**CLINICAL ASSESSMENT TOOL FOR BABIES/CHILDREN UNDER 2 YEARS WITH SUSPECTED BRONCHIOLITIS IN THE COMMUNITY**

**Suspected Bronchiolitis?**

\*Snuffly nose \*Poor feeding \*Pyrexia \*Head bobbing

\*Bronchiolitis season \*Inspiratory crackle +/-wheeze

\*Chesty Cough \*Vomiting \*Increased work of breathing \*Cyanosis \*HR

Offer all babies/children with suspected bronchiolitis a **face-to-face appointment** with a clinician

Obtain full history (if not previously taken)

Measure: Temperature, oxygen saturations, heart rate and respiratory rate

If any amber features and no red (see Table 1)

If all green features and no amber or red (see Table 1)

If any red features (see Table 1)

Provide parents/carers with discharge advice.

Consider arranging a follow up appointment with an appropriate healthcare professional.

Consider referral to community nursing team if available.

**Advice from a paediatrician should be sough and/or a clear management plan agreed with parents.**

**.**

* Contact the paediatrician via **CONSULTANT CONNECT**
* Provide written or verbal information on warning symptoms and accessing further healthcare
* [Bronchiolitis leaflet for parents](https://www.hwehealthiertogether.nhs.uk/professionals/gp-primary-care-staff/safety-netting-documents-parents/bronchiolitis)
* Consider referral to community nursing team if available
* Consider arranging a follow up or review

Refer immediately for emergency care – consider 999.

Commence relevant treatment to stabilise baby/child for transfer if appropriate.

Consider commencing high flow oxygen supply.

Send relevant documentation.

Admit

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|  |
|  | **Green – low risk** | **Amber – intermediate risk** | **Red – high risk** |
| **Behaviour** | AlertNormal | IrritableNot responding to normal social cuesDecreased activityNo smile | Unable to rouseWakes only with prolonged stimulationNo response to social cuesWeak, high pitched or continuous cryAppears ill to a healthcare professional |
| **Skin** | CRT < 2 seconds Normal colour skin, lips and tongueMoist mucous membranes | CRT 2-3 secondsPallor reported by parent/carerCool peripheries | CRT over 3 secondsPale/mottled/ashen blueCyanotic lips and tongue |
| **Respiratory Rate** | <12 months <50 breaths/minute>12 months <40 breaths/minuteNo respiratory distress | <12 months 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 | 50-70% 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* | *SATS: saturations in air* |
| *\*Apnoea: For 10-15 seconds or shorter if accompanied by a sudden decrease in saturations/central cyanosis or bradychardia* |

**Table 1. Traffic light system for identifying likelihood of serious illness**

**Healthcare professionals should be aware of the increased need for hospital admission in infants with the following:**

* Pre-existing lung disease, congenital heart disease, neuromuscular weakness, immune-incompetence
* Age <6 weeks (corrected)
* Prematurity
* Family anxiety
* Families ability to look after child at home (including distance to healthcare facilities)
* Re-attendance
* Duration of illness is less than 3 days and Amber – may need to admit

**Signs and Symptoms can include:**

* Rhinorrhoea (Runny nose)
* Cough
* Poor Feeding
* Vomiting
* Pyrexia
* Respiratory distress
* Apnoea
* Inspiratory crackles +/- wheeze
* Cyanosis

**This guidance is written in the following context:**

This assessment tool is based on NICE guidance, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.