TREATING ILLNESSES, INFECTIONS AND INJURIES

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All children get ill from time to time, and every parent has watched anxiously as their normally cheerful child becomes sad and listless. Most infections pass quickly and leave children better able to resist them in the future. Sometimes, if the illness or accident is serious, immediate (and possibly long-term) help is needed. This chapter deals with common childhood illnesses and accidents, the best ways to prevent them, and the action to take in an emergency.

- It's always better to be safe than sorry. If you are ever in doubt about your child's health, talk to a health professional.
- Many childhood illnesses get better by themselves and can easily be treated at home. But common medicines like paracetamol and ibuprofen are not safe for all children. Always ask for advice first.
- Be wary of antibiotics, which only work against bacteria. Most common childhood illnesses are caused by viruses, not bacteria. Taking antibiotics too often can affect your child's ability to fight off infection.
- Serious childhood illnesses are, thankfully, extremely rare. But if you think your child might be affected, always trust your instincts and get medical help straight away.
- It's a good idea to learn some basic first aid skills. Read the guidance in this chapter, buy a book or, better still, go on a short course and learn how to put the theory into practice.
- Be prepared to deal with an emergency. If you know what to do, you will be giving your child the best help you can, and you are also more likely to stay calm.

When it's urgent

It is very difficult to describe when to call an ambulance and/or go to the accident and emergency department (A&E), but you could use the following as a guide.

You should call an ambulance for your child if they:

- stop breathing
- are struggling for breath
- are unconscious or seem unaware of what is going on
- will not wake up
- have a fit for the first time, even if they seem to recover.

You should take your child to A&E if they:

- have a fever and are persistently lethargic despite having paracetamol or ibuprofen
- are having difficulty breathing
- have severe abdominal pain
- have a cut that will not stop bleeding or is gaping open
- have a leg or arm injury and cannot use the limb
- have ingested a poison or tablets.

KNOWING WHEN YOUR CHILD IS ILL

Sometimes there is no mistaking the signs; at others, it can be hard to tell whether your child is ill. They may be listless, hot and miserable one minute, and running around quite happily the next.

- Watch out for physical signs of illness, like vomiting, a high temperature, a cough, a runny nose or runny eyes, and unusual behaviour, like crying, being very irritable, refusing food and drink, or being listless or drowsy.
- Signs of illness are always more worrying in a baby or very young child. If you have seen your GP or health visitor and your baby is either not getting any better or actually getting worse, contact your GP again the same day. If you cannot get hold of your GP or GP out-of-hours service, contact the accident and emergency department. If you are still worried, take your child straight to the accident and emergency department of the nearest hospital. If your child is older and you are not sure whether or not to see your GP, you might want to carry on normally for a while and see whether the signs of illness or pain continue.
- Above all, trust your instincts. You know better than anyone what your child is like day to day, so you will know what is unusual or worrying. If you are worried, always contact your GP. Even if it turns out that nothing is wrong, at least you will know.

Looking after a sick child

The first rule is to listen to your child. If they say they don't need to be in bed, they probably don't. They might be better off, and feel less lonely, tucked up in an armchair or on the sofa. Wherever they are:

- If the room is too warm, they will probably feel worse. Keep it airy without being draughty.
- Your child will need plenty to drink. For the first day or so don't bother about food unless they want it. After that, you can start trying to tempt them with bits of food, and encouraging them to have nutritious drinks like milk.
- Try to give your child time for quiet games, stories, company and comfort.
- Sick children get very tired and need lots of rest. Encourage your child to doze off when they need to, perhaps with a story read by you or on tape.

Never fall asleep with a sick baby on the sofa. Even though you may both be exhausted, this increases the chances of cot death.

See page 26 for more information about **reducing the risk of cot death**.

See page 118 for what to do if your child has a temperature.

Remember, looking after a sick child, even for a couple of days, is exhausting. Make things as easy for yourself as you can. Get rest and sleep when you can, and try to get somebody else to take over every now and then to give you a break.

Helpful tips

Always contact your GP if you think your baby is ill, and your baby has one or more of the symptoms listed on the next page.

The following symptoms should always be treated as serious…

- Your baby seems floppy when you pick them up.
- Your baby will not drink for more than eight hours (taking solid food is not so important).
- Your baby has a bulging fontanelle (the soft spot on the top of their head).
- Your baby has a weak, high-pitched, continuous cry.
- Your baby has repeated vomiting or vomits green bile.
- Your baby has a temperature of over 38ºC if they are less than three months old or over 39ºC if they are three to six months old.
- Your baby has a fit (or convulsion or seizure – these words all mean the same thing).
- Your baby turns blue, mottled or very pale.
- Your baby has a high temperature, but their hands and feet feel cold.
- Your child's temperature is high and they are quiet or listless all the time, with no 'ups and downs'.
- Your child has difficulty breathing, breathes fast or grunts while breathing, or seems to be working hard to breathe (for example, sucking in under the ribcage).
- Your baby or child is unusually drowsy or hard to wake or doesn't seem to know you.
- Your child has a stiff neck.
- Your child is unable to stay awake after being roused.
- Your child has a spotty purple-red rash anywhere on the body, which could be a sign of meningitis (see page 127 for a tip on using the 'glass test' for suspected meningitis).

look for symptoms of illness

Remember, not all children will develop all the symptoms listed above.

Getting expert help

Most general practices are very supportive of parents of small children. Many GPs will fit babies into surgeries without an appointment, or see them at the beginning of surgery hours. Many doctors will also give advice over the phone. Even so, if you are worried about a particular problem that will not go away, it's right to keep going back to or contacting your GP. See page 155 for information on how to change your GP.

Your health visitor, practice nurse, nurse practitioner, GP and pharmacist can all give you advice and help you decide whether your child is unwell. Your GP can treat your child and prescribe medicines. Increasingly, health visitors, nurses and pharmacists can also diagnose illnesses and prescribe medicines for your child. If you think your child is ill, it's best in the first instance to contact your local pharmacy. If they cannot help you, contact your GP's surgery or out-of-hours GP service.

If you are unsure whether to go to the surgery or ask for a home visit, phone and ask the receptionist if you can talk to your GP. Explain how your child is and what is worrying you. Usually it doesn't do a child (or anyone else) any harm to be taken to the surgery, and you are likely to get attention more quickly this way. But explain if it's difficult for you to get there.

Medicines

Medicines are not always needed for childhood illnesses. Most illnesses simply get better by themselves and make your child stronger and better able to resist similar illness in the future. Paracetamol and ibuprofen are the most commonly used medicines for pain or discomfort with a high temperature. Some children, for example those with asthma, may not be able to take ibuprofen, so check with your pharmacist, GP or health visitor. Both paracetamol and ibuprofen are safe and effective. Always have one or both in a safe place at home.

Children don't often need antibiotics. Most childhood infections are caused by viruses, and antibiotics don't fight viruses, they only treat bacterial illnesses. If you are offered a prescription, especially an antibiotic, talk to your GP about why it's needed, how it will help, and whether there are any alternatives. Ask about any possible side effects. Could it, for example, make your child sleepy or irritable?

If your child is prescribed an antibiotic, always finish the whole course to make sure all the bacteria are killed off. Your child may seem better after two or three days, but if the course of treatment is, say, five days, you must keep going. The illness is more likely to return if you don't finish all the antibiotics.

Make sure you know how much and how often to give a medicine. Write it down if need be in your child's 'red book' (see page 61). If in doubt, check with your pharmacist or GP. Never give the medicine more frequently than recommended by your GP or pharmacist.

With liquids, always measure out the right dose for your child's age. The instructions will be on the bottle. Sometimes, liquid medicine may have to be given with a 'liquid medicine measure', which looks like a syringe, or a special spoon. It allows you to give small doses of medicine more accurately. Never use a teaspoon, as they are often different sizes. Ask your pharmacist or health visitor to explain how the liquid medicine measure should be used. Always read the manufacturer's instructions supplied with the measure, and always give the exact dose stated on the medicine bottle. If in doubt ask the pharmacist for help.

Common painkillers

Aspirin should not be given to children under 16 unless specifically prescribed by a doctor. It has now been linked with a rare but dangerous illness. Ask your health visitor, midwife or GP for advice before taking aspirin yourself if you are breastfeeding.

Paracetamol can be given for pain and fever to children over two months. Make sure you get the right strength for your child. Overdosing is dangerous. Read the label and/or check with your pharmacist.

Ibuprofen can be given for pain and fever in children of three months and over who weigh more than 5kg (11lb). Check the correct dose for your child's age. Avoid if your child has asthma unless advised by your GP.

make doses accurate

If you buy medicines at the pharmacy, always tell the pharmacist how old your child is. Some medicines are for adult use only. Always follow the instructions on the label or ask the pharmacist if you are unsure. Ask for sugar-free medicines if they are available. Look for the date stamp. Don't use out-of-date medicines. Take them back to the pharmacy for safe disposal.

Only give your child medicine prescribed for them by your GP, pharmacist or usual healthcare professional. **Never** use medicines prescribed for anyone else.

Keep all medicines out of your child's reach and preferably out of sight. The kitchen is ideal, as it means you can keep an eye on them, although you should make sure they don't get too warm.

Helpful tips

Bad reactions

If you think your child is reacting badly to a medicine, for example if your child has a rash or diarrhoea, stop giving the medicine and speak to a health professional. Keep a note of the name of the medicine in your personal child health record so you can avoid it in future.

digital...

quick and accurate

TREATING COMMON ILLNESSES

Fever and high temperature

A fever is a temperature of over 37.5°C (99.5°F). Fevers are quite common in young children but are usually mild. If your child's face feels hot to the touch and they look red or flushed, they may have a fever. You can also check their temperature with a thermometer. Measured under the arm, normal temperature is about 36.4°C (97.4°F). Under the tongue, normal temperature is slightly higher, at about 37°C (98.4°F). This may vary a bit.

If you are worried about your child, trust your instincts. Speak to your GP or heath visitor/family nurse.

If the surgery is closed, contact your GP out-of-hours service. If you are still concerned or if your GP or out-of-hours service cannot come quickly enough, take your child straight to the nearest hospital's accident and emergency department.

Thermometers

Digital thermometers: Digital thermometers are quick to use and accurate and can be used under the armpit (always use the thermometer under the armpit with children under five). Hold your child's arm against their body and leave the thermometer in place for the time stated in the manufacturer's instructions.

Ear thermometer: 'Tympanic' thermometers are put in the child's ear. They take the child's temperature in one second and do not disturb the child, but are expensive. Ear thermometers may give low readings when not correctly placed in the ear. Carefully read the manufacturer's instructions and familiarise yourself with how the thermometer works (this applies to all thermometers).

Strip-type thermometer: Strip-type thermometers, which you hold on your child's forehead, are not an accurate way of taking their temperature. They show the temperature of the skin, not the body.

Mercury-in-glass thermometers: Mercury-in-glass thermometers have not been used in hospitals for some years, and are no longer available to buy. They can break, releasing small shards of glass and highly poisonous mercury. You should not use mercury thermometers. If your child is exposed to mercury, seek medical advice quickly.

How to treat a fever

It's important to encourage your child to drink as much fluid as possible. Even if your child is not thirsty, try to get them to drink a little and often to keep their fluid levels up. Don't bother about food unless they want it.

Bringing a temperature down is important because a continuing high temperature can be very unpleasant. Paracetamol or ibuprofen will ease discomfort and fever. In a small child, a fever occasionally brings on a fit or convulsion (see page 130). Note that bringing the temperature down with paracetamol or ibuprofen will not stop fits happening.

The following suggestions may help:

- Give your child plenty of cool, clear fluids.
- Undress your child to their nappy or vest and pants.
- Cover them with a sheet if necessary.
- Keep the room at a comfortable temperature (about 18°C (65°F)) by adjusting the radiators or opening a window.
- If your child is distressed and uncomfortable, try giving them paracetamol or ibuprofen. You cannot give them both at the same time, but if one doesn't work you may want to try the other. Always check the instructions on the bottle or packet to find out the correct dose and frequency for your child's age.
- If you have a thermometer, try taking your child's temperature under their armpit. If it's 40–41°C (104–105°F), or if your child still feels feverish, contact your GP or GP out-of-hours service.

Help and support

Always contact your GP, health visitor, practice nurse or nurse practitioner if your child (of any age) has other signs of illness (see page 116) as well as a raised temperature. In the case of babies up to six months, contact your GP, health visitor, practice nurse or nurse practitioner if your baby's temperature is 38°C (101°F) or higher (for babies under three months) or 39°C (102°F) or higher (for babies aged three to six months) even if your baby has no other signs of illness. If the doctor doesn't find a reason for the temperature, they may ask you to collect a urine sample in a sterile container so they can test for infection.

In older children, a little fever is not usually a worry. Contact your GP if your child seems unusually ill, or has a high temperature that doesn't come down.

Colds

It may seem like your child has always got a cold or upper respiratory tract infection. It's completely normal for a child to have a cold eight or more times a year. This is because there are hundreds of different viruses, and young children are meeting each one of them for the first time. Gradually they build up immunity and get fewer colds. Most colds will get better in five to seven days.

Here are some suggestions on how to treat them:

- Saline nose drops can help loosen dried nasal secretions and relieve a stuffy nose. Ask your pharmacist, GP or health visitor about them.
- Increase the amount of fluid your child normally drinks.
- If your child has a fever, pain and discomfort, paracetamol or ibuprofen will help ease discomfort and fever. There are products especially for children. It will state on the packet how much you should give children of different ages.
- Encourage the whole family to wash their hands regularly to help stop the cold spreading.
- Because colds are caused by viruses, not bacteria, antibiotics don't help.
- Nasal decongestants can make stuffiness worse. Never use them for more than two or three days.

Smoking and childhood illnesses

Each year over 17,000 children are admitted to hospital because of illnesses related to second-hand smoke. Children who live in a smoky atmosphere are more likely to suffer from:

- coughs and colds
- chest infections (temperature with a bad cough)
- asthma attacks, and
- ear infections and glue ear.

You are up to four times more likely to stop smoking successfully with support.

For more information visit www.want2stop.info

smoking causes 17,000 child hospital admissions every year

Ear infections

Ear infections are common in babies and small children. They often follow a cold and sometimes cause a bit of a temperature. A child may pull or rub at an ear, but babies cannot always tell where pain is coming from and may just cry and seem unwell and uncomfortable.

If your child has earache but is otherwise well, you can give them paracetamol or ibuprofen for 12–24 hours. Don't put any oil or eardrops or cotton buds into your child's ear unless your GP advises you to do so. Don't be surprised if your doctor does not prescribe antibiotics. Most ear infections are caused by viruses and so cannot be treated with antibiotics, and just get better by themselves.

After an ear infection your child may have a hearing problem for two to six weeks. If the problem lasts for any longer than this, ask your GP for further advice.

'Glue ear'

Repeated bouts of middle ear infections ('otitis media') may lead to 'glue ear' ('otitis media with effusion'), where sticky fluid builds up and can affect your child's hearing. This may lead to unclear speech or behaviour problems. If you smoke, your child is more likely to develop glue ear and will not get better so quickly. They may need to have grommets fitted to help drain the ear and stop further infections. A health professional will give you advice on treating glue ear.

Sore throats

Many sore throats are caused by viral illnesses like colds or flu. Your child's throat may be dry and sore for a day or so before the cold starts. Sometimes with a sore throat your child may find it hard and painful to swallow, have a high temperature and have swollen glands at the front of the neck, high up under the jaw. The majority of sore throats will clear up on their own after a few days. Paracetamol or ibuprofen can be given to help reduce the pain.

If your child has a sore throat for more than four days, has a high temperature and is generally unwell or is unable to swallow fluids or saliva, see your GP.

Teething

See page 70.

Coughs

Children often cough when they have a cold because of mucus trickling down the back of the throat. If your child is feeding, drinking, eating and breathing normally and there is no wheezing, a cough is not usually anything to worry about. But if your child has a bad cough that will not go away, see your GP. If your child has a high temperature and cough and/or is breathless, they may have a chest infection. If this is caused by bacteria rather than a virus, your GP will prescribe antibiotics to clear up the infection. These will not soothe or stop the cough straight away.

If a cough continues for a long time, especially if it's more troublesome at night or is brought on by your child running about, it could be a sign of asthma. Some children with asthma also have a wheeze or some breathlessness. If your child has any of these symptoms, take them to your GP. If your child seems to be having trouble breathing, contact your GP, even if it's the middle of the night.

Go to page 116 for further information on looking out for symptoms that should be treated as serious.

Helpful tips

Although it's upsetting to hear your child cough, coughing does help to clear away phlegm from the chest or mucus from the back of the throat. You can ease a cough by giving your child plenty of warm, clear fluids to drink. If your child is over the age of one, try a warm drink of lemon and honey.

honey and lemon

Bronchiolitis

RSV is a virus which causes cold-like symptoms and can cause breathing difficulties if it affects the lungs. When it does, the condition is called bronchiolitis. In babies under one, it is most common between October and March, although the virus exists all year round. Around two-thirds of babies get RSV before they are a year old.

If your baby was born very prematurely, is prone to getting lung infections or was born with a congenital heart condition, they could have a greater risk of becoming seriously ill. Babies who depended on additional oxygen for several months or who went home on oxygen are also more at risk. These babies will usually be under the care of a paediatrician, who can discuss the risks of RSV with you.

In most babies RSV infection lasts between one and three weeks. More severely ill babies will need to spend two or three days in hospital. A baby with underlying lung problems may need to be in longer.

Childhood diabetes

Signs of diabetes are:

- Going to the toilet more often
- Increased thirst
- Bed wetting
- Excessive tiredness
- Blurred vision
- Weight loss

Don't wait if your child has any of these symptoms – they could have diabetes. Visit your GP if you have any symptoms.

Asthma

Asthma is an inflammatory condition of the airways (bronchial tubes) of the lungs. With asthma

Croup

Croup is a result of inflammation of the windpipe and voicebox. Your child will have a hoarse, barking cough and noisy breathing. Sometimes, though not often, croup can be severe. It's important to watch out for danger signals like:

- indrawing between the ribs or below the ribs with breathing
- restlessness and irritability
- blueness of the lips or face
- constant noisy breathing, even when the child is sitting quietly.

If you notice any of these signs, call your GP. If a doctor is not available, take your child straight to the nearest hospital with an accident and emergency department.

these airways are extra sensitive to irritating substances (or trigger factors) like dust, exposure to certain pets and cigarette smoke. The exact cause of asthma is unknown, but attacks can be caused by an allergy to a trigger factor. There may also be other non-allergic causes. Asthma often runs in families.

When they come into contact with a trigger factor, the airways narrow and produce a sticky mucus (phlegm), making it difficult for air to pass through. Symptoms include repeated attacks of coughing and wheezing, usually with colds, shortness of breath and bringing up phlegm. Symptoms are often worse at night or after exercise.

Not everyone with asthma gets all the symptoms. For many young children, a dry irritating cough may be the only symptom. See your GP if you think your child has asthma.

Viral infections are a very common trigger of wheezing. In young children this does not necessarily mean they have asthma. In children with asthma, virus-triggered attacks are common. Usually your child will have a runny nose or sore throat, then the wheezing will start two to three days later.

Be prepared

If your child has asthma, you are going to have to make sure that you are always prepared. Make sure that your child uses their brown

Helpful tips

Reducing the risk of getting asthma

Smoking during pregnancy or around a child can increase the child's risk of asthma. Breastfeeding your child for as long as possible can help reduce their risk of getting asthma.

Minimising the triggers – the following may help...

Reducing the amount of dust in your house by getting rid of clutter and shaggy carpets or rugs can help. Piles of soft toys or cushions on beds can also harbour dust. If you are planning to change a carpet, think about getting a short-pile carpet or putting down a laminate or wood floor instead. You may also want to think twice about having pets.

inhaler (the preventer inhaler, which contains steroids) as prescribed, not just when they get symptoms. Your child should keep using their brown inhaler even when they are feeling better. As soon as wheezing starts, they should use the blue inhaler (for quick relief from symptoms) and repeat doses as prescribed. If this doesn't work, contact your GP.

Scoliosis – curvature of the spine

Scoliosis is an abnormal curvature of the spine to one side. The curvature of the spine can vary from being slight to severe.

In children, the signs of scoliosis are:

- One shoulder being higher than the other
- One shoulder being higher and more prominent than the other
- One hip being more prominent than the other
- Clothes not hanging properly
- The child may lean to one side
- In babies, a bulge on one side of the chest or back. The baby may be consistently lying curved to one side.

If you are worried, contact your doctor, health visitor or school nurse.

Diarrhoea and vomiting (gastroenteritis)

Babies

Most babies have occasional loose stools, and breastfed babies have looser stools than formula-fed babies. Diarrhoea is when your baby is frequently passing unformed, watery stools. Infections can cause diarrhoea with or without vomiting. This is called gastroenteritis (a stomach bug). Most stomach bugs are more common in formula-fed than breastfed babies.

If other family members or people your baby comes into contact with (for example, at nursery) have a stomach bug, ask them to wash their hands frequently using liquid soap in warm running water and drying their hands carefully. Keep toilets clean and wash towels frequently. With formula-fed babies, make sure bottles are sterilised extremely carefully.

Babies are more at risk from diarrhoea and vomiting than older children because they can lose too much fluid from their bodies and become dehydrated. They may become lethargic or irritable and have a dry mouth and loose, pale or mottled skin, and their eyes and fontanelle may become sunken. They may pass very little urine and may feed poorly, but it may be difficult to tell how much urine they are passing when they have diarrhoea. They may have cold extremities.

If your baby becomes dehydrated, they will need extra fluids. You can buy special oral rehydration fluids from the local pharmacy or chemist or get a prescription from your GP. Brands include Dioralyte, Electrolade and Rehidrat.

Contact your GP or health visitor urgently for advice if your child has passed six or more diarrhoeal stools in the past 24 hours or if your child has vomited three times or more in the past 24 hours.

In general, for mild diarrhoea:

- **Give extra fluids.** Give your baby oral rehydration fluids in between feeds or after each watery stool.
- **Don't stop breastfeeding.** Give the extra fluid in addition to breastmilk (or formula, if you are formula feeding).

For more severe diarrhoea, or diarrhoea with vomiting:

- **Don't stop breastfeeding.** Give oral rehydration fluid in addition to breastmilk.
- **Stop formula feeds.** Instead, give small amounts of oral rehydration fluids every 10 minutes or so. Keep doing this even if your baby is still vomiting. Most of the fluid will stay in, even if it doesn't seem that way!
- **Restart normal formula feeds after three to four hours.** Your GP will give you advice.
- **Get expert advice.** If your baby is unwell, or if vomiting has lasted more than a day, get your GP's advice straight away.

Toddlers and older children

Some children between the ages of one and five pass frequent, smelly, loose stools which may contain recognisable food. Usually these children are otherwise perfectly healthy and are growing fine, and the GP cannot find any cause. This type of diarrhoea is known as 'toddler diarrhoea'.

Contact your GP if your child has diarrhoea and is vomiting at the same time, if the diarrhoea is particularly watery, has blood in it or goes on for longer than two or three days, or if your child has severe or continuous tummy ache.

Otherwise diarrhoea is not usually a cause for concern. Just give your child plenty of clear drinks to replace the fluid that has been lost, but only give them food if they want it. A lot of squash or fruit juice can cause diarrhoea. Anti-diarrhoeal drugs can be dangerous so avoid these. Oral rehydration treatment can be helpful for older children.

Help to prevent any infection spreading by using separate towels for your child and by reminding everyone in the family to wash their hands after using the toilet, changing nappies and before preparing, serving and eating food. Children should not go back to their school or other childcare facility until at least 48 hours after the last episode of diarrhoea or vomiting. Children should also not swim in swimming pools for two weeks after the last episode of diarrhoea.

Threadworms

Many children get threadworms. They spread by producing large numbers of tiny eggs which are too small to see. The eggs are present in dust and stick to food, carpets, towels, bed linen and toilet seats. Because they are so small and widespread they can get on to fingers and under fingernails and are easily swallowed. In the bowel they hatch into worms that then lay eggs around the anus. You will see them in your child's stools, looking like tiny white threads. Your child may have an itchy bottom and may scratch it a lot, especially at night.

If you think your child has worms, speak to your GP or health visitor, or ask your pharmacist for treatment. The whole family will need to be treated because threadworm eggs spread very easily. To stop the infection spreading:

- Keep your child's nails short.
- Let your child wear pyjamas or pants in bed.
- Bath your child or wash around their bottom each morning.
- Keep your child's towel separate.
- Make sure everyone in the family washes their hands and scrubs their nails before every meal and after going to the toilet.
- Disinfect the toilet seat, toilet handle and chain regularly.
- Vacuum and dust bedrooms thoroughly.

Nappy rash

See page 33.

Eczema

Eczema in babies is common. Your baby will usually grow out of it, and many doctors will not use the term eczema at this early age, for this reason.

The symptoms include dry, bumpy skin. Atopic eczema (which occurs mainly where there is a family history of eczema, asthma or hayfever) is thought to affect one in eight children. It often starts between the ages of two and four months, with patches of red, dry and itchy skin on the face or behind the ears and in the creases of the neck, knees and elbows. In children of Asian, Black Caribbean and Black African ethnic groups, eczema may not affect creases but may affect other areas. It can be very itchy. This can lead to your baby scratching, and the eczema may sometimes become infected. If you think your child has eczema, speak to your GP, health visitor or pharmacist.

The following tips will help you manage your child's eczema:

- Apply an unperfumed emollient to the skin several times a day (for example, when you feed your baby or change their nappy). This will stop their skin getting dry.
- If your child is hot, it can make eczema worse. Keep them and their bedroom cool.
- The faeces of the house dust mite can sometimes cause an allergic reaction and make eczema worse.

Dust mites tend to collect on soft toys, so limit these to one or two favourites. Each week, either wash them at 60˚C or put them in a plastic bag in the freezer for 24 hours to kill the mites. Bed linen should also be washed at 60˚C.

- Aqueous cream, which can be bought cheaply from pharmacies, is often as effective a moisturiser as more expensive creams. You can also use it for washing, instead of soap.
- If using a cream apply it with downward strokes – don't rub it up and down.
- Soap, baby bath, bubble bath and detergents can dry or irritate your baby's skin so do without them if you can.
- Try to identify and avoid anything that irritates the skin or makes the problem worse, such as soap powder, animals, chemical sprays and cigarette smoke.
- Some fabrics can irritate the skin. Try to avoid wool and nylon, and stick to cotton instead.
- Don't cut out important foods, such as milk, dairy products, wheat or eggs, without consulting your GP or health visitor. It's fine to cut out such foods as citrus fruits, juice or tomatoes if you think these are irritating the skin. Discuss any dietary changes with a health professional.
- Steroid creams can stop eczema from getting worse. They are safe as long as they are used properly, so it's good to ask your pharmacist for advice.

Head lice

Head lice are tiny insects, slightly smaller than a pinhead. They can be difficult to see. Lots of children get head lice, regardless of whether their hair is clean or dirty. They catch them just by coming into contact with someone who is already infested. When heads touch, the lice simply walk from one head to the other. They cannot jump or fly.

Look for the following signs:

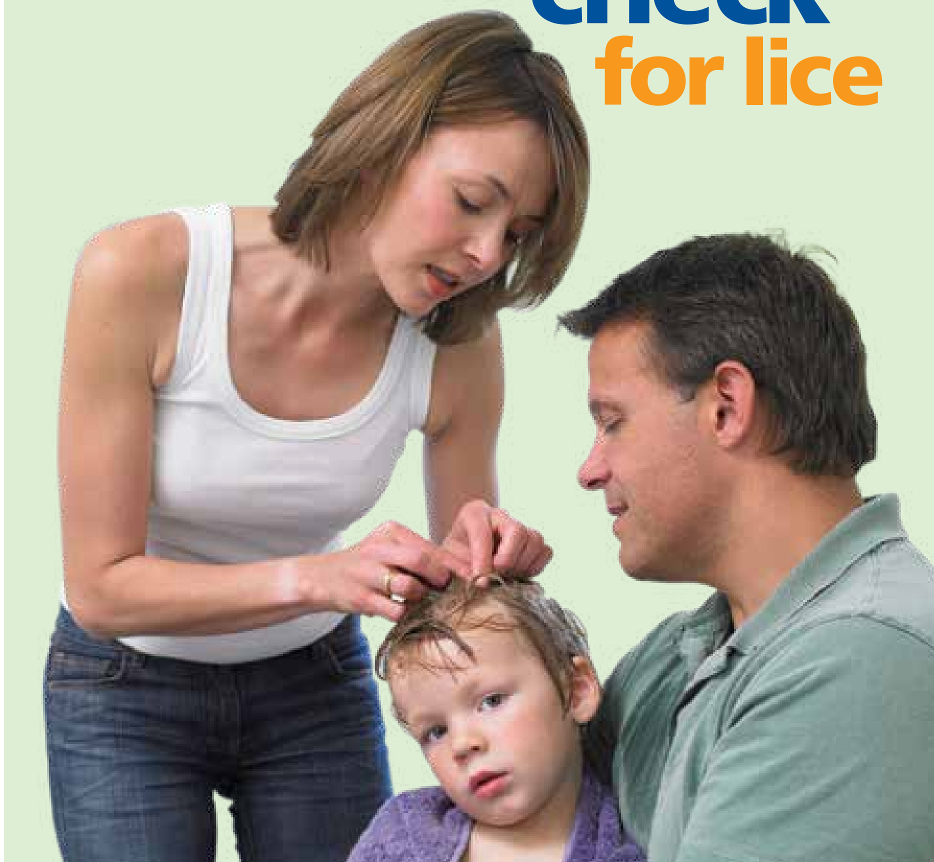
- A rash on the scalp.
- Lice droppings (a black powder, like fine pepper) may be seen on pillowcases.
- An itchy head. Note that this is not always the first sign. Lice will usually have been on the scalp for three or four months before the head starts to itch, or they may not cause itching at all.
- You may also spot eggs (nits).

Checking for head lice

Head lice eggs are dull and well camouflaged. They hatch after around seven to 10 days. Nits are the empty eggshells. They are white, shiny and about the size of a small pinhead. Often, they are found further down the scalp, particularly behind the ears. It's easy to mistake them for dandruff but, unlike dandruff, they are firmly glued to the hair and cannot be shaken off.

The easiest way to check for lice is by combing. Wet your child's hair and part it about 30 times. Then comb each section carefully with a plastic, fine-tooth nit comb. Do this over a pale surface, such as a paper towel, white paper or basin of water, or when your child is in the bath. If there are any lice, you will be able to see them on the scalp or the comb, or they may fall on the paper or in the water. They are usually grey or brown in colour.

check for lice



Treating head lice

There are two ways of dealing with lice. The first is 'wet combing' (or the non-insecticide method):

- Wash the hair normally using your usual shampoo.
- Using lots of hair conditioner and while the hair is very wet, comb through the hair from the roots with a fine-tooth comb. Make sure the teeth of the comb slot into the hair at the roots with every stroke.
- Clear the comb of lice between each stroke with a tissue or paper towel.
- Wet lice find it difficult to escape, and the conditioner makes the hair slippery and harder for them to keep a grip, so they are easier to remove.
- Repeat this routine every three to four days for two weeks so that any lice emerging from the eggs are removed before they can spread.

The second method involves using a lotion containing, insecticide: malathion, phenothrin, permethrin or carbaryl. Lotions containing carbaryl can only be obtained on prescription from your GP. The others can be bought over the counter or obtained on prescription. Research shows that lotions containing a silicone compound, dimeticone, may also be effective. Your school nurse, health visitor, pharmacist or GP can advise you on which one to use. You should only use lotions when you have already detected head lice, not to try to prevent them. Head lice shampoos and repellents are not recommended.

Using head lice lotions

- Follow the instructions carefully on how to use the lotion.
- Always make sure you use enough lotion to cover the whole head. Usually, you will need at least 50ml per application, but always check the instructions.
- Make a small parting, pour a few drops of lotion on to this and spread over the scalp and hair with the fingers.
- Repeat this process, making small partings roughly every 2cm or three-quarters of an inch, until the whole head is covered.
- If, after you have rinsed the lotion off, you can still see live lice on the head or you see them again within a day or two of treatment, they may be resistant to this particular insecticide. In this case, use the 'wet combing' method (see above), or switch to a product with a different active ingredient. If you have used a product containing phenothrin or permethrin, don't switch to another product containing either of these as they belong to the same insecticide group.
- You may need to apply the same treatment again after seven days.
- Don't use any product containing malathion or carbaryl more than once a week for three weeks at a time.

'Natural' methods of treating head lice that use essential or aromatherapy oils, such as lavender, rosemary or tea tree oil, or blends of different oils, are popular with some parents. However, little research has been done into their effectiveness or whether they can

Important safety advice

Keep hair being treated with head lice treatment away from sources of ignition, especially naked flames and burning cigarettes as it can easily burn your child's hair.

be toxic if used repeatedly or in the wrong amount. Some oils can also irritate the skin or may not be suitable for children. If you do use essential oils to treat head lice, be cautious, and don't use them to try to prevent lice. Some essential oils should not be used in pregnancy, so if you are pregnant always check before using an oil to treat your child.

Remember:

- One infected child can infect an entire nursery – so do treat your child as soon as you discover head lice.
- Tell the nursery and other parents.
- Check your child's hair regularly, and always check their hair if there is an outbreak at the nursery or school.
- If your child has head lice, check the whole family (including dad!) and treat them if necessary.
- Older people, such as grandparents, may have head lice without knowing it and could pass them on to children.
- Brush and comb your child's hair often. This may help stop head lice taking hold.

More information

For more information about detecting and treating head lice, go to the Community Hygiene Concern website at www.chc.org/bugbusting

recognise the signs

Meningitis and septicaemia

Meningitis is an inflammation of the lining of the brain. It is a very serious illness but, if it's picked up and treated early, most children make a full recovery. Septicaemia is blood infection, which may be caused by the same germs that cause meningitis. Septicaemia is also very serious and must be treated straight away.

In recent years, there has been a lot of concern about meningitis in children. There are several different types of meningitis and septicaemia and some can be prevented by immunisation (see 'MenC and MenB' on page 101).

Early symptoms of meningitis and septicaemia may be similar to a cold or flu (fever, vomiting, irritability and restlessness). However, children with meningitis or septicaemia can become seriously ill within hours, so it is important to be able to recognise the signs.

The main symptoms of meningitis and septicaemia may include:

- fever (a temperature of 38°C or more in babies under three months and of 39°C or more in babies between three and six months)
- vomiting and refusing feeds
- cold hands and feet
- skin that is pale, blotchy or turning blue
- rapid or unusual patterns of breathing
- irritability, especially when picked up (this can be due to limb or muscle pain)
- a high-pitched, moaning cry
- shivering
- red or purple spots that don't fade under pressure (do the glass test explained in the box on the right)
- floppiness and listlessness or stiffness with jerky movements
- drowsiness, or your child is less responsive, vacant or difficult to wake
- a bulging fontanelle, and
- neck stiffness or a stiff neck.

Remember, not **all** infants and older children will develop all the symptoms listed above.

If your child develops some of the symptoms listed above, especially red or purple spots, get medical help urgently.

The rash does not always appear if a child is sick get medical help even if there isn't a rash.

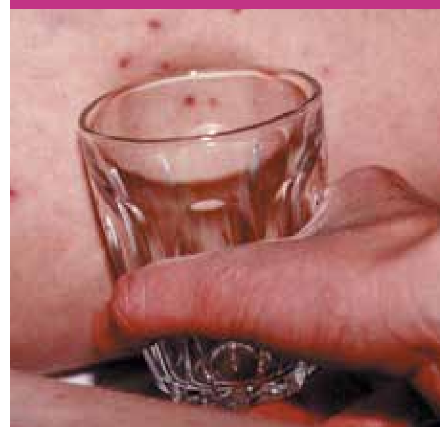
The 'glass test'

Press the side of a clear drinking glass firmly against the rash so you can see if the rash fades and loses colour under pressure. If it doesn't change colour, contact your doctor immediately.

This rash can be harder to see on darker skin, so check for spots over your baby's whole body, especially on paler areas like palms of the hands, the soles of the feet, on the tummy, inside the eyelids and on the roof of the mouth.

For more information, phone the Meningitis Research Foundation's free 24-hour helpline on 080 8800 3344 or go to www.meningitis.org, or contact the Meningitis Trust helpline on 0800 028 18 28 or go to www.meningitis-trust.org

You can also ask your GP, practice nurse or health visitor for advice.



Kawasaki disease

Kawasaki disease is uncommon and mainly affects children under five. Diagnosis is important because of the risk of serious complications, particularly heart disease. The symptoms include:

- a persistent fever lasting five or more days that cannot be lowered with paracetamol or ibuprofen
- irritability, and being very difficult to console
- conjunctivitis (red eyes)
- a rash
- dry, red, swollen lips or a 'strawberry tongue'
- red, swollen toes, fingers, hands or feet
- swollen glands in the neck, and/or
- peeling of the skin a few days after symptoms first appear.

check for rashes

Long-term or life-limiting medical conditions

Some children develop medical conditions that don't go away, like diabetes, cystic fibrosis and cancer. If this happens to your child, they will need your help and support to learn to live with their condition. You will also want to know more about your child's illness and, perhaps, about where you can go for financial support or how your child can get help at school.

You may also find it helpful to talk to another family whose child has a similar condition.

it can help to talk

The charity Contact a Family can help with all these areas (see page 157). See also the list of useful organisations on pages 182–185.

More information

To learn basic first aid skills that could save your baby or child's life, visit www.childrenfirstaid.redcross.org.uk

INJURIES AND ACCIDENTS

Most young children have some injuries and accidents. Hopefully, most will be minor, but it's a good idea to know what to do in a more serious situation. Here are some suggestions:

- You could learn some basic first aid, or revise what you already know. You will find some information on the following pages, or you could think about buying a book.
- Better still, do a first aid course. St John Ambulance and your local HSC ambulance service will run courses. Look in the phone book, or contact the address in the useful organisations section. Alternatively, you could ask your health visitor to organise a course.
- The Royal Life Saving Society UK has a leaflet, *Save a baby's life*, which includes a step-by-step guide to dealing with an emergency. To find out more, go to www.lifesavers.org.uk

- Make sure you know what to do and how to get help in an emergency. See pages 114 and 131.

If you are worried or uncertain about your child's injuries, get a GP's advice.

If you are not sure whether you should move your child, make sure they are warm and then call an ambulance. If you know it's safe to move your child, go to the accident and emergency department of your nearest hospital or to a local doctor, whichever is quickest.

You should always take your child to hospital after an accident if they:

- are unconscious
- have fallen from above head height or been hit by a vehicle
- are vomiting or drowsy
- complain of severe pain anywhere
- have choked on an object and not fully recovered, and/or
- are having fits (see page 130).

Helpful tips

Remember...

Don't give your child anything to eat or drink after an accident. If your child has had a serious injury like a fracture and you need to take them to hospital, they may need an anaesthetic.

Dealing with some common injuries and accidents

Objects in nose or ears

If your child has something lodged firmly in their nose or ear, leave it where it is. If you try and remove it yourself, you may push it further in. Take your child to the nearest accident and emergency department or minor injury unit. If their nose is blocked, explain to your child that they will have to breathe through their mouth.

Cuts

If there is a lot of bleeding, press firmly on the wound, using a clean cloth such as a tea towel or flannel. If you don't have a cloth, use your fingers. Keep pressing until the bleeding stops. This may take 10 minutes or more. Don't use a tourniquet or tie anything so tightly that it stops the circulation.

If possible, raise the injured limb. This will help to stop the bleeding. But don't do it if you think the limb might be broken. If you can find a clean dressing, cover the wound. If blood soaks through the pad or dressing, leave it there and put another pad or dressing over the top.

It's very unusual for a wound to bleed so much that there is serious blood loss. An ambulance is not usually needed. But if the cut keeps bleeding, or there is a gap between the edges of the wound, go to accident and emergency (A&E) or a minor injury unit. If there is a possibility of a foreign body (e.g. glass) in the cut, go to A&E.

If your child's immunisations are not up to date, ask your GP whether your child should have a tetanus jab.

Burns and scalds

Immediately put the burn or scald under running cold water to reduce the heat in the skin. Do this for up to 10 minutes but no longer, as babies and toddlers can get too cold. If there is no running water, immerse the burn or scald in cold water, or any other cool fluid like milk or another cold drink.

Use something clean and non-fluffy like a cotton pillowcase, linen tea-towel or clingfilm to cover the burn or scald. This will reduce the danger of infection. If your child's clothes are stuck to the skin, don't try to take them off. Don't put butter, toothpaste, oil or ointment on a burn or scald, as it will have to be cleaned off before the burn or scald can be treated. Depending on the severity of the burn or scald, see your GP or go to a minor injuries unit or the accident and emergency department.

Blisters will burst naturally. The raw area underneath needs a protective dressing. Ask your pharmacist or practice nurse for advice.

Swallowing poisons

Here is what you should do if you think your child may have taken pills or medicines:

- Unless you are absolutely sure your child has swallowed them, spend a minute or two looking for the missing pills (have they rolled under a chair?).
- If you still think your child has swallowed something, take them straight away to your GP or hospital, whichever is quickest.
- Take the full set of tablets with you so the doctors can check the labelling and calculate how much your child may have taken.
- Keep a close watch on your child and be prepared to follow the CPR steps starting on page 132.
- If possible, take the container (or its label) with you, along with a sample of whatever you think your child has swallowed.
- Don't give salt and water or do anything else to make your child sick.

If you think your child may have swallowed household or garden chemicals:

- Calm your child down as much as you can. This will be easier if you can stay calm yourself. **But act quickly to get your child to hospital.**
- If possible, take the container (or the label) with you and a sample of whatever you think your child has swallowed – or write it down.
- If your child is in pain or there is any staining, soreness or blistering around their mouth, they have probably swallowed something corrosive. Give them milk or water to sip to ease the burning, and get them to hospital quickly.

Shock

If your child looks pale and/or feels unwell after an accident, get them to lie down. Keep them covered up and warm, but not too hot. If your child feels faint, get them to keep their head down and, ideally, lie down. The faint feeling will wear off in a minute or two.

Emergency first aid

Fits or convulsions

Although febrile convulsions or 'fever fits' may look alarming, they are common in children under the age of three. Although there are other reasons why children have a 'fit', a high temperature is the most common trigger. Use paracetamol or ibuprofen if your child appears distressed or is unwell.

See page 119 for more information on how to relieve a fever.

If your child has a fit they may suddenly turn blue and become rigid and staring. Sometimes their eyes will roll and limbs start to twitch and jerk. Alternatively, they may just suddenly go floppy. The following suggestions will help you deal with the fit:

- Keep calm.
- Lie your child on their side to make sure they don't vomit or choke. Don't put anything in their mouth. If you think they are choking on food or an object, try to remove it.

Electrocution

Always turn off the power before approaching your child. If this is not possible, push your child away from the source of the shock with a wooden or plastic object, such as a broom handle. Then try gentle stimulation by tapping their feet or stroking their neck and shouting 'hello' or 'wake up'. If you get no response from your child, **you must follow the CPR steps** shown on page 132.

- Remove your child's clothing and any coverings, and make sure they are cool but not chilly.
- Most fits will stop within three minutes. When it's over, reassure your child, make them comfortable and then call a doctor.
- If the fit has not stopped within three minutes call 999. If it stops, but it was your child's first ever fit, take them to the nearest accident and emergency department to be checked over.
- Don't panic. Fits need to last over 30 minutes for there to be any risk of brain damage.
- Even if it is not the first time, and your child recovers quickly, you should still let your GP know that your child has had a fit.

Febrile convulsions become increasingly less common after the age of three and are almost unknown after the age of five. Febrile convulsions are not usually connected with epilepsy.

Life-threatening emergencies

It's far better to start resuscitating your child than to do nothing. Even if you are using the 'wrong' technique, it's better than doing nothing. If you know the technique for resuscitating an adult, use it – it will make a difference.

Cardiopulmonary resuscitation (CPR) is different in children to adults. Start with five rescue breaths (if you don't know how to give rescue breaths, move straight on to chest compressions). When you give chest compressions, compress your child's chest by about a third of its diameter (this will be fairly obvious when you have to do it).

If you are completely on your own and no one has heard your shout for help, do CPR for one minute before leaving to call for help. You may be able to take a small child with you and continue CPR while you call for help. If you have a mobile phone with you, use that – even if you don't have any credit, you can still make 999 calls.

The most important message is, **do something**. On the next page is the full, detailed CPR sequence for infants and children. It might seem complicated, but it's much easier to understand if you can practise it on a course. It's highly recommended that you do a course – for details see page 128.

in an emergency call 999

CPR steps

STEP 1

1 Ensure the area is safe

- Check for hazards, such as electrical equipment, traffic etc.

STEP 2

2 Check your child's responsiveness

- Gently stimulate your child and ask loudly, 'Are you all right?'
- Don't shake infants or children with suspected neck injuries.

STEP 3

3A If your child responds by answering or moving:

- Leave them in the position in which they were found (provided they are not in further danger).
- Check their condition and get help if needed.
- Reassess regularly.

3B If the child doesn't respond:

- Shout for help.

If your child is under one year:

- Ensure a neutral position of the head.
- Ensure head and neck are in line and not tilted.
- At the same time, with your fingertip(s) under the point of your child's chin, lift the chin. Do not push on the soft tissues under the chin, as this may block the airway.

If your child is one year or over:

- Open your child's airway by tilting the head and lifting the chin:
  - – Leaving the child in the position in which you found them, place your hand on their forehead and gently tilt their head back.
  - – Chin lift (as above).
  - – This may be easier if the child is turned carefully on to their back.

If you suspect that there may have been an injury to the neck, tilt the head carefully and by a small amount at a time until the airway is open.

STEP 4

4 Keeping the airway open, look, listen and feel for normal breathing by putting your face close to your child's face and looking along their chest

- **Look** for chest movements.
- **Listen** at the child's nose and mouth for breathing sounds.
- **Feel** for air movement on your cheek.

Look, listen and feel for **no more than 10 seconds** before deciding that breathing is absent.

STEP 5

5A If your child is breathing normally:

- Turn them onto their side.
- Check for continued breathing.

5B If your child is not breathing or is only breathing infrequently and irregularly:

- Carefully remove any obvious obstruction in the mouth.
- Give five initial rescue breaths.
- While doing this, note any gag or cough response. These responses, or the lack of them, will form part of your assessment of 'signs of life' (see step 6 on page 133).

Rescue breaths (or mouth-to-mouth resuscitation) for a baby under one year:

- Ensure the head is in a neutral position and lift the chin.
- Take a breath and cover both your baby's mouth and nose with your mouth, making sure you have a good seal. If you cannot cover both the mouth and nose at the same time, just seal either with your mouth. If you choose the nose, close the lips to stop air escaping.
- Blow five breaths steadily into the baby's mouth and nose for about 1 to 1.5 seconds each, sufficient to make the chest rise visibly.
- Keeping their head tilted and chin lifted, take your mouth away and watch for the chest to fall as air comes out.
- Take another breath and repeat the sequence five times.

Rescue breaths for a child aged one year or over:

- Tilt head and lift chin.
- Pinch the soft part of their nose closed with the index finger and thumb of your hand on their forehead.
- Open their mouth a little, but keep the chin pointing upwards.
- Take a breath and place your lips around the mouth, making sure you have a good seal.
- Blow steadily into their mouth for about 1 to 1.5 seconds, watching for the chest to rise.
- Maintaining the head tilt and chin lift, take your mouth away and watch for the chest to fall as air comes out.
- Take another breath and repeat this sequence five times. Check that your child's chest rises and falls in the same way as if they were breathing normally.

STEP 5 (continued)

5C If you have difficulty achieving effective breathing in your child, the airway may be obstructed:

- Open the child's mouth and remove any visible obstruction. Don't poke your fingers or any object blindly into their mouth.
- Ensure that there is adequate head tilt and chin lift, but that the neck is not over-extended.
- Make up to five attempts to achieve effective breaths (sufficient to make the chest visibly rise). If still unsuccessful, move on to chest compression.

STEP 6

6 Check for signs of life

- Take no more than 10 seconds to look for signs of any movement, coughing or normal breathing (not just infrequent, gasping breaths).

STEP 7

7A If you are confident that you can detect signs of life within 10 seconds:

- Continue rescue breathing, if necessary, until your child starts breathing effectively on their own.
- Turn your child onto their side (the recovery position) if they remain unconscious.
- Reassess frequently.

7B If there are no signs of life or you are not sure:

- Start chest compression.
- Combine rescue breathing and chest compression.

Chest compressions – general guidance

- To avoid compressing the stomach, find where the lowest ribs join in the middle. Compress the breastbone one finger's breadth above this.
- Depress the breastbone by roughly one-third of the depth of the chest.
- Release the pressure, then repeat at a rate of about 100 compressions per minute.
- After 30 compressions, tilt the head, lift the chin and give two effective breaths.
- Continue compressions and breaths in a series of 30 compressions followed by two breaths.

Although the rate of compressions will be 100 per minute, the actual number delivered will be less than 100 because of pauses to give breaths. The best method for compression varies slightly between infants and children, as follows.

Chest compression in babies less than one year old:

- Compress the breastbone with the tips of two fingers.

Chest compression in children one year or over:

- Place the heel of one hand over the lower third of the breastbone (as described above).
- Lift the fingers to ensure that pressure is not applied over the ribs.
- Position yourself vertically above the chest and, with your arm straight, compress the breastbone to depress it by approximately one-third of the depth of the chest.
- In larger children, or if you yourself are small, this may be done more easily by using both hands with the fingers interlocked, while avoiding pressure on the ribs.

If no one has responded to your shout for help at the beginning and you are alone, continue resuscitation for about one minute before trying to get help (for example, by dialling 999 on a mobile phone).

STEP 8

8 Continue resuscitation until:

- Your child shows signs of life (normal breathing, coughing, movement of arms or legs).
- Further qualified help arrives.
- You become exhausted.

Choking

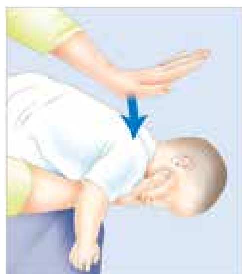
Children, particularly between the ages of about one and five, often put objects in their mouth. This is a normal part of how they explore the world. Some small objects, like marbles and beads, are just the right size to get stuck in a child's airway and cause choking. **The best way to avoid this is to make sure small objects like these are out of your child's reach.** No matter how careful you are, though, your child may choke on something.

In most cases you, or someone else, will see your child swallow the object that causes the choking. However, there can be other reasons for coughing. If your child suddenly starts coughing, is not ill and often tries to put small objects in their mouth, then there is a good chance that they are choking.

Try these suggestions:

- If you can see the object, try to remove it. But **don't poke blindly with your fingers**. You could make things worse by pushing the object in further.
- If your child is coughing loudly, there is no need to do anything. Encourage them to carry on coughing and don't leave them.
- If your child's coughing is not effective (it's silent or they cannot breathe in properly), **shout for help** immediately and decide whether they are still conscious.
- If your child is still conscious but either they are not coughing or their coughing is not effective, use back blows (see below).

Back blows for children under one year:



- Support the child in a head-downwards position. Gravity can help dislodge the object. It's easiest to do this if you sit or kneel, and support the child on your lap.
- Don't compress the soft tissues under the jaw, as this will make the obstruction worse.
- Give up to five sharp blows to the back with the heel of one hand in the middle of the back between the shoulder blades.

Back blows for children over one year:

- Back blows are more effective if the child is positioned head down.
- Put a small child across your lap as you would a baby.
- If this is not possible, support your child in a forward-leaning position and give the back blows from behind.

If back blows don't relieve the choking, and your child is still conscious, give **chest thrusts to infants under one year** or **abdominal thrusts to children over one year**. This will create an 'artificial cough', increasing pressure in the chest and helping to dislodge the object.

Chest thrusts for children under one year:

- Support the baby down your arm, which is placed down (or across) your thigh as you sit or kneel.
- Find the breastbone, and place two fingers in the middle.
- Give five sharp chest thrusts, compressing the chest by about a third of its diameter.

Abdominal thrusts for children over one year:

- Stand or kneel behind the child. Place your arms under the child's arms and around their upper abdomen.
- Clench your fist and place it between the navel and ribs.
- Grasp this hand with your other hand and pull sharply inwards and upwards.
- Repeat up to five times.
- Make sure you don't apply pressure to the lower ribcage as this may cause damage.

Following chest or abdominal thrusts, reassess your child:

- If the object is still not dislodged and your child is still conscious, continue the sequence of back blows and either chest thrusts or abdominal thrusts.
- Call out or send for help if you are still on your own.
- Don't leave the child at this stage.

Even if the object is expelled, get medical help. Part of the object may have been left behind, or your child may have been hurt by the treatment.

Unconscious child with choking:

- If a choking child is, or becomes, unconscious, put them on a firm, flat surface.
- Call out or send for help if you are still on your own.
- Don't leave the child at this stage.
- Open the child's mouth. If the object is clearly visible, and you can grasp it easily, remove it.
- Start CPR (see page 132).

Don't use blind or repeated finger sweeps. These can push the object further in, making it harder to remove and causing more injury to the child.

Strangulation

Blind cord chain safety

Looped cords such as blind cords and chains can pose a risk to small children. Research indicates that most accidental deaths involving blind cords happen in the bedroom and occur in children between 16 months and 36 months

old, with the majority (more than half) happening at around 23 months.

Making it safe

There are many solutions available for existing and new blinds. It is important to ensure that any device used is appropriate for the particular blind.

Some simple steps to take:

- **Examine every blind in your home. If they have a looped control chain or cord and do not have a safety device fitted one should be fitted. This is inexpensive and easy to do.**
- **Ensure that all blind cords and chains are taut and cannot be reached by children.**
- **If buying a new blind make sure it does not have cords or has concealed cords or an in-built safety device that complies with the European Standards and British Standards for child safety.**
- **Move cots, beds and any furniture away from windows and blinds - remember children love to climb.**
- **For more information and to download a free blind cord safety leaflet visit the RoSPA website at www.rospa.com/blindcords**

Also:

- **Do not hang toys or objects that could be a hazard on the cot or bed.**
- **Don't hang drawstring bags where a small child could get their head through the loop of the drawstring.**

CHILDREN IN HOSPITAL

Hospitals can be strange, frightening places for children. Being ill or in pain is frightening too. Although you might feel a bit helpless in this situation, there are some things that you can do.

Prepare your child as best you can. You could play 'doctors and nurses' or 'operations' with teddies and dolls and read story books about being in hospital. It's worth doing this even if you don't know your child is going into hospital. Quite a large number of under fives do have to go into hospital at some stage, and many go in as emergencies.

Be with your child in hospital as much as possible. It's extremely important for you to be with your child in hospital as much as possible and, with young children especially, to sleep there. Do all you can to arrange this. All hospital children's departments now have some provision for parents to stay overnight with their children. Talk to hospital staff beforehand and be clear about arrangements and what will happen.

Explain as much as possible to your child. Even quite young children need to know about what is happening to them. What children imagine is often worse than reality. Be truthful, too. Don't, for example, say that something will not hurt when it will. Some hospitals will arrange visits for children and their families before the child is admitted for a planned treatment or operation. Your child will also want to know things like when they will be able to see you, and whether you will be staying with them.

You may find it helpful to explain to your child what the hospital environment may be like. You may want to talk to them about the fact that they will most likely be sharing a ward with other children of their own age, and that it will be different from the familiar surroundings of their own bedroom and home.

Talk to hospital staff about anything that is important to your child. You may need to explain cultural differences (for example, hospital food might seem very strange to your child). You should also tell staff about any special words your child uses (such as for needing to go to the toilet) and any special ways you have of comforting them.

Let your child take a favourite teddy or comforter with them into hospital.

Be prepared for your child to be upset by the experience. They may continue to be upset for some time afterwards. Give them as much reassurance as you can. You can get a lot of helpful information and advice on how to cope when your child is in hospital from organisations such as Action for Sick Children (see page 182 for contact details).

Broken bones

If you think your child's neck or spine may be injured, don't move them. Call an ambulance. Unnecessary movement could cause paralysis. A bone in your child's leg or arm may be broken if they have pain and swelling, and the limb seems to be lying at a strange angle. If you cannot easily move your child without causing pain, call an ambulance. If you have to move your child, be very gentle. Put one hand above and the other below the injury to steady and support it (using blankets or clothing if necessary). Comfort your child and take them to hospital. If you think your child is in pain, give them painkillers, even if you are going to the accident and emergency department.

Children who need special care

Newborns are tested for sickle cell disorders, phenylketonuria (PKU), congenital hypothyroidism (CHT), cystic fibrosis (CS), medium chain ocylocoa de hydrogenase deficiancy (MCADD) and sickle cell disorders (SCD) and a number of other inherited metabolic conditions may also be identified, eg homocystinuria. If your child has any of these conditions, they will require specialist care. You should be involved in making decisions about that care. Voluntary organisations can provide information, support and advice (see the useful organisations section).

BEREAVEMENT

See page 149 for more general information about bereavement.

When a child dies

This is a loss like no other. For a child to die before their parents feels so wrong that great shock (as well as, sometimes, anger, bewilderment and even a kind of guilt) is added to the enormous grief and sadness you will already be feeling. All these feelings are important to you. They are not to be set aside quickly or hidden away.

You need to let yourself grieve in your own way. If you need to cry, don't hold back. It may be the only way you can let your feelings out. If you feel angry, as many parents do, or find you are blaming yourself or others, it's important to talk about it. Ask the questions you want to ask of, for example, hospital staff, your GP, midwife or health visitor. Often the reasons for a baby's death are never known, not even after a post-mortem. But you will probably feel that you need to find out all you can.

It may help you to think about ways of remembering your child. If you don't already have photographs, you may want to have a photograph of your baby or child taken, and perhaps one of you with them. Talk to the hospital about this. Think about any service or ceremony you might want to have, and any mementos you may want to keep. It's important to do what feels right for you.

If you have other children, try to explain what has happened as simply and honestly as you can. They need to understand why you are sad, and will have their own feelings to cope with. Sometimes older children worry that the death is linked to something they have done. They may be very quiet, or behave very badly, for a while. It's not always easy to give them the love and reassurance they need when you are grieving yourself. It may help to get support from others close to your child.

Be realistic. Grieving takes a long time, and there will be many ups and downs. Talking may not come easily to you, but it can help, even if it's been a while since your child died. The more you and your partner can talk to each other, the more it will help you both. A partner's experience of a child's death can be different from a mother's. Although you will share a lot, your feelings and moods will not be the same all the time. Try to listen to each other so you can support each other as best you can. Although you may be reacting in different ways, you have both lost a child.

talking can help

Sometimes talking to someone outside the family is helpful – a close friend, your doctor or health visitor, hospital staff or a religious leader. It can be difficult at first to cope with the outside world and other people. You may find that even people quite close to you don't know what to say, say the wrong thing, or avoid you. Take the support that is offered. Just do what feels right to you.

Help and support

The following organisations can offer support and advice and put you in touch with other parents who have gone through something similar:

- The Stillbirth and Neonatal Death Society (Sands) is run by and for parents whose baby has died either at birth or shortly afterwards.
- The Foundation for the Study of Infant Deaths supports parents bereaved by a cot death (also called Sudden Infant Death Syndrome, or SIDS).
- Compassionate Friends is run by and for all bereaved parents.
- Cruse provides support, information, advice, education and training to help anyone who has been bereaved to understand their grief and cope with their loss.
- Winston's Wish supports children and families after a parent or sibling has died.
- The Child Bereavement Charity provides specialised support, information and training for everyone affected when a baby or child dies, or when a child is bereaved. It also runs an online forum for bereaved parents.

See page 182 for contact details.