Adult Emergency Nurse Protocol

Health
South Eastern Sydney
Local Health District

DIARRHOEA and VOMITING

SESLHDPR/386

Aim:
- Early identification and treatment of life threatening causes of diarrhoea and vomiting, escalation of care for patients at risk.
- Early initiation of treatment / clinical care and symptom management within benchmark time.

Assessment Criteria: On assessment the patient should have a history of diarrhoea and vomiting plus one or more of the following signs / symptoms:

- Nausea
- Fever
- Abdominal cramps
- Dry mucus membranes
- Decreased oral intake
- General body aches

Escalation Criteria: Immediate life-threatening presentations that require escalation and referral to a Senior Medical Officer (SMO):

- Acute confusion / agitation
- Hypovolemic shock
- Blood in Stool - Malaena
- Severe abdominal pain / tenderness
- Pallor / mottling (cap refill > 2 sec)
- Haematemesis
- BGL < 3mmol/L or > 20mmol/L
- Severe dehydration
- Hypotension and tachycardia

Primary Survey:
- Airway: patency
- Circulation: perfusion, BP, heart rate, temperature
- Breathing: resp rate, accessory muscle use, air entry, SpO_2.
- Disability: GCS, pupils, limb strength

Notify CNUM and SMO if any of following red flags is identified from Primary Survey and Between the Flags criteria (1).

- Airway - at risk
  - *Partial / full obstruction*
- Breathing - Respiratory distress
  - *RR < 5 or >30 /min*
  - *SpO_2 < 90%*
- Circulation - Shock / altered perfusion
  - *HR < 40bpm or > 140bpm*
  - *BP < 90mmHg or > 200 mmHg*
  - Postural drop > 20mmHg
  - *Capillary return > 2 sec*
- Disability - Decreased LOC
  - *GCS ≤ 14 or any fall in GCS by 2 points*
- Exposure
  - *Temperature < 35.5°C or > 38.5°C*
  - *BGL < 3mmol/L or > 20mmol/L*

History:
- Presenting complaint
- **A**llergies
- **M**edications: Drugs or toxins, Anticoagulant Therapy, Anti-hypertensives, Diabetic meds, Analgesics, Inhalers, Chemotherapy, Non-prescription meds, any recent change to meds.
- **P**ast medical past surgical history relevant – GORD, Crohn's disease, Diverticulitis, Irritable Bowel Syndrome, Diabetes
- **L**ast ate / drank and last menstrual period (LMP) - When and what did they last eat, Thirst or unable to tolerate fluids
- **E**vents and environment leading to presentation - Contact with others with same symptoms, amount of diarrhoea and vomiting?
- Pain Assessment / Score: **PQRST** (Palliating/ provoking factors, Quality, Region/radiation, Severity, Time onset)
- Associated signs / symptoms: fever, dizziness or light headedness, headache, abdominal cramping, concentrated dark urine, anuria, weight loss or anorexia
- History: family, trauma, travel or foods: (food poisoning, gastroenteritis, infectious colitis)

Systems Assessment:

Focused abdominal / mucosal assessment:
- *Inspection:* signs of dehydration – dry mucous membranes, skin mottling, poor skin turgor and any surgical scars
- *Auscultation:* Bowel sounds - hyperactive, reduced or absent.
- *Palpation:* light and deep palpation of the abdomen - Identify location of pain (quadrants), any signs of peritonism i.e. guarding or rigidity, rebound tenderness.

Notify CNUM and Senior Medical Officer (SMO) if any of following red flags is identified from History or Systems Assessment.

- Hyperactive or absent bowel sounds
- Blood in stool - Malaena
- Dizziness / lightheadedness
- Elderly > 65 years
- Severe abdominal pain / tenderness
- Acute confusion / agitation
- Decreased urine output - oliguria
- Immunosuppressed
- Pallor / mottling (cap refill > 2 sec)
- Weak thready pulse
- History of recent surgery
- Diabetes Mellitus

Investigations / Diagnostics:

Bedside:
- BGL: If < 3mmol/L or > 20mmol/L notify SMO
- ECG: [as indicated] look for Arrhythmia
- Urinalysis / MSU - ketones, glucose, nitrates
- Stool Culture (if suspected infective)

Laboratory / Radiology:
- **Pathology**: Refer to local nurse initiated **STOP**
  FBC, UEC, Lipase, LFTs *(moderate- severe dehydration)*
  Urine βHCG and Quantitative ßHCG if positive
  Group and Hold (if bleeding suspected)
  Blood Cultures (if Temp >38.5 or <35°C)
- **Radiology:** Not generally indicated - refer to SMO

Nursing Interventions / Management Plan:

Resuscitation / Stabilisation:
- Oxygen therapy and cardiac monitor [as indicated]
- IV Cannulation (16-18gauge if unstable)
- IV Fluids: Sodium Chloride 0.9% 1 L IV stat versus over 8 hours *(discuss with SMO)*

Symptomatic Treatment:
- **Antiemetic:** as per district standing order
- **Analgesia:** as per district standing order
- **IV Fluids:** as per district standing order

Supportive Treatment:
- Nil By Mouth (NBM) or Trial of Fluids
- Monitor vital signs as clinically indicated (BP, HR, T, RR, SpO_2)
- Monitor neurological status GCS as clinically indicated
- Monitor pain assessment / score
- Fluid Balance Chart (FBC)
- Stool Chart
- Oral care to decrease mucous membrane dryness
- Trial of fluids for mild dehydration in gastroenteritis, oral rehydration therapy (e.g. Hydralyte®) or 4:1 ratio diluted juice

Practice Tips / Hints:
- Diarrhoea and vomiting is most commonly caused by viral gastroenteritis or food poisoning.
- Monitor for signs and symptoms of dehydration
- Isolate patient and use personal protective equipment (including surgical mask P2 if norovirus suspected)
- Keep NBM if patient potentially requires surgical intervention
- Provide a written discharge advice sheet for "Vomiting and Diarrhoea" from Emergency Care Institute (ECI) ACI Diarrhoea and Vomiting Fact Sheet - https://www.aci.health.nsw.gov.au/networks/eci/clinical/ndec/vomiting-and-diarrhoea-nmg

Further Reading / References:
1. SESLHDPR/283 Deteriorating Patient - Clinical Emergency Reponses System for the Management of Adult and Maternity inpatients
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6. SESIAHS CIN Working Group (2010) Vomiting- Non Specific Adults.

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- Murphy, M (2007) Emergency Department Toolkits Westmead Hospital , SWAHS
- Hodge, A (2011) Emergency Department, Clinical Pathways. Prince of Wales Hospital SESLHD.

Revision and Approval History

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