When and how to obtain a faecal specimen from a resident

Information for Care Staff

A faecal specimen (single) should be obtained as soon as possible following onset of symptoms of diarrhoea.

Definition of diarrhoea:
Diarrhoea is defined as the passage of 3 or more loose or liquid stools per day, or more frequently than is normal for the individual (usually at least 3 times in a 24 hour period). Diarrhoea is usually a symptom of gastrointestinal infection, which can be caused by a variety of bacterial, viral and parasitic organisms. The frequent passing of formed stools is not diarrhoea.

Preparation for faecal specimen collection:
Gather all relevant equipment:

- Clean, disposable/reusable bedpan or similar container.
- Leak proof sterile specimen container preferably with attached spoon or a clean disposable spatula. (Complete patient details on the specimen container before obtaining the specimen - see Additional Information).
- Leak proof sealable bag (with separate compartment for the specimen).
- Laboratory request form (if possible complete patient details before obtaining the specimen).

Examples of specimen containers

NB Use Infection Prevention and Control Precautions throughout this procedure. Guidance contained in page 6 of the norovirus guidance .

Procedure:

1. Explain the need for the procedure to the resident including the reason for the test (e.g. symptoms of diarrhoea), when and how the results will be given.
2. Ask the resident to pass faeces into the bedpan or container avoiding if possible passing urine at the same time.
3. Put on gloves and aprons to receive the bedpan.
4. Transfer faeces into a leak proof sterile specimen container using the spoon built into the container or a clean spatula to the fill line of the specimen container (or as a minimum covering the cone shape of the container). If the specimen contains blood, pus or mucus try to get these into the container.
5. Put on the container lid and secure. Avoid contaminating the outside of the container.
6. Discard bedpan and contents as usual. Discard other healthcare waste as defined in care home local policy.
7. Remove gloves and apron and wash and dry hands.
8. Place the specimen container directly into the leak proof sealable bag (The outside of this bag must not be visibly contaminated).
9. Wash and dry hands.
10. Ensure the transport of specimen within 2 hours of collection (If necessary specimens can be refrigerated for up to 24 hours at 4^{o}C in a designated non-food fridge).

Additional Information:

- **A negative test result does not necessarily exclude infection especially if clinical symptoms are highly suggestive**. These cases should be discussed with the General Practitioner or Health Protection Team.
- Normally only 1 faecal specimen is required per resident. There are exceptions to this and your Health Protection Team will advise.
- Larger amounts of faeces may be required for food borne pathogens.
- Document in the medical and nursing notes when the faecal specimen was taken and the reason(s) this was required.
- Stool charts should be used to monitor bowel pattern when residents have diarrhoea.
- The Health Protection Team will advise if an additional stool sample is necessary.
- The laboratory request form should contain relevant clinical information. Which may include:
  - Name.
  - CHI no or Date of Birth (if CHI not known).
  - Care home details/GP Practice.
  - Name and contact details of Clinician requesting the test.
  - Test required such as culture and sensitivity/virology.
  - Date/time faecal specimen was obtained.
  - Date of onset of symptoms.
  - Nature of symptoms.
  - Duration of symptoms.
  - Any current or recent antibiotic history (up to 3 months previously).
  - Relevant medical history and or diagnosis.
  - Travel history.
  - If the faecal specimen has been contaminated with urine or obtained from an incontinence product.
  - If an outbreak is suspected.