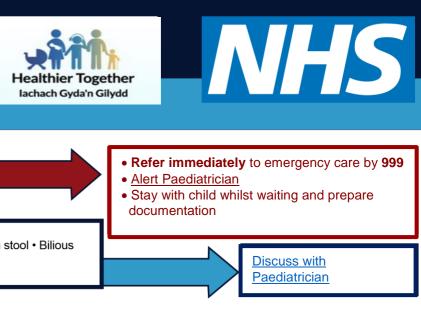
Diarrhoea and/or Vomiting (Gastroenteritis) Pathway

Clinical Assessment / Management for Children with suspected Gastroenteritis

Management - Primary Care and Community Settings



SUSPECTED GASTROENTERITIS

Patient

History

Assessment of Vital Signs - Temp, Heart Rate, RR, capillary refill time Consider differential diagnosis Risk factors for dehydration - see figure 1

Do the symptoms and/or signs suggest an immediately life threatening (high risk) illness?

Yes

Consider any of the following as possible indicators of diagnoses other than gastroenteritis: Fever: Temperature of > 38°C • Shortness of breath • Altered state of consciousness • Signs of meningism • Blood in stool • Bilious (green) vomit • Vomiting alone • Recent head Injury • Recent burn · Severe localised abdominal pain • Abdominal distension or rebound tenderness • Consider diabetes

presents with or has a history of diarrhoea and / or vomiting

Tab

Clinical Findings	Green - Iow risk	Amber - intermediate risk	Red - high risk			
Age	Over 3 months old	Under 3 months old			eased risk of dehydration are	
Behaviour	 Responds normally to social cues Content / smiles Stays awake / awakens quickly Strong normal crying / not crying Appears well 	Altered response to social cues No smile Decreased activity Irritable	 No response to social cues Unable to rouse or if roused does not stay awake 	 Aged <1 year old (and especially the < 6 month age group) Have not taken or have not been able to tolerate fluids before presental Have vomited three times or more in the last 24 hours Has had six or more episodes of diarrhoea in the past 24 hours History of faltering growth Fig 2 Management of Clinical Dehydration Trial of oral rehydration fluid (ORS) 2mls/kg every 10 mins 		ds before presenta rs
		Lethargic Appears unwell	 Weak, high pitched or continuous cry Appears ill to a healthcare professional 			
Skin Hydration	 Normal skin colour Warm extremities Normal turgor CRT < 2 secs 	Normal skin colour Warm extremities Reduced skin turgor CRT 2-3 secs	 Pale / mottled / ashen blue Cold extremities CRT> 3 secs 	 Consider checking blood glucose, esp in <6 month age group Consider referral to acute paediatric community nursing team if availa If child fails to improve within 4 hours, refer to paediatrics Reintroduce breast/bottle feeding as tolerated Continue ORS if ongoing losses 		
.,	 Moist mucous membranes (except after a drink) Fontanelle normal 	 Dry mucous membranes (except for mouth breather) Sunken fontanelle 				
				*Normal p	*Normal paediatric values:	
Urine output	Normal urine output	Reduced urine output / no urine output for 12 hours	No urine output for >24 hours	(APLS [†])	Respiratory	Heart Rate
Respiratory	 Normal breathing pattern and rate* 	Normal breathing pattern and rate*	 Abnormal breathing / tachypnoea* 		Rate at rest: [b/min]	[bpm]
				< 1 year	30 - 40	110 - 160
Heart Rate	 Heart rate normal Peripheral pulses normal 	 Mild tachycardia* Peripheral pulses normal 	Severe tachycardia**	1-2 years	25 - 35	100 - 150
				> 2-5 years	25 - 30	95 - 140
Eyes	Not sunken	Sunken Eyes		5-12 years	20-25	80-120
Other		Additional parent/carer support required		>12 years	15-20	60-100



	Additional p			
Green Action		Amber Action		
Provide written and Verbal advice (<u>see patient advice</u> Continue with breast and/or bottle feeding Encourage fluid intake, little and often e.g. 5mls every 5 r Children at increased risk of dehydration [see Fig 1]		Begin management of clinical dehydration algorithm [see Fig 2]. Agree a management plan with parents +/- seek advice from <u>paediatrician.</u> Consider referral to <u>acute paediatric community nursing team</u> if		

Childre Confirm if they are comfortable with the decisions/advice given and then think "Safeguarding" before sending home

available

Urgent Action

Refer immediately to emergency care - consider 999 Alert Paediatrician

Consider initiating Management of Clinical Dehydration [Fig 2] awaiting transfer

Consider commencing high flow oxygen support

This guidance has been reviewed and adapted by healthcare professionals across ABUHB with consent from the Hampshire develo nent group

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer.

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Glossary of Terms				
ABC	Airways, Breathing, Circulation			
APLS	Advanced Paediatric Life Support			
AVPU	Alert Voice Pain Unresponsive			
B/P	Blood Pressure			
CPD	Continuous Professional Development			
CRT	Capillary Refill Time			
ED	Hospital Emergency Department			
GCS	Glasgow Coma Scale			
HR	Heart Rate			
МОІ	Mechanism of Injury			
PEWS	Paediatric Early Warning Score			
RR	Respiratory Rate			
WBC	White Blood Cell Count			

