North West London
Collaboration of
Clinical Commissioning Groups

FAQs for GPs Assessing Febrile Children

This document answers your frequently asked questions about febrile children in GP Practices

Is it safe to assess children with a high temperature or fever face-to-face?

Yes. GPs can be reassured by the recent evidence that children presenting to primary care with a fever are less likely to be COVID-19 positive than adults. The risk of a child transmitting COVID if seen at the surgery is almost certainly lower than the risk from an adult. Febrile children are more likely to have a non-COVID infection, and children with COVID-19 are often asymptomatic. Reduce the risk of transmission with use of appropraite PPE and other simple measures, such as use of a separate entrance

What PPE do we need?

The current Public Health England advice is that using basic personal protective equipment (PPE) (fluid-resistant mask, apron, gloves, good hand hygiene and visors) is sufficient. This is the current standard in secondary care, alongside thorough cleaning of environments in between patients and appropriate social distancing. Advanced PPE (such as FFP3 masks) is only required for aerosol generating procedures which are not commonly performed in primary care settings

Can patients be seen virtually instead?

Virtual consultations, especially video, can be used effectively as a method of triaging patients – talk before you walk - they should not, however, replace the face to face assessment of unwell children. It is important to note the limitations of virtual consultation- poor image quality makes it challenging to perform a visual inspection, and the inability to auscultate, palpate and accurately measure vital signs makes it challenging to assess a patient. Any patients seen virtually require robust safety-netting advice. “AccuRx” is useful for this

When must a child be seen face-to-face?

All children classed as unwell on triage should be seen face to face by a GP or experienced clinician in primary care. If on triage/ face to face assessment the child is deemed seriously unwell (for example, decreased activity levels, poor feeding, reduced urine output, etc.) according to the “Community based management of illness in children during the COVID-19 pandemic” traffic light guideline, they should be directed to A&E urgently

Are Escalated Care Clinics ("hot hubs") still running?

Whilst some Escalated Care Clinics are still running, a number are being scaled back due to reduced demand. We recommend checking with your local services

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Should children be referred to the Escalated Care Clinics?

Under-12s who are febrile are likely to have a non-COVID infection. They should therefore not be referred to an Escalated Care Clinic, but instead should assessed by their registered practice. Consider simple control measures to see the child face-to-face.

Children under the age of 12 may be seen by an Escalated Care Clinic if there is substantial reason to suspect that they have COVID-19, such as:
- Another family member, above the aged of 12 and from the same household, has symptoms or confirmed COVID-19 in the last 10 days.
- A confirmed outbreak in the child's school or childcare provider;
- A positive test result for COVID-19

Over-12s requiring face-to-face assessment may be seen at the Escalated Care Clinic but it is good practice to see young people up to age 18 in their own GP Practice, to take into consideration wider diagnostics and family factors

How to assess patients with suspected tonsilitis?

Tonsillar examination is currently deemed a higher risk procedure, and should only be performed if essential. However, the RCPCH has advised that children should not be referred to secondary care solely for a tonsillar examination. For children over the age of 3, the “feverpain” scoring system can be used to decide if antibiotics are indicated. In lieu of examination, the patient can automatically be given a score of 2 if there is a history consistent with tonsillitis. If tonsillitis is suspected, and the patient is being assessed via video consultation, ask the patient to send a photograph of their tonsils and watch them drinking a glass of water - are they able to swallow? If the tonsils must be examined, droplet PPE is required (gown, gloves, surgical mask, and eye protection / visor)

Are there any tips for how to assess a child virtually?

- Establish the heart rate by asking the patient’s parent/carer to tap out their pulse
- Ask the patient’s parent / carer to feel the patient’s hands to see if they are cool. Feel up the arms, moving centrally until they feel warm (rough indication of intravascular volume status and peripheral perfusion)
- Hydration status (mucous membranes, frequency of urination, alertness, etc.) can be assessed via video. The parent can be asked to calculate capillary refill time by applying moderate pressure to the finger for 5 seconds, and the clinician will count the seconds for refill. To assess skin turgor, have the parent pinch the tummy and observe for recoil.
- Ask the patient to put their hand on their chest to more easily calculate the respiratory rate, and use video to look for signs of respiratory distress
- If any concerns about rashes, the doctor can ask the parent/carer to send photos (which have a better image quality than video) and they can perform the glass test while on the video call
- For a rough screening tool for peritonitis you can ask the patient to ‘blow their tummy out’ or ‘cough’ – a patient with peritonitis will often grimace (although it is not possible to observe peritonitis remotely)
For more guidance on remote consultations, refer to guidance from NHS England: *www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479-principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf*

What are the best antibiotic choices for children?

You can continue to use your usual choice of antibiotics. In general, the antibiotics we would recommend for paediatric infections in the community are:

- **Meningoccal meningitis: im benzylpenicllin**
- **Otitis media: (nothing or) amoxicillin**
- **Tonsillitis: amoxicillin or pen V**
- **Pneumonia: amoxicillin or azithromycin**
- **UTI- cefalexin or co-amociclav**

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Case studies

A child with a fever of ⩾38.5 degrees

All children with a significant fever need to be seen by a GP. Consult the traffic light document. Don basic PPE and consider utilising side entrances / consult away from other service users (to avoid unnecessary contact). Consider the differentials (COVID-19 being the least likely cause) and treat accordingly. For test and trace purposes these patients should get a COVID-19 swab (organised by the parent via the NHS portal or by calling 119)

Fever, cough and parents with COVID-19 symptoms in a 9-year old

A child displaying COVID-19 symptoms, such as fever and cough, who has parent with symptoms or confirmed COVID-19 within the last 10 days may be referred to the Escalated Care Clinic if these are still operating in your area. If the Escalated Care Clinic is not available, these children may be suitable for remote consultation, with escalation to secondary care if deemed to be unwell

A child with COVID-19 symptoms

If a child presents with COVID-19 symptoms (fever, new cough, loss of sense of taste and smell) they should be seen by the GP, using appropriate PPE. A COVID-19 swab (organised by the parent via the NHS portal or by calling 119) is important for test and trace purposes, not for diagnosis. Consider other causes of fever such as; otitis media, tonsillitis and UTI.

A child who presents to A&E will have their immediate health needs addressed (in this case encouraging fluids, paracetamol and antibiotics) but will not have a COVID swab. These swabs are only available in hospital for patients who are being admitted

A child with simple coryza

Children under 12 years who present with coryza can be reassured and safety netted. If the patient has concomitant fever, assess clinically and consider other causes of fever (e.g. sepsis)

connecting care for children

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