**Clinical Pathway for the management of Gastroenteritis in Children**

Diarrhoea and/ or vomiting symptoms.

Admit to PAU and complete assessment, consider alternative diagnoses.

Diagnosis Gastroenteritis:

Assess dehydration (see table 1)

Green symptoms

No clinical dehydration:

Prevent dehydration by:

* Continuing with breast feeds, oral fluids.
* Commence fluid challenge with normal fluids.
* Consider ORS for those at increased risk of dehydration (<1yr +/- low birthweight)

1 or more Amber symptoms

Clinical dehydration:

* Commence fluid challenge 2ml/kg every 10mins with ORS or EBM.
* Supplement with breast-feeding or usual fluids if tolerated
* Consider ORS via Nasogastric tube if refused or vomiting continues.

1 or more Red symptoms

Severe dehydration/shock:

Contact Paeds Reg.

* Give rapid intravenous infusion of 20ml/kg 0.9% sodium chloride solution.
* Repeat infusion if child remains shocked.
* Consider HDU/ITU if no improvement.

When shock symptoms resolve:

* Commence IV maintenance fluids plus deficit replacement.
* Commence oral fluids

Monitor regularly. Re-assess at 2hours

Stable/ improving: Tolerating oral fluid for 2 hours, observations within normal limits for age. Refer to Care Closer To Home for home visit.

Assessed as green (low risk).Discharge patient with fluid management advice and refer to Care Closer To Home for a follow up phone call.

CCTH home visit:

Assess observations and hydration. Record on PEWS/fluid charts.

Provide advice on fluid management (as per NICE guidelines).

CCTH phone call:

Provide advice regarding ongoing fluid management (as per NICE guidelines).

Consider home visit if any Amber features.

CCTH discharge criteria: Tolerating fluids for at least 12 hours with no vomiting

Observations within normal limits for age & all symptoms green.

OPEN ACCESS TO WARD UNTIL DISCHARGE FROM CCTH.

NICE Dehydration Assessment for children under 5 years

|  |  |  |  |
| --- | --- | --- | --- |
| Increasing severity of dehydration | | | |
|  | **No clinically detectable dehydration** | **Clinical dehydration** | **Clinical shock** |
| **Symptoms** (remote and face-to-face assessments) | Appears well | flag image blue background v1Appears to be unwell or deteriorating | – |
| Alert and responsive | flag image blue background v1 Altered responsiveness (for example, irritable, lethargic) | Decreased level of consciousness |
| Normal urine output | Decreased urine output | – |
| Skin colour unchanged | Skin colour unchanged | Pale or mottled skin |
| Warm extremities | Warm extremities | Cold extremities |
| **Signs** (face-to-face assessments) | Alert and responsive | flag image blue background v1 Altered responsiveness (for example, irritable, lethargic) | Decreased level of consciousness |
| Skin colour unchanged | Skin colour unchanged | Pale or mottled skin |
| Warm extremities | Warm extremities | Cold extremities |
| Eyes not sunken | flag image blue background v1 Sunken eyes | – |
| Moist mucous membranes (except after a drink) | Dry mucous membranes (except for ‘mouth breather') | – |
| Normal heart rate | flag image blue background v1 Tachycardia | Tachycardia |
| Normal breathing pattern | flag image blue background v1 Tachypnoea | Tachypnoea |
| Normal peripheral pulses | Normal peripheral pulses | Weak peripheral pulses |
| Normal capillary refill time | Normal capillary refill time | Prolonged capillary refill time |
| Normal skin turgor | flag image blue background v1 Reduced skin turgor | – |
| Normal blood pressure | Normal blood pressure | Hypotension (decompensated shock) |

**At increased risk of dehydration:**

* Children younger than 1 year, especially those younger than 6 months
* infants who were of low birth weight
* children who have passed six or more diarrhoeal stools in the past 24 hours
* children who have vomited three times or more in the past 24 hours
* children who have not been offered or have not been able to tolerate supplementary fluids before presentation
* infants who have stopped breastfeeding during the illness
* children with signs of malnutrition.

**Suspect hypernatraemic dehydration if there are any of the following:**

* jittery movements
* increased muscle tone
* hyperreflexia
* convulsions
* drowsiness or coma

**Laboratory investigations:**

* Do not routinely perform blood biochemistry.
* Measure plasma sodium, potassium, urea, creatinine and glucose concentrations if:

> intravenous fluid therapy is required **or**

> there are symptoms or signs suggesting hypernatraemia.

* Measure venous blood acid–base status and chloride concentration if shock is suspected or confirmed.