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**Recognition of Sepsis and the Deteriorating Child or Young Person Policy**

**July 2025**

**Document Profile**

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**Version Control/Changes Made**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Version** | **Summary of changes** | **Author** |
| Dec 2022 | 1 | New Policy, which replaces the previous SOPs for the ‘Assessment, Measurement and Monitoring of vital signs as indicators of health or deterioration’. Addition of NICE Sepsis Risk Stratification Tools for Children and Young People. Policy includes procedures to follow for assessing vital signs |  |
| July 2025 | 2 | Change of Title to Recognition of Sepsis and the Deteriorating Child or Young Person Policy2.2.1 Addition of further explanation regarding the training non registrants receive.2.1.2 – Addition of a paragraph to explain implementation of a new inpatient PEWS documentation by NHS England.3.4 – Move to the use of NICE 2024 table evaluating levels of risk of severe illness or death for under 5 years old from NICE 20173.4.1 – Move to the use of NICE 2024 table evaluating levels of risk of severe illness or death 5 – 11 year olds from NICE 20173.4.2 – Move to the use of NICE 2024 table evaluating levels of risk of severe illness or death for 12 – 15 year olds, and in people aged 15 or above if they are in community or custodial settings or if they are in an acute setting and are or have recently been pregnant from NICE 20174- Addition of evidence of proactive approach to auditing 9 – Updated references10 – Updated appendices |  |
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# INTRODUCTION

## Rationale

Vital signs assessment takes place as part of the art of observation and monitoring of children and young people. The monitoring and measurement of vital signs and clinical assessment are core essential skills for all health care professionals. The term ‘assessment’ describes the broader process involving visual observation, palpation (touch), listening and communication to evaluate the child or young person’s condition. Assessment can include the characteristics, interactions, non-verbal communication, and reaction to physical surroundings that children or young people may display.

Sepsis is defined as ‘a life-threatening organ dysfunction due to a deregulated host response to infection’ (NICE 2024). It is the major cause of death in the under-five’s population worldwide, and many sepsis-related deaths are preventable. This group of patients is vulnerable, and they often present with atypical or vague signs and symptoms, potentially resulting in delayed in inappropriate treatment (Sepsis Trust 2022)

This Policy aims to establish the minimum standard of type and frequency of clinical observations to be undertaken on children and young people in community settings, including their own homes or clinics. This is to:

* Provide a baseline of vital signs for children admitted to the CCNT caseload
* Identify potential children at risk of deterioration e.g. recognition of sepsis
* Ensure staff are aware of when, how and who to inform of deterioration

This Policy should be used in conjunction with the Royal College of Nursing ‘Standards for Assessing, Measuring and Monitoring Vital Signs in Infants, Children and Young People’ (RCN 2025) and the National Institute of Health and Care Excellence ‘Sepsis Risk Stratification Tools’ (NICE 2024)

## Scope

This Policy applies mainly to staff working as part of the Children’s Community Nursing Team (CCNT). It is also relevant to any other staff working within Child and Family Services who may be required to monitor vital signs and to be aware of the recognition of sepsis

## Role and Responsibilities

**Chief Executive Officer (CEO)**

The CEO has overall responsibility for ensuring there are effective arrangements in place so that staff are appropriately trained and competent to effectively fulfil their role within the organization and to maintain the safety of patients.

**Director of Governance and Care**

The Director of Governance and Care will ensure systems are in place to implement and review this Policy in line with evidence-based practice.

**Operational Lead Child and Family Services**

The Operational Lead is responsible for ensuring that high standards are maintained within their area of responsibility and the standards set out in this Policy are adhered to.

**Team Leads**

Each Team Lead is responsible for ensuring that staff attend all relevant statutory and mandatory training; and to monitor attendance on a routine basis. They must ensure all appropriate equipment is available and in good working order and ensure staff are appropriately

**Employees**

Each staff member must ensure they attend all relevant mandatory training and other training if relevant for their role and keep themselves up to date. Staff must be competent in the assessment, measurement and monitoring of vital signs and recognition of sepsis in children and young people

# POLICY

## Assessment of Vital Signs

All children and young people admitted to the Children’s Community Nursing Team should have a baseline set of clinical observations (heart rate/pulse, temperature and respirations) recorded as part of their primary assessment. Ideally this should be done prior to their nursing/therapy intervention. These children should also have an agreed frequency or observations documented (with rationale provided) in the child’s care plan.

Assessment of vital signs should be performed within the broader observation and assessment of the infant, child or young person, and at the appropriate level to meet the needs of the infant, child or young person. Practitioners need to be aware of normal physiological parameters and specific conditions that may alter parameters.

For those children who are receiving end of life/palliative care or have palliative care needs, it may not be appropriate to continue routine recording of clinical observations. Such decisions should always be jointly discussed and agreed with the child (as age-appropriate)/family/clinical team/MDT etc. and clearly recorded as agreed with the child’s care plan.

Parents and guardians can provide useful context regarding how a child is in comparison to their normal state. Staff undertaking observation and monitoring of infants, children and young people must be cognizant of this and acknowledge and record any concerns raised.

Assessment tools should only be used to Registered Nurses and Health Care Assistants and Pediatric Care Workers who are trained and competent to make accurate assessment and recording of vital signs as a delegated task ([see 2.1.1](#_Delegation_to_non-registrants))

### Delegation to non-registrants

The monitoring of a child’s condition may be delegated to a Health Care Assistant who has been deemed competent to undertake the task.

Where the monitoring of a child’s condition has been delegated to a non-registrant, clear parameters for vital signs/observations must be recorded in the care plan to enable timely and appropriate escalation where this is required.

The frequency of review by a Registered Nurse must also be recorded on the care plan when care is delegated to support staff.

### Pediatric Early Warning Score (PEWS)

Currently there is no standardised PEWS system in place in England or Wales, although this is currently under review.

In November 2023 a new inpatient PEWS document was released by NHS England as part of a System Wide Paediatric Observation Tracking (SPOT). This has been implemented in collaboration with the Royal College of Nursing as well as Royal College of Paediatrics and Child Health, to eventually be implemented in a variety of health settings, but as yet this has not been ratified.

Scotland does use a standardised system, although this is not validated for use in primary care (see [Appendix 1](#_Appendix_1_NHS)). It can be useful to refer to these tables to ascertain how far outside the normal range a set of observations is. This may aid individual and team awareness of children at risk of deterioration and can assist with the structured referral of acutely unwell patients.

However, it is acknowledged that a PEWS will not identify all children at risk of deterioration, either due to the speed or the mechanism of deterioration. Therefore, it is essential that all staff are trained to recognize common patterns of deterioration with or without the use of a PEWS and not just use the score for reassurance.

## Education and Training

### Assessment of Vital Signs

Registered Nurses, Health Care Assistants and paediatric care workers who assess and monitor infants, children and young people’s vital signs must be competent in these clinical skills. As a minimum this should cover measurements of temperature, heart/pulse rate and respirations, including effort of breathing. They must also be competent to record such measurements accurately.

 Non registrants are to be trained and assessed only by a registrant, until both parties are satisfied that they are equipped to complete the task safely and are also aware of the escalation procedure should they have concerns that the observations fall outside of expected parameters. Once completed a copy of the signed competency documentation should be given and retained by the non-registrant as evidence of completion and a further copy to be sent to FNHC education department. If undertaking the Level 3 diploma in healthcare support, then to ensure they complete unit 19: Undertake physiological measurements.

As part of their competence, Registered Nurses, Health Care Assistants and Pediatric Care Workers should be able to evidence their understanding of the following:

* Legal and professional issues in relation to monitoring and assessing infants, children and young people
* Anatomy and physiology related to physiological ‘norms’ in vital signs and why these alter with age.
* Normal parameters for vital signs in infants, children and young people
* Practical skills in assessing and measuring vital signs in infants, children and young people
* Critical thinking when vital signs fall outside the accepted ‘norm’ for the child.

### Recognition of Sepsis and/or the Deteriorating Child

All staff working within Child and Family Services must attend regular and appropriate training in the recognition of Sepsis, including an annual refresher on Virtual College.

# PROCEDURE

## Vital Signs Assessment Recording Tools

The following tools are currently used by CCNT for the assessment, measurement and monitoring of vital signs and are implemented when clinical need indicates their use. The frequency of monitoring is also determined according to clinical need and detailed in the child's care plan.

* General Health Assessment – records, responsiveness, rash, respirations, pulse, hydration, pain, temperature, feeding.
* Short Term Assessment – less detailed then the General Health Assessment and used for children requiring up to five contacts (face to face/telephone)
* Pain Assessment for Children 0-18 years – records assessment of pain
* Pre-flight Nursing Assessment – records assessment of general health for a named child before flights to attend UK appointments.

The tools listed above can be found as templates on EMIS.

## Assessment of Vital Signs

Gain consent from the child/young person and/or parent/carer prior to any assessment/intervention.

Any actions required to restrain or hold the child/young person still, should comply with best practice guidance, in line with the FNHC Policy and Procedures for ‘Restrictive Physical Interventions and the clinical holding of children and young people’

### Respiration

Normal respiratory pattern is an easy, relaxed, subconscious activity which takes place at a rate dependent on the age and activity of the child.

Observe and record the pattern, effort and rate of breathing. Count respirations for one minute.

Observe and document skin colour, pallor, mottling, cyanosis and any traumatic petechiae around the eyelids, face and neck.

Infants and children less than six to seven years of age are predominantly abdominal breathers, therefore, count abdominal movements.

Look, listen and document any signs of respiratory distress e.g., nasal flaring, grunting, wheezing, stridor, dyspnoea, recession, use of accessory and intercostal muscles, chest shape and movement.

### Heart/Pulse Rate

Parents/Carers/Health Play Specialists can assist in distracting the child to reduce anxiety whilst the child/young person’s heart rate/pulse is measured.

Use an appropriately sized stethoscope to auscultate the apex heart rate of children less than two years of age.

The pulse of an older child is taken at the radial site at the write. Palpate the artery using the first and second fingertips, pressing firmly on the site until a pulse is felt.

Count the heart/pulse rates for one minute noting the rate, depth and rhythm.

The pulse rate should be consistent with the apex beat.

Electronic data should be cross-checked by auscultation or palpation of the pulse.

### Temperature

If a child says they feel cold, feels cold to the touch or if the skin appears mottled, measure and record their temperature.

Measure and record a temperature on all children who present with an acute presentation of illness with the device applicable for age.

The thermometer should be left in position for the appropriate time, suggested by the manufacturer’s instructions, to gain an accurate reading.

In infants under the age of four weeks, measure temperature with an electronic thermometer in the axilla

For infants and children aged from four weeks to five years, use an electronic/chemical dot thermometer in the axilla or an infrared tympanic thermometer.

For children five years and upwards, use an electronic/chemical dot thermometer in the axilla or mouth or an infrared tympanic thermometer.

### Pain

Observe and document findings using a standardized assessment tool appropriate for the child’s age and developmental level.

For children up to 7 years old who are non-verbal and/or have cognitive impairments use the FLACC (Face, Legs, Activity, Cry, Consolable) Scoring Tool ([Appendix 2](#_Appendix_2_))

For children 3 years and upwards who are able to use the Wong-Baker Faces Pain Rating Scale ([Appendix 3](#_Appendix_3_Wong-Baker)) and ask them to point to the face that best represents the pain they are feeling.

## Recognition of Sepsis and/or Deteriorating Child

Screening of sepsis should take place for all infants and children who look unwell or are feverish, particularly with a temperature greater than 39\* C.

Infants younger than three months with a temperature of just 38\* C or more, is a sepsis ‘Red Flag’.

A low temperature of <36\*C can be more concerning and is a sepsis ‘Red Flag’ in all children and infants under 12 years.

A child may have sepsis if he or she:

* Is breathing very fast
* Has a ‘fit’ or convulsion
* Looks mottled, bluish, or pale
* Has a rash that does not fade when you press it
* Is very lethargic or difficult to wake
* Feels abnormally cold to the touch.



### Recognition of Sepsis Algorithm



## Table 1: Criteria for Stratification of Risk of Severe Illness or Death from Sepsis in Children Under 5.

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Age** | **High Risk Criteria** | **Moderate to High Risk Criteria** |
| Behaviour | Any | * 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
 | * Not responding normally to social cues
* No smile
* Wakes only with prolonged stimulation
* Decreased activity
* Parent/Carer concern that child is behaving differently from usual
 |
| Respiratory | Any | * Grunting
* Apnoea
* Oxygen saturation of less than 90% in air or increased oxygen requirement over baseline
* See recommendation 1.4.10 for safety warnings about the use of pulse oximeters
 | * Oxygen saturation of less than 92% in air or increased oxygen requirement over baseline
* Nasal flaring
* See recommendation 1.4.10 for safety warnings about the use of pulse oximeters
 |
| Respiratory | Under 1 Year | * Raised respiratory rate: 60 breaths per minute or more
 | * Raised respiratory rate: 50 to 59 breaths per minute
 |
| Respiratory  | 1 to 2 Years | * Raised respiratory rate: 50 breaths per minute or more
 | * Raised respiratory rate: 40 to 49 breaths per minute
 |
| Respiratory | 3 to 4 Years | * Raised respiratory rate: 40 breaths per minute or more
 | * Raised respiratory rate: 35 to 39 breaths per minute
 |
| Circulation and Hydration | Any | * Bradycardia: heart rate less than 60 beats per minute
 | * Capillary refill time of 3 seconds or more
* Reduced urine output
* For catheterised patients, passed less than 1 ml/kg of urine per hour.
 |
| Circulation and Hydration | Under 1 Year | * Rapid heart rate: 160 beats per minute or more
 | * Rapid heart rate: 150 to 159 beats per minute
 |
| Circulation and Hydration | 1 to 2 Years | * Rapid heart rate: 150 beats per minute or more
 | * Rapid heart rate: 140 to 149 beats per minute
 |
| Circulation and Hydration | 3 to 4 Years | * Rapid heart rate: 140 beats per minute or more
 | * Rapid heart rate: 130 to 139 beats per minute
 |
| Skin | Any | * Mottled or ashen appearance
* Cyanosis of skin, lips or tongue
* Non-blanching petechial or purpuric rash
* For signs and symptoms of meningococcal disease, see the NICE guidelines on bacterial meningitis and meningococcal disease.
 | * Pallor of skin, lips or tongue.
 |
| Temperature | Any | * Less than 36\*C
 |  - |
| Temperature | Under 3 months | * 38\*C
 |  - |
| Temperature | 3 to 6 months |  - | * 39\*C or more
 |
| Other | Any |  - | * Leg pain
* Cold hands or feet
 |

### **Table 2: Criteria for Stratification of Risk of Severe Illness or Death from Sepsis in Children aged 5 to 11 Years**.

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Age** | **High Risk Criteria** | **Moderate to High Risk Criteria** |
| Behaviour | Any | * Objective evidence of altered behaviour or mental state.
* Appears ill to a Healthcare Professional
* Does not wake or if roused does not stay awake
 | * Not behaving normally
* Decreased activity
* Parent or Carer concern that the child is behaving differently from usual
 |
| Respiratory | Any | * Oxygen saturation of less than 90% in air or increased oxygen requirement over baseline
* See recommendation 1.4.10 for safety warnings about the use of pulse oximeters
 | * Oxygen saturation of less than 92% in air or increased oxygen requirement over baseline.
* See recommendation 1.4.10 for safety warnings about the use of pulse oximeters
 |
| Respiratory | Aged 5 Years | * Raised respiratory rate: 29 breaths per minute or more
 | * Raised respiratory rate: 24 to 28 breaths per minute
 |
| Respiratory | Aged 6 to 7 Years | * Raised respiratory rate: 27 breaths per minute or more
 | * Raised respiratory rate: 24 to 26 breaths per minute
 |
| Respiratory | Aged 8 to 11 Years | * Raised respiratory rate: 25 breaths per minute or more
 | * Raised respiratory rate: 22 to 24 breaths per minute
 |
| Circulation and Hydration | Any | * Heart rate less than 60 beats per minute
 | * Capillary refill time of 3 seconds or more
* Reduced urine output
* For catheterised patients, passed less than 1 ml/kg of urine per hour.
 |
| Circulation and Hydration | Aged 5 Years | * Raised heart rate: 130 beats per minute or more
 | * Raised heart rate: 120 to 129 beats per minute
 |
| Circulation and Hydration | Aged 6 to 7 Years | * Raised heart rate: 120 beats per minute or more
 | * Raised heart rate: 110 to 119 beats per minute
 |
| Circulation and Hydration | Aged 8 to 11 Years | * Raised heart rate: 115 beats per minute or more
 | * Raised heart rate: 105 to 114 beats per minute
 |
| Temperature | Any | - | * Tympanic temperature less than 36\*C
 |
| Skin | Any | * Mottled or ashen appearance.
* Cyanosis of skin, lips or tongue
* Non-blanching petechial or purpuric rash
* For signs and symptoms of meningococcal disease, see the NICE guideline on bacterial meningitis and meningococcal disease
 |  - |
| Other | Any |  - | * Leg pain
* Cold hands or feet
 |

### Table 3: Criteria for Stratification of risk of severe illness or death from sepsis in children (in any setting) aged 12 to 15, and in people aged 16 or above if they are in community or custodial settings or if they are in an acute setting and are or have recently been pregnant.

|  |  |  |
| --- | --- | --- |
| **Category** | **High Risk Criteria** | **Moderate to High Risk Criteria** |
| History | * Objective evidence of new altered mental state
 | * History from patient, friend or relative of new onset of altered behaviour or mental state
* History of acute deterioration of functional ability
* Impaired immune system (illness or drugs including oral steroids)
* Trauma, surgery or invasive procedures in the last 6 weeks.
 |
| Respiratory | * Raised respiratory rate: 25 breaths per minute or more
* New need for oxygen (40% FiO2 or more) to maintain saturation more than 92% (or more than 88% in known chronic obstructive pulmonary disease)
* See recommendation 1.4.10 for safety warnings about the use of pulse oximeters.
 | * Raised respiratory rate: 21 to 24 breaths per minute.
 |
| Blood Pressure | * Systolic blood pressure 90 mmHg or less or systolic blood pressure more than 40 mmHg below normal
 | * Systolic blood pressure 91 to 100 mmHg
 |
| Circulation and Hydration | * Raised heart rate: more than 130 beats per minute
* Not passed urine in previous 18 hours
* For catheterised patients, passed less than 0.5 ml/kg of urine per hour.
 | * Raised heat rate: 91 to 130 beats per minute (100 to 130 beats per minute in pregnancy) or new-onset arrhythmia.
* Not passed urine in the past 12 to 18 hours.
* For catheterised patients, passed 0.5 ml/kg to 1 ml/kg of urine per hour.
 |
| Temperature |  - | * Tympanic temperature less than 36\*C
 |
| Skin | * Mottled or ashen appearance
* Cyanosis of skin, lips or tongue
* Non-blanching petechial or purpuric rash
* For signs and symptoms of meningococcal disease, see the NICE guideline on bacterial meningitis and meningococcal disease
 | * Signs of potential infection, including redness, swelling or discharge at surgical site or breakdown of wound
 |

# MONITORING COMPLIANCE

Adherence with this policy will be monitored as part of the quarterly nursing process audit. Reasons for not completing physiological observations should be documented at the time of entry and this will enable the auditor to determine if the deviation from the standards was reasonable. Compliance will also be monitored on an ad hoc basis e.g. informally through peer-to-peer review or during planned reassessments of care where previous care is reviewed in the care records.

Tools such as After-Action Reviews may be used following any significant adverse clinical event to determine if the care provided was in line with this policy.

Compliance with any mandatory/essential training will also be undertaken and this information made available to Team Leaders. The maintenance of competence with the knowledge and skills required to provide the care detailed in this policy will be monitored as part of staff members’ PDP process.

Appropriate action should be taken where non-compliance with this policy is identified.

# CONSULTATION PROCESS

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Date** |
| Michelle Cumming | Operational Lead, Child and Family Services | 10.03.25 |
| Gill John | Team Lead CCNT | 06.01.25 |
| Lara Deer | CCNT | 06.01.25 |
|  |  |  |

# EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and ‘religion, belief, faith and spirituality’ as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

**Always:**

* Putting patients first
* Keeping people safe
* Have courage and commitment to do the right thing
* Be accountable, take responsibility and own your actions
* Listen actively
* Check for understanding when you communicate
* Be respectful and treat people with dignity
* Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times. See overleaf/below for the Equality Impact Assessment for this policy.

## EQUALITY IMPACT SCREENING TOOL

|  |
| --- |
| **Stage 1 - Screening**  |
| Title of Procedural Document: Policy for the Assessment, measurement and monitoring of vital signs and the recognition of sepsis and/or the deteriorating child. |
| Date of Assessment | January 2025 | Responsible Department | CCNT |
| Completed by | Lara Deer | Job Title | Children community deputy sister |
| **Does the policy/function affect one group less or more favourably than another on the basis of**: |
|  | **Yes/No** | **Comments** |
| Age | no |  |
| Disability*(Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia)* | no |  |
| Ethnic Origin *(including hard to reach groups)* | no |  |
| Gender reassignment | no |  |
| Pregnancy or Maternity | no |  |
| Race | no |  |
| Sex | no |  |
| Religion and Belief | no |  |
| Sexual Orientation | no |  |
| **If the answer to all of the above questions is NO, the Equality Impact Assessment is complete. If YES, a full impact assessment is required: go on to stage 2.** |
| **Stage 2 – Full Impact Assessment** |
| **What is the impact** | **Level of Impact** | **Mitigating Actions****(what needs to be done to minimise / remove the impact)** | **Responsible Officer** |
|  |  |  |  |
| **Monitoring of Actions** |
| The monitoring of actions to mitigate any impact will be undertaken at the appropriate level |

# IMPLEMENTATION PLAN

|  |  |  |
| --- | --- | --- |
| **Action** | **Responsible Person** | **Planned timeline** |
| Policy to be uploaded to the Procedural Document Library | Education and Development Administrator | Within 2 weeks following ratification |
| Email to all staff  | Education and Development Administrator | Within 2 weeks following ratification |
| Upload policy (+/- assessment tool) to Virtual College and allocate to relevant staff | Education and Development Department | Within 2 weeks following ratification |
| Relevant staff to sign (via Virtual College) that they have read and understood policy. | All staff notified via Virtual College. | Within 2 months of notification |
|  |  |  |
|  |  |  |

# GLOSSARY OF TERMS

# REFERENCES

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# APPENDICES

## Appendix 1 NHS Scotland Paediatric Early Warning Scores

[202003-gp-poster\_pews-tables-final.pdf](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fihub.scot%2Fmedia%2F7217%2F202003-gp-poster_pews-tables-final.pdf&data=05%7C02%7CLinda.Hefford%40fnhc.org.je%7C7b1977e0138e4306429208dd51ce5ab3%7Cd517ed24212b4fe4902644ccc5c447ee%7C0%7C0%7C638756669181708043%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=a3ITeMU0bgmemtszFCD5I79Pp38yxuxXN65F8i%2FN1mk%3D&reserved=0)



## Appendix 2 [Revised FLACC Paperwork](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmedia.gosh.nhs.uk%2Fdocuments%2FRevised_FLACC_Paperwork.pdf&data=05%7C02%7CLinda.Hefford%40fnhc.org.je%7C7b1977e0138e4306429208dd51ce5ab3%7Cd517ed24212b4fe4902644ccc5c447ee%7C0%7C0%7C638756669181684156%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=Ui3tzcEC9ONu%2F9k2KtwIGa3Q%2BaOmtY04J%2FKNKVWBPCU%3D&reserved=0)



## Appendix 3 Wong-Baker FACES Pain Rating Scale

