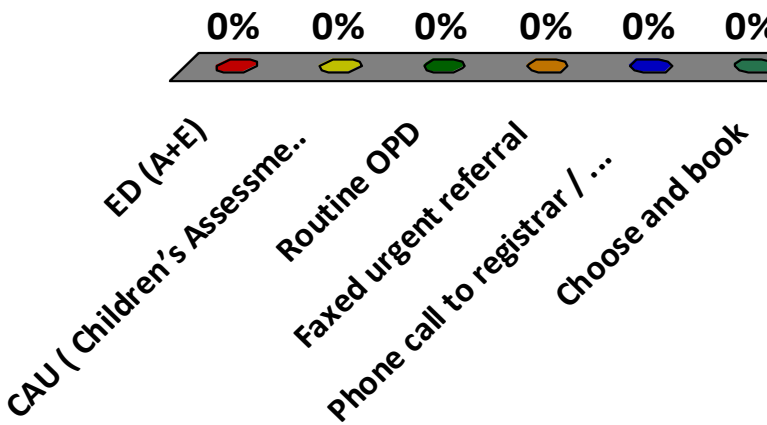
A. ED (A+E)
B. CAU (Children's Assessment Unit)
C. Routine OPD
D. Faxed urgent referral
E. Phone call to registrar / consultant for discussion / advice
F. Choose and book



Case 4

10 year old with 2 month history of weight loss, pain in left hip

A. ED (A+E)
B. CAU (Children's Assessment Unit)
C. Routine OPD
D. Faxed urgent referral
E. Phone call to registrar / consultant for discussion / advice
F. Choose and book



Consultant of the week

- In rotation rather than awarded for good behaviour
- Provides continuity of care for acute admissions (including neonates)
- Always available for advice / support
- Looks at faxed referrals and arrange acute assessments (including child protection medicals)
- Screens Choose and Book letters

Choose and Book

- We read all referrals and may need to redirect if
  - We think child clinically needs a sooner appointment
  - There is an alternative service which is more appropriate (eg paediatric surgeon)
- Please ensure letters placed on system promptly to help us do this, and please look for rejections and ?let families know
- Some services locally may not be on Choose and Book (eg allergy clinic) – if unsure, please ask paediatric secretaries

Pathways for the sick child – ideal principles

- Safety first
- Minimise duplication / handovers / unnecessary waits
- Need to factor in time / active observation period
- Avoid unnecessary admissions
- Avoid unnecessary re-attendances
- Safety netting

Requests from ED re paediatric referrals

- If you are referring in, please give the family something in writing
  - This lets ED know if child expected by paediatrics or not (ie triage for them, or assessment by ED)
  - If a child has been seen by a GP that day would not then be diverted to Care UK

The Sick Child - Pathways

- What do you need in terms of
  - Information?
  - Specific guidance / guidelines?
  - We can put this on BEST website

- BHNFT actively looking into paediatric ED / CAU set-up
- BHNFT looking to recruit paediatrician with interest in / responsibility for ambulatory care

Other resources

- CCNs – we have an excellent team of specialist community nurses –generic, allergy, respiratory, diabetes, neonates
- Epilepsy nurses – work closely with local paediatric epilepsy clinic and tertiary paediatric neurologists

- Spotting the Sick Child
  - www.spottingthesickchild.com
- RCPCH Paediatric Care Online
  - www.rcpch.ac.uk/pcouk