Ashford and St. Peter's Hospitals
NHS Foundation Trust

Guideline for the management of Fever in under 5s

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Guideline History		
Date	**Comments**	**Approved By**
August 2018	Guideline created by Dr MacCarthy	
March 2022	Guideline updated	
June 2026	Updates to assessment of risk of serious illness, updated signs and symptoms of specific illnesses in line with corresponding NICE guidelines, and new antibiotic guidance in line with Trust Eolas.	Paediatric Guideline Committee

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Guideline for the management of Fever in under 5s

Introduction

This guideline is to aid clinician's assessment and management of children aged 0-5 years presenting with symptoms of fever, focusing on recognition of serious illness.

It is advised to use this guidance in conjunction with sepsis and PUO guidelines.

Measurement of body temperatures

- Do not routinely use oral and rectal routes to measure temperature.
- Forehead chemical thermometers are unreliable.
- In infants under 4 weeks old, measure body temperature with an electronic thermometer in the axilla.
- In children aged 4 weeks to 5 years, measure body temperature by; electronic thermometer in axilla, infra-red tympanic thermometer or chemical dot thermometer in the axilla.
- *Parental reported temperatures should be considered valid by healthcare professionals.

Clinical assessment of children with fever

- Identify immediate life-threatening features including airway/breathing/circulation compromise and decreased level of consciousness.
- Think **"Could this be Sepsis?"**. Refer to sepsis guidance if symptoms and signs indicate possible sepsis.

SEPSIS = life-threatening condition causing organ dysfunction due to dysregulated host response to infection.

Assessment of risk of serious illness

Assess children with feverish illness 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 below:

NICE National Institute for Health and Care Excellence

Traffic light system for identifying risk of serious illness in under 5s

Refer to the summary version of table 3 for the NICE guideline on sepsis if a child presents with fever and symptoms or signs that indicate possible sepsis

	Green – low risk	Amber – intermediate risk	Red – high risk
Colour (of skin, lips or tongue)	• Normal colour	• Pallor reported by parent/carer	• Pale/mottled/ashen/ blue
Activity	• Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying	• Not responding normally to social cues • No smile • Wakes only with prolonged stimulation • Decreased activity	• No response to social cues • Appears ill to a healthcare professional • Does not wake or if roused does not stay awake • Weak, high-pitched or continuous cry
Respiratory		• Nasal flaring • Tachypnoea: – RR >50 breaths/ minute, age 6–12 months – RR >40 breaths/ minute, age >12 months • Oxygen saturation ≤95% in air • Crackles in the chest	• Grunting • Tachypnoea: RR >60 breaths/minute • Moderate or severe chest indrawing
Circulation and hydration	• Normal skin and eyes • Moist mucous membranes	• Tachycardia: – >160 beats/minute, age <12 months – >150 beats/minute, age 12–24 months – >140 beats/minute, age 2–5 years • CRT ≥3 seconds • Dry mucous membranes • Poor feeding in infants • Reduced urine output	• Reduced skin turgor
Other	• None of the amber or red symptoms or signs	• Age 3–6 months, temperature ≥39°C • Fever for ≥5 days • Rigors • Swelling of a limb or joint • Non-weight bearing limb/not using an extremity	• Age <3 months, temperature ≥38°C* • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures

CRT, capillary refill time; RR, respiratory rate
* Some vaccinations have been found to induce fever in children aged under 3 months

This traffic light table should be used in conjunction with the recommendations in the NICE guideline on fever in under 5s.

Measure and record temperature, heart rate, respiratory rate and capillary refill time as part of the routine assessment of a child with fever.

- Capillary refill time of 3 seconds or longer is an intermediate risk group marker for serious illness.
- Recognise that tachycardia is at least an intermediate risk for serious illness.

ADVANCED PAEDIATRIC LIFE SUPPORT CRITERIA FOR TACHYCARDIA	
AGE	**HEART RATE (bpm)**
<12 months	>160
12-24 months	>150
2-5 years	>140

- Measure blood pressure of children with fever if the heart rate or capillary refill time is abnormal. NB: hypotension is a late sign of shock in serious illness. Children with serious illness may remain normotensive due to compensatory mechanisms; therefore, the absence of hypotension should not delay recognition and treatment of shock.
- In children older than 6 months, do not use height of temperature alone to identify those with serious illness.
- Do not use duration of fever to predict the likelihood of serious illness HOWEVER, children with fever lasting 5 days or longer should be assessed for Kawasaki disease and PIMS-TS (post covid).
- When assessing a child with feverish illness, enquire about recent travel abroad and consider the possibility of imported infections according to the region visited.
- Febrile children with proven viral illness, should still be assessed for features of serious illness, and concurrent or secondary bacterial infection
- Assess children with fever for signs of dehydration:
    - Prolonged capillary refill time
    - Abnormal skin turgor
    - Abnormal respiratory pattern
    - Weak pulse
    - Cool extremities

Summary of Symptoms and Signs suggestive of Specific illnesses

Diagnosis to be considered	Symptoms and Signs in conjunction with Fever
Meningococcal disease See NICE guidance: **https://www.nice.org.uk/guidance/ng240**	Non-blanching rash, particularly with 1 or more of the following: • an ill-looking child • lesions larger than 2 mm in diameter (purpura) • capillary refill time of ≥3 seconds • neck stiffness
Bacterial meningitis See NICE guidance: **https://www.nice.org.uk/guidance/ng240**	Neck stiffness Bulging fontanelle Decreased level of consciousness Convulsive status epilepticus
Herpes simplex encephalitis	Focal neurological signs Focal seizures Decreased level of consciousness
Pneumonia See NICE guidance (NB: includes children >1 month up to adults): **https://www.nice.org.uk/guidance/ng250** See Tables 2 and 4 in the NICE guideline for antibiotic recommendations for community and hospital-acquired pneumonia respectively	Tachypnoea: • >60 breaths/minute, age 0–5 months • >50 breaths/minute, age 6–12 months • >40 breaths/minute, age >12 months Crackles in the chest Nasal flaring Chest indrawing Cyanosis Oxygen saturation ≤95% in room air
Urinary tract infection See NICE UTI guidance: **https://www.nice.org.uk/guidance/ng224**	Vomiting Poor feeding/reduced fluid intake Lethargy/irritability Abdominal pain or tenderness Urinary frequency and/or dysuria

	Malodourous and/or cloudy urine Frank haematuria Shivering New bedwetting Previous history of confirmed UTI.
Septic arthritis	Swelling of a limb or joint Not using an extremity Non-weight bearing
Kawasaki disease See Department's Kawasaki Guideline Ask parents or carers about the presence of these features since the onset of fever, because they may have resolved by the time of assessment. Be aware that children under 1 year may present with fewer clinical features of Kawasaki disease in addition to fever but may be at higher risk of coronary artery abnormalities than older children.	Fever for 5 days or longer and may have some of the following: • bilateral conjunctival injection without exudate • erythema and cracking of lips; strawberry tongue; or erythema of oral and pharyngeal mucosa • oedema and erythema in the hands and feet • polymorphous rash • cervical lymphadenopathy
PIMS-TS = **Paediatric Multisystem Inflammatory Syndrome temporally associated with SARS-CoV-2** See STRS clinical guidance on St Peter's Paediatric guidelines.	Persistent fever 3 days or more Lethargy and myalgia Abdominal symptoms: pain, diarrhoea and vomiting Rash or muco-cutaneous inflammation Bilateral non-purulent Conjunctivitis Cardiac involvement: Hypotension, tachycardia +/-shock

Fever can also be related to malignancy or inflammatory conditions rather than just infection. Please see department guidelines on Pyrexia of Unknown Origin for details.

Assessment and Management according to risk of serious illness

CLINICAL ASSESSMENT: identify signs of life-threatening illness, signs and symptoms of serious illness (traffic light tool) and look for specific disease indicators.

Child aged <3 months

Observe and Monitor:
- Temperature
- Heart rate
- Respiratory rate

Perform:
- FBC
- CRP
- Blood culture
- Urine dip +MCS
- CXR (if resp signs)
- Stool culture (if diarrhoea)

Admit
Perform LP and Start IV antibiotics if:
- <1 month old
- Aged 1-3 months appearing unwell
- Aged 1-3 months with WBC <5 or >15
- No contraindication for LP

Wherever possibly, perform LP before giving antibiotics.

Child aged >3 months

If all features Green, without apparent source.

Perform:
- Urinalysis
- Assess for signs of pneumonia

Do not routinely perform blood tests or CXR.

If NO diagnosis reached but child well, manage child at home with appropriate advice. Leaflet (appendix) and verbal safety netting advice should be given.

If any amber features and no red, without apparent source.

Perform:
- Urinalysis
- CRP
- FBC
- Blood culture
- CXR if fever >39C and WBC >20
- Consider LP if child less than 1 year (guided by assessment)

If any red features and no apparent source.

Immediate senior r/v:
- Blood culture
- FBC
- CRP
- Urinalysis

Consider guided by assessment:
- LP
- CXR
- Blood gas
- Electrolytes

Always think "**Could this be sepsis?**" If yes, see Sepsis guideline and sepsis 6 protocol.

In children >3months with fever without apparent source, a period of observation in hospital should be considered as part of assessment.

*Response to antipyretics alone is not reliable in differentiating serious from non-serious infection. In order to detect clinical deterioration, all children with amber and red features should be reassessed after 1-2 hours.

Consider admission according to clinical and social circumstances.

Give **immediate** parental antibiotics to any child presenting with fever and who are also appearing;

- Septic
- Shocked
- Unrousable
- Showing signs of meningococcal disease (give at the earliest opportunity, antibiotic selection as per Trust's Eolas guidance)

Manage sepsis and shock as per APLS and Paediatric Sepsis Six Protocol (see Paediatric Sepsis guidelines). Request urgent senior support and discuss early with PICU (STRS - 02071885000).

Antibiotics – Refer to Trust Eolas guidance

When antibiotics are indicated for Infants <1 month: IV cefotaxime + IV amoxicillin. Stop amoxicillin once Listeria meningitis excluded by negative cultures at 48 hours.

When antibiotics indicated for infants 1 – 3 months old: IV ceftriaxone + consider adding IV amoxicillin (for Listeria cover)

>3 months old, when parenteral antibiotics are indicated: IV ceftriaxone should be given until culture results are available. If bacterial meningitis likely, add IV dexamethasone 15mg/kg QDS (give with or just before the first antibiotic dose and continue for 4 days).

Give IV aciclovir promptly to any child with fever and clinical suspicion or features suggestive of herpes simplex virus (HSV) infection or encephalitis, including focal neurological signs, focal seizures, reduced level of consciousness, and unexplained derangement of liver function tests/transaminitis. Maintain a particularly low threshold for considering IV aciclovir in febrile infants, especially those aged 1 month or younger.

In penicillin-allergic patients, discuss with microbiology.

Avoid use of oral antibiotics in children with fever without an apparent source.

Admission to and discharge from hospital

In addition to the child's clinical condition, consider the following factors when deciding whether to admit a child with fever to hospital:

- social and family circumstances
- other illnesses that affect the child or other family members

- parental anxiety and instinct (based on their knowledge of their child)
- contacts with other people who have serious infectious diseases
- recent travel abroad to tropical/subtropical areas, or areas with a high risk of endemic infectious disease
- when the parent or carer's concern for their child's current illness has caused them to seek healthcare advice repeatedly
- where the family has experienced a previous serious illness or death due to feverish illness which has increased their anxiety levels
- when a feverish illness has no obvious cause, but the child remains ill longer than expected for a self-limiting illness.

If it is decided that a child does not need to be admitted to hospital, but no diagnosis has been reached, provide a safety net for parents and carers, including verbal and/or written information on warning symptoms and how further healthcare can be accessed. (See **appendix** for patient information leaflets.)

Discharge Advice

Advise parents or carers on antipyretics and how to manage their child's temperature at home.

- Tepid Sponging is not recommended. They should dress the child normally.
- If child appears distressed or unwell, give either paracetamol or ibuprofen.
- Do not routinely administer both simultaneously with the sole aim of reducing fever or preventing febrile seizure. Alternate if distress persists before next dose is due.

Advise parents or carers looking after a feverish child at home:

- to offer the child regular fluids (where a baby or child is breastfed the most appropriate fluid is breast milk)
- how to detect signs of dehydration by looking for the following features: sunken fontanelle, dry mouth, sunken eyes, absence of tears, poor overall appearance.
- to encourage their child to drink more fluids and consider seeking further advice if they detect signs of dehydration.
- how to identify a non-blanching rash.
- to check their child during the night.
- 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.

They should seek further advice if:

- the child has a seizure
- the child develops a non-blanching rash

- the parent or carer feels that the child is less well than when they previously sought advice
- the parent or carer is more worried than when they previously sought advice
- the fever lasts 5 days or longer
- the parent or carer is distressed or concerned that they are unable to look after their child.

2. Supporting References

1. NICE Guideline: Fever in under 5s: assessment and initial management. Clinical Guideline (CG160). Published Nov 2019, last updated Nov 2021. Last reviewed April 2025 – no changes made.

   https://www.nice.org.uk/guidance/ng143

2. Evelina London Paediatric Critical Care Guidance on PIMS-TS. Published Jan 2021. Updated Dec 2025.

   https://www.evelinalondon.nhs.uk/resources/our-services/hospital/south-thames-retrieval-service/pims-ts-paediatric-multisystem-inflammatory-syndrome-temporally-associated-with-sars-cov2-v2.pdf

3. St George's hospital guideline for the management of paediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2. Published Jan 2021.

   https://www.georgespicu.org.uk/wp-content/uploads/bsk-pdf-manager/2021/01/COVID-PIMS-TS-v5-Jan2021.pdf

3. Supporting relevant trust guidelines

1. Ashford and St Peter's Hospital Trust Eolas
2. Sepsis Guidelines – Paediatric Sepsis Six
3. Pyrexia of unknown origin (PUO) clinical guideline

4. Management of fever and petechiae
5. Guideline for the management of Meningococcal Septicaemia in Paediatric ED
6. Kawasaki Disease
7. Guideline for the management of UTIs in children.

4. Guideline Governance

a. Scope

This guideline is relevant to all staff caring for all children from 0-18 years old across the emergency department, inpatient ward and outpatient department.

b. Purpose

i. This guidelines aims to facilitate a common approach to the management of children. At times deviation from the guideline may be necessary, this should be documented and is the responsibility of the attending consultant.

ii. This guideline is subject to regular review to ensure ongoing evidence based practice.

c. Duties and Responsibilities

All healthcare professionals responsible for the care of all children 0-18years should be aware of practice according to this guideline.

d. Approval and Ratification

This guideline will be approved and ratified by the Paediatric Guidelines Group.

e. Dissemination and Implementation

i. This guideline will be uploaded to the trust intranet 'Paediatric Guidelines' page and thus available for common use.
ii. This guideline will be shared as part of ongoing education within the Paediatric Department for both medical and nursing staff.
iii. All members of staff are invited to attend and give comments on the guideline as part of the ratification process.

f. Review and Revision Arrangements

a. This policy will be reviewed on a 3 yearly basis by the appropriate persons.
b. If new information comes to light prior to the review date, an earlier review will be prompted.
c. Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. Minor amendments will be ratified through the Paediatric Guidelines Group. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

g. Equality Impact Assessment

Background • Who was involved in the Equality Impact Assessment
Author and the supervising consultants.
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
All groups of staff and patients were taken into consideration and there is no bias towards or against any particular group.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
There is no evidence of discrimination.
Conclusion • Provide a summary of the overall conclusions
There is no evidence of discrimination.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
This guideline is appropriate for use.

h. Document Checklist

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Fever in under 5's Guideline

Policy (document) Author: Dr Shriya Vishwanathan (FY1) and Dr Charlotte Card, Paediatric Registrar (Post CCT)

Executive Director: N/A

		Yes/No/ Unsure/NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	**Y**	
	Is it clear whether the document is a guideline, policy, protocol or standard?	**Y**	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	**Y**	
	Is the purpose of the document clear?	**Y**	
	Are the intended outcomes described?	**Y**	
	Are the statements clear and unambiguous?	**Y**	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	**Y**	
	Who was engaged in a review of the document (list committees/ individuals)?	**Y**	**Eolas, paediatric guidelines committee. Authors and supporting consultant**
	Has the policy template been followed (i.e. is the format correct)?	**Y**	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	**Y**	**NICE**

		Yes/No/ Unsure/NA	Comments
	Are local/organisational supporting documents referenced?	**Y**	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	**Y**	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	**Y**	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	**Y**	
	Does the plan include the necessary training/support to ensure compliance?	**Y**	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	**Y**	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	**Y**	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	**Y**	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Y	

Committee Approval (Paediatric Guidelines Group)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	**Alexandra Jones**	**Date**	**19/08/2026**
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: n/a			

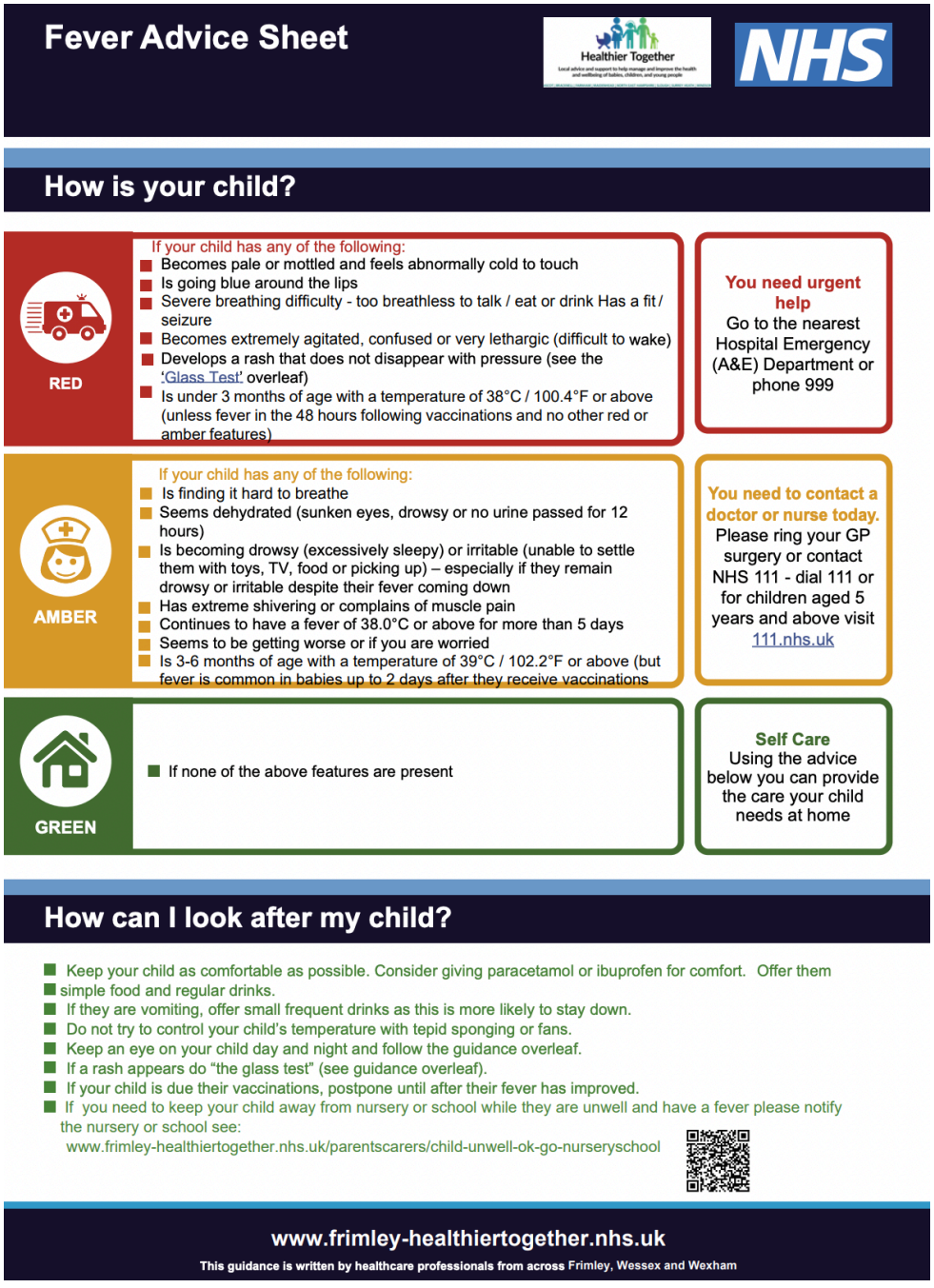
5.Appendix

St Peter's Paediatric Department's Fever in Children Patient Information Leaflet.

https://www.ashfordstpeters.info/images/leaflets/paediatrics/PA239-Fever-in-Children-Aug-2024.pdf

NHS Fever Advice Sheet for Parents:

https://frimley-healthiertogether.nhs.uk/application/files/8616/2366/2849/NHS_Advice_Sheet.pdf_May_2021.pdf



Fever Advice Sheet

Most children with a fever do get better very quickly but some children can get worse. You need to regularly check your child during the day and also through the night and follow the advice given below.

About fever in children

- Fever is extremely common in children and usually suggests that your child has an infection.
- Your child has a fever if their temperature is over 38°C. The most accurate way of measuring your child's temperature is with a digital thermometer.
- Viral infections are far more common than bacterial infections. Symptoms such as runny nose, cough, wheeze, sore throat, red eyes and diarrhoea are more suggestive of a viral infection than a bacterial infection. If a number of people are unwell in the same household, this also suggests a viral infection.
- Viral infections tend to get better on their own and do not need treatment with antibiotics.

Using medicines to help

- If your child is distressed you should consider giving them paracetamol or ibuprofen to help them feel more comfortable. Use one and if your child has not improved 2-3 hours later you may want to try giving the other medicine.
- Carefully read the instructions on the medicine for dose and frequency.
- You could ask your local pharmacist for more advice about medicines.
- In general, we do not recommend cough medicines.

The Glass Test

Do the 'glass test' if your child has a rash. Press a glass tumbler firmly against the rash. If you can see the spots through the glass and **they do not fade as you press the glass onto the skin** then this is called a 'non-blanching rash'. If you see this type of rash, seek medical advice immediately. The rash is harder to see on dark skin so check paler areas, such as palms of the hands, soles of the feet and tummy.

(Photo courtesy of the Meningitis Research Foundation 2013)

CS51313

www.frimley-healthiertogether.nhs.uk

This guidance is written by healthcare professionals from across Frimley, Wessex and Wexham