Affix Patient Label here or record

NAME: . . . . . .

NHS NO: | | | | | | | | | | |

HOSP NO: | | | | | | | | | | |

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD_____ CONS_____

INFECTION PREVENTION AND CONTROL
PATIENT STOOL RECORD CHART

Complete D&V Risk Assessment on reverse if patient admitted with or develops D&V. (Regardless of likely cause.)

SITE: ALEX / KTC / WRH (Please circle)

Date specimen sent:.....
Result:.....
Received by:.....

Date specimen sent:.....
Result:.....
Received by:.....

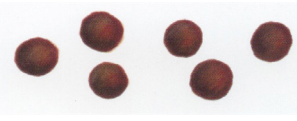
Definition of Diarrhoea is frequent watery stool (Type 5, 6 and 7)

Send Specimen after first episode of diarrhoea (indicated by stool recorded in shaded area of the chart.)

DO NOT SEND STOOL SPECIMENS FOLLOWING ADMINISTRATION OF LAXATIVES OR ENEMAS

Date & Time	Bed Space	Vomit	CONSISTENCY / DESCRIPTION (Please refer to key and tick all that apply)										Colour	Bowels Not Open	Signed
			1	2	3	4	5	6	7	Mucus	Blood	Offensive			

KEY

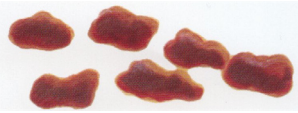


Type 1
Separate hard lumps like nuts (hard to press)

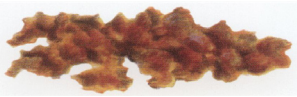
Type 2
Sausage-shaped but lumpy

Type 3
Like a sausage but with cracks on it's surface

Type 4
Like a sausage or snake, smooth and soft



Type 5
Soft formed blobs with clear-cut edges (passed easily)



Type 6
Semi-liquid/mushy stool fluffy pieces with ragged edges

Type 7
Entirely liquid/watery, no solid pieces

PROOF ONLY DO NOT SCAN

PLEASE FILE IN PATIENTS MEDICAL NOTES

PROOF ONLY DO NOT SCAN

Affix Patient Label here or record

NAME: . . . . . .

NHS NO: | | | | | | | | | | |

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D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD_____ CONS_____

INFECTION PREVENTION AND CONTROL

DIARRHOEA AND/OR VOMITING ASSESSMENT TOOL

NHS

Worcestershire Acute Hospitals NHS Trust

PULL TOGETHER TO PREVENT INFECTION

Outcome of Assessment		
Date:.....	Pathway:.....	Signed:.....
Date:.....	Pathway:.....	Signed:.....

NOTE: If a patient is admitted with diarrhoea/vomiting (regardless of cause) OR develops diarrhoea /vomiting, complete assessment and follow Pathway A, B or C. Isolate if Pathway B or C. Send specimen if indicated

ASSESSMENT CRITERION

(Answer all questions)

Circle and initial appropriate responses

1. Is diarrhoea/vomiting normal for this patient or do they have; a pre-existing medical condition (i.e. colitis/IBS/diverticulitis/ca bowel) or receiving enteral (NG / PEG) feeding, or have a colostomy/ ileostomy?

NO

2. Has the patient had recent chemotherapy, bowel surgery or been taking any medication (excluding antibiotics, laxatives and/or enemas), that may cause diarrhoea?

NO

3. Is the patient known/thought to be constipated/ have overflow and/or been prescribed laxatives/ enemas?

NO

4. Is the patient currently on, or completed within the previous six weeks, one or more courses of antibiotics, even if underlying cause for symptoms or treatment?

NO

5. Is the onset of D or V sudden and unexplained?
a) Not due to any of the above; CHECK
b) Has patient had recent contact with anyone with D&V (last 48 – 72hrs)?

YES follow Pathway A and record in notes.

YES follow Pathway A and record in notes.

YES follow Pathway A and record in notes.

PATHWAY A

(Probable non-infectious cause)

Maintain accurate stool record on chart, recording frequency/type according to the Bristol Stool Chart

Ensure that the Medical Team are aware the patient has diarrhoea and assess the patient

If possible, isolate the patient in a single room during assessment, use standard isolation precautions (yellow/ red isolation door sign)

Reassess patient after 24hrs, keep under daily review

If frequency and/or type of stool change/increase, contact the Infection Prevention and Control Team (IPCT) for advice (out of hours contact senior site nurse and leave message for IPCT on either 44744 or 38752)

YES follow Pathway B and record in notes.

PATHWAY B

(Clostridium difficile suspected)

Contact the IPCT (out of hours, contact senior site nurse and leave message for IPCT on either 44744 or 38752)

Obtain a stool specimen.
NB: Specimens can be obtained even if mixed with urine

Inform the Medical Team and ask them to assess patient and follow protocol for management of C.difficile/pseudomembranous colitis if indicated and refer to CDF quick guide

Isolate the patient in a single room with standard isolation precautions (yellow/red isolation door sign)

Vacated bed space to be AMBER cleaned (in occupied bay) or RED clean (in unoccupied room). After discharge RED clean room.

Maintain accurate stool record on stool chart

Record TPR and BP four hourly

Follow CDF Care Plan, if confirmed.

YES follow Pathway C and record in notes.

PATHWAY C

(Probable Norovirus / other viral cause)

Contact IPCT to assess need to cohort patient and contacts, close bay or ward (out of hours, contact senior site nurse and leave message for IPCT on either 44744 or 38752)

Obtain stool specimen – formed stool if vomiting only
NB: Specimens can be obtained even if mixed with urine

Inform Medical Team and ask to assess patient and follow care plan for Norovirus if indicated

After discussion with IPCT, isolate patient in a single room, on the same ward or cohort with contacts if advised by IPCT. Use standard isolation precautions (yellow/red isolation door sign). Out of hours, discuss with senior site nurse and quarantine affected bay pending review next day by IPCT.

Vacated bed space to have AMBER clean (in occupied bay) or RED clean (in unoccupied room). After discharge RED clean room.

Maintain accurate stool record on patient and ward stool chart

Record TPR and BP four hourly.

PROOF ONLY DO NOT SCAN

PROOF ONLY DO NOT SCAN