Clinical Assessment tool for Children with suspected gastroenteritis 0-16 years



Management Out of Hospital Setting

Child presenting with diarrhoea and/or vomiting: Assess for signs of dehydration, see table 1 (and consider Boxes 1 & 2 overleaf).

Utilise AccuRx for its video-consultation and patient questionnaire functionalities.

If all green features and If any amber features and no red If any red features no amber or red No clinical dehydration Clinical dehydration Clinical shock suspected or confirmed Depending on severity of child and social circumstances Send child for urgent assessment in Preventing dehydration: in this category action should be based on clinical hospital setting. Commence relevant Continue breastfeeding judgement (consider Box 2). treatment to stabilise baby/child for and other milk feeds transfer if appropriate. Consider appropriate transport means (999). Encourage fluid intake. Home with advice to give 50ml/kg of oral rehydration solution over 4 hours without delay, often and in small Discourage fruit juices and carbonated drinks If there is blood or mucus in the stool (especially those in Box 2) or a suspicion of septicaemia or if the In addition give on-going ORS fluid maintenance. child is immunocompromised, bleep Offer Oral Rehydration on call paediatrician 01234 355122, Continue breastfeeding. Solution (ORS) as bleep 605 or 208. supplemental fluid to Consider supplementing with usual fluids (including milk those at increased risk or feeds/water, but not fruit juices or carbonated drinks). Consider admission according to dehydration (Box 2). clinical and social circumstance. If after 4 hours child is not tolerating ORS / vomiting / Refer to Box 4 for stool Seek further advice - bleep on microbiology advice. call paediatrician 01234 355122, should be instructed to consider face to face bleep 605 or 208. reassessment from a healthcare professional. En-route parents should be Provide parents / carers encouraged to give child fluids Refer to Box 4 for stool microbiology advice. often and in small amounts with advice. Follow up by Give advice sheet. (including milk feeds/water, but arranging an appointment not fruit juices or carbonated with the appropriate healthcare professional. drink).

	Green – low risk	Amber – intermediate risk	Red – high risk
Activity	 Responds normally to social cues Content/smiles Stays awake/awakes quickly Strong normal cry/not crying 	 Altered response to social cues Decreased activity No smile 	 Not responding normally or no response to social cues Appears ill to a healthcare professional Unable to rouse or if roused does not stay awake Weak, high-pitched or continuous cry
Skin	Normal colour skinNormal turgor	Normal skin colourWarm extremities	Pale/Mottled/Ashen blueCold extremitiesReduced skin turgor
Respiratory	- Normal breathing	- Tachypnoea (ref to norm values box 3)	- Tachycardic (ref to normal values box 3)
Hydration	 CRT ≤ 2 secs Moist mucous membranes (except after a drink) Normal urine 	 CRT 2 – 3 secs Dry mucous membranes (except for mouth breather) Reduced urine output 	- CRT > 3 secs
Pulses/Heart rate	- Heart rate normal - Peripheral pulse normal	Heart rate normal Peripheral pulses normal	Tachycardic (ref to norm values box 3) Peripheral pulses weak
Blood Pressure	- Normal (red to normal values box 3)	- Normal (ref to normal values box 3)	- Hypotensive (ref to normal values box)
Eyes	- Normal eyes	- Sunken eyes	

CRT: capillary refill time RR: respiration rate

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Box 1 Consider the following that may indicate diagnosis other than gastroenteritis:

- Temperature of 38°C or higher (younger than 3 months) Bulging fontanelle (in infants)
- Temperature of 39°C or higher (3 months or older)
- Shortness of breath or tachypneoa
- Altered conscious state
- Neck-stiffness
- Abdominal distension or rebound tenderness
- History/suspicion of poisoning

- Non-blanching rash
- Blood and/or mucus in stool
- Bilious (green) vomit
- Severe or localised abdominal pain
- History of head injury

Box 2 These children are at increased risk of dehydration:

- Children younger than 1 year, especially those younger than 6 months
- Infants who were 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 last 24 hours
- Children who have failed to tolerate ORS
- Infants who have stopped breastfeeding during the illness
- Children with signs of malnutrition

Box 3: Normal	sox 3: Normal Paediatric Values (also refer to PEWS chart)						
Age	Respiratory rate/min	Heart rate/min	Systolic Blood pressure mmHg				
0 – 3 months	30 – 60	110 – 160	> 60				
3 – 12 months	25 – 50	100 – 150	80				
1 – 4 years	20 – 40	90 – 120	90 + (2 x age in years)				
4 – 12 years	20 – 30	70 – 110	90 + (2 x age in years)				
12+	12 - 16	60 - 100	120				

Box 4 Stool microbiology advice:

Consider performing stool microbiological investigations if:

- the child has recently been abroad
- the diarrhoea has not improved by day 7
- suspected septicaemia
- immunocompromised child
- blood in stool

Information to give to parent/carer:

•	Ensure parent/c	arer	has name and	l contact numl	ber of G	3P/	practice nurse/	rel	evant l	neal	thcare pr	ofessi	ional
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- Children's Rapid Response Team
- **NHS 111**
- D&V patient information leaflet
- Send oral fluid challenge to parents

This guidance has been produced by Primary Care and consultant clinicians across Bedfordshire, Luton and Milton Keynes, and subsequently reviewed and updated by the BLMK CYP Health Group.

This assessment tool was developed with careful consideration of the evidence available including but not exclusively NICE, SIGN, Bristol guideline, EBM data and NHS evidence. Healthcare professionals are expected to take this guidance 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 guardian or carer. Issue date: Oct 2023

Oral fluid challenge



<u>Name</u>		<u>DOB</u> /_	J
Date /	_/	MRN Number	
Weight of child			
Age of child	24 Hour fluid replacement (plus NICE 50ml/kg over 4		
	se give mls of every		S.
your child has had an	chart below to show when you have given fluid, hy vomiting and/or diarrhoea and/or has urinated. nal when/if your child is seen.		
Time	Fluid Amount Taken (ml/oz)	Vomit/Diarrhoea (tick please)	Urine (tick please)