NSW PHARMACIST PRACTICE STANDARDS FOR ACUTE NAUSEA AND VOMITING

CONTENTS

A. APPROVED MEDICINES

Approved Medicines listed in the NSW Health Authority (dated 5 August 2025) are:

a. Ondansetron
b. Metoclopramide

B. GENERAL REQUIREMENTS

Pharmacists must hold general registration under the Health Practitioner Regulation National Law and have successfully completed the training requirements detailed in the NSW Health Authority (dated 5 August 2025).

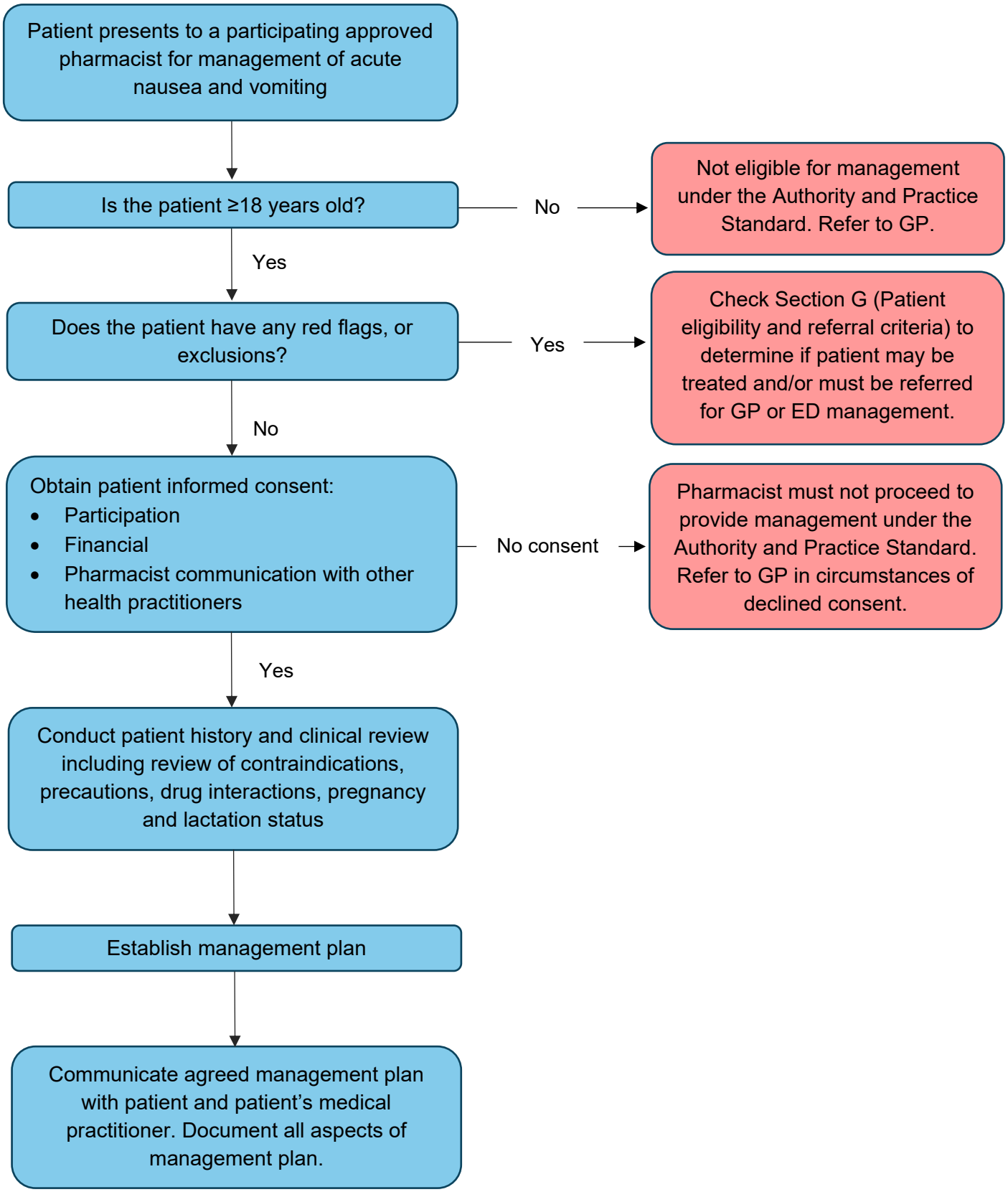
C. ADVERSE EVENTS

If the treating pharmacist becomes aware of an uncommon, unexpected or serious adverse event following treatment with an Approved Medicine, this should be reported to the Therapeutic Goods Administration. This should be conducted via the usual processes, by reporting online at https://aems.tga.gov.au/.

Additionally, you must notify the patient's usual general practitioner (if they have one).

D. PATIENT ASSESSMENT FLOWCHART

The following flowchart should be used in consultations to assess the eligibility, identity and govern supply of suitable treatments, and guide associated referral requirements.



E. SUPPLEMENTARY INFORMATION AND NOTES

This supplementary information provides guidance and information for pharmacists managing patients with acute nausea and vomiting under the Community Pharmacy Acute Nausea and Vomiting Service. It is to be used together with the training modules and other resources provided by education providers.

Key points

a. The Practice Standard provides the framework for appropriately trained approved pharmacists to manage eligible patients under the NSW Health Authority (dated 5 August 2025).
b. To receive management for acute nausea and vomiting under this service, the patient must fulfill the eligibility requirements set out under Part G of the Practice Standard. Patients who have requested the service but are not eligible for management should be referred to their regular medical practitioner or health service.
c. Pharmacists can supply up to 24 hours of oral therapy before referring a patient to a medical practitioner, or a higher quantity specified in the Authority.
d. Pharmacists must only supply formulations listed in the Authority.
e. Patients must be physically present in the pharmacy to be eligible for management.
f. Patients are required to have a consultation with an approved pharmacist before a medication can be supplied under the Authority.
g. Pharmacists must make a full clinical record of the consultation and the details of all consultations and outcomes must be recorded using secure digital software. Records must be stored securely for minimum seven (7) years.
h. Pharmacists must exercise professional discretion and judgement when applying the information within this Practice Standard. The Practice Standard does not override the responsibility of the pharmacist to make decisions appropriate to the circumstance of the individual, in consultation with their patient.

F. PATIENT CONSENT

Informed clinical and financial consent must be obtained from the patient prior to providing care under this practice standard.

The pharmacist must seek the patient's consent to share a record of the consultation and any subsequent consultations (including adverse events) with the patient's usual treating medical practitioner or medical practice, where the patient has one. If the patient consents to the disclosure, the record must be shared within a week following the consultation.

G. PATIENT ELIGIBILITY AND REFERRAL CRITERIA

- Patients must be aged 18 and over to be eligible for the service.

- Patients who meet any of the urgent referral criteria below are not eligible for this service and require immediate referral to their regular medical practitioner, health service, or Emergency Department (ED) as indicated in the table. Note that these are not exhaustive lists.
- Patients who require non-urgent referral to GP or maternity provider are to be referred (in accordance with the usual referral processes).
- Pharmacists must apply clinical judgement and refer any patient considered appropriate for medical care for any reason.
- Pharmacists must consult the Therapeutic Guidelines and other relevant references to confirm management is appropriate, including for:
    - Contraindications and precautions
    - Drug interactions
    - Pregnancy and lactation

	Referral criteria	Treat	Referral
'Red flag' warning signs	**General**		
	Prolonged vomiting (greater than 24 hours)	No	Urgent: GP or ED
	Patient appears very unwell and/or very drowsy	No	Urgent: ED
	Significant unexplained weight loss	No	Urgent: ED
	Signs of hypovolaemic, hypoglycaemic, or septic shock	No	Urgent: ED
	History of significant toxin ingestion or overdose	No	Urgent: ED
	Gastroenterological		
	Severe abdominal pain, abdominal distension, rigidity, and/or tenderness	No	Urgent: ED
	Green, bile-stained, feculent, or bloody (including "coffee grounds") vomitus	No	Urgent: ED
	Absolute constipation (with lack of flatus)	No	Urgent: ED
	Per rectal bleeding (including melaena)	No	Urgent: ED
	Severe abdominal pain, abdominal distension, rigidity, and/or tenderness	No	Urgent: ED
	Isolated vomiting without nausea	No	Urgent: GP or ED
	Neurological		
	Severe new headache (not patient's usual headache)	No	Urgent: ED
	Altered level of conscious	No	Urgent: ED
	Neck stiffness, confusion, visual abnormalities, or seizure	No	Urgent: ED
	History of head injury or trauma	No	Urgent: ED
	Non-blanching rash anywhere on the body	No	Urgent: ED
	Metabolic		
	High blood sugar level (BSL) for the patient	No	Urgent: ED
	Low BSL (without signs of hypoglycaemic shock)	No	Urgent: GP
	Patients taking SGLT inhibitors	No	Urgent: GP
	Obstetric		
	Pregnant patients: signs of pre-eclampsia such as headache, blurred vision, altered mental state, abdominal or epigastric pain, reduced foetal movements, oliguria, and/or peripheral oedema	No	Urgent: ED
	The patient is pregnant and is 16 weeks' gestation or more	No	Urgent: GP or ED or maternity care provider

	Referral criteria	Treat	Referral
	Other		
	Chest pain, heaviness, or discomfort	No	Urgent: ED
	Shortness of breath or difficulty breathing	No	Urgent: ED
	The patient has a history of diabetes, Addison's disease, immunocompromise, or renal or liver failure	No	Urgent: GP or ED
	The patient has recently returned from overseas.	No	Urgent: GP
	The cause of the patient's acute nausea and vomiting is unclear.	No	Urgent: GP
	The acute nausea and vomiting are post-operative, radiation-induced or suspected to be drug-induced	No	Urgent: GP or ED
	The patient's condition or symptoms worsen	No	Urgent: GP or ED
	The patient's symptoms have not resolved within 24-48 hours of first commencing	No	Urgent: GP
	Intramuscular injection of an anti-emetic is indicated	No	Urgent: GP
Details of presenting complaint	The patient is <18 years of age	No	GP
	The patient is <20 years of age and cannot receive any other anti-emetic other than metoclopramide	No	GP
	The nausea and vomiting is chronic (defined by 4 weeks or more of symptoms)	Yes	GP
	The patient is >65 years of age	Yes*	GP
	The patient is pregnant (less than 16 weeks' gestation)	Yes	GP or maternity care provider

**Patients who are >65 years of age should only receive a single dose an approved medicine (where indicated) and be referred for medical review.*

H. BACKGROUND

- Acute nausea and vomiting are nonspecific symptoms that can be caused by a range of factors and conditions. Two of the most common causes of acute nausea and vomiting are viral gastroenteritis and bacterial food poisoning, however it may be a sign of a wide range of gastrointestinal, neurological, endocrine/metabolic, infectious, toxin-induced, substance use, mental health, or other health factors.
- Presentation of acute nausea and vomiting encompass a broad range of clinical categories and contexts. **Potential life-threatening causes** include, but are not limited to:
    - Surgical conditions: such as mechanical obstruction, paralytic ileus, gastrointestinal haemorrhage, and causes of an acute abdomen.
    - Endocrine and metabolic conditions: including diabetic ketoacidosis, Addisonian crisis, and liver or renal failure, as well as pre-eclampsia in patients who are pregnant.
    - Neurological conditions: such as meningitis/encephalitis and increased intracranial pressure (which may be from trauma, a space-occupying lesion, or other intracranial pathology).
    - Other: myocardial infarction and sepsis may present with nausea and vomiting, although are usually associated with other symptoms.
- **A patient presenting with a potentially life-threatening cause for their acute nausea and vomiting must be immediately referred to emergency health services for urgent review and management.**
- Other causes of acute nausea and vomiting include, but are not limited to:

    - Gastrointestinal conditions such as gastroenteritis, gastroparesis, hepatitis, and peptic ulcer disease.
    - Neurological causes such as migraine, motion sickness, Ménière's disease, and labyrinthitis.
    - Metabolic/Endocrine conditions such as hypercalcaemia, hyponatraemia, or pregnancy.
    - Medication and substance use, including alcohol, cannabis, antibiotics, opiates, or cytotoxic agents.
    - Mental health conditions, noting that nausea and vomiting may also be self-induced, functional, or associated with an eating disorder.
- **Nausea and vomiting in pregnancy:** In people of childbearing age, it is important to consider pregnancy as a potential cause of symptoms, noting that nausea and vomiting commonly occurs in early gestation, and the person may not be aware that they are pregnant. Severe vomiting, prolonged vomiting, or vomiting that persists or starts after 16 weeks' gestation should warrant urgent referral for medical investigation and management. When nausea and vomiting in pregnancy is within scope for treatment in line with these Practice Standards (i.e. at initial onset of symptoms or acute exacerbation of symptoms at less than 16 weeks gestation), treatment should be accompanied by a referral to the patient's GP and/or existing maternity care provider for ongoing management.
- Management of patients with acute nausea and vomiting should focus on appropriate treatment of the underlying cause and ensuring adequate hydration. In adults with acute nausea and vomiting, spontaneous improvement is likely, however, antiemetic therapy can be considered for symptom relief.
- Many common causes of acute nausea and vomiting are infectious, and appropriate use of personal protective equipment and environmental cleaning should be considered for all consultations.

I. PATIENT ASSESSMENT

A patient history and examination that is tailored to the patient's presentation is required to inform the management approach, including appropriate referral. The prompts provided below are not exhaustive, pharmacists should maintain an open mind and be aware of cognitive bias.

PATIENT HISTORY

Sufficient information must be obtained from the patient to assess the safety and appropriateness of management. The My Health Record should be reviewed where appropriate and available.

The patient history should include:

- History of the presenting concern, including onset, and duration of symptoms, the timing of nausea and vomiting in relation to meals, and the frequency, amount, and content (liquid, solid, bile, blood (including "coffee ground" appearance)) of vomitus to identify a cause.
    - Associated symptoms, including pain (in particular abdominal pain, chest pain, or headache), neurological symptoms (such as blurred vision, vertigo, confusion, neck stiffness, photophobia, and presence of non-blanching rash), and the frequency and characteristics of stool (including presence and character of diarrhoea or constipation).

    - If abdominal pain is present, exploration of the character, duration, frequency, time of occurrence, location and distribution, and any exacerbating and relieving factors that may indicate an intraabdominal cause.
    - Associated history, including any symptoms in household or other close contacts, recent travel, potential exposure to food poisoning sources, recent weight loss, and recent head trauma/injury.
    - Assessment of clinical status including fluid input and output, level of consciousness, and presence of fever and other signs of infection.
    - Pregnancy assessment, noting that patients may not be aware that they are pregnant, particularly as nausea / vomiting commonly occurs in early gestation. If they confirm they are pregnant, ask about gestation and any relevant pregnancy history. Incorporate the PUQE-24 tool as part of the assessment of pregnant women.
- Past medical history including gastrointestinal, neurological, and metabolic/endocrine conditions (including diabetes mellitus).
- Surgical history, including any recent abdominal surgical procedures.
- Medication and allergy history, including recent commencement or cessation of medications, and any medications or therapies taken to address current symptoms.
- Drug and alcohol history.
- Mental health history, noting that nausea and vomiting may be functional, or associated with eating disorders such as bulimia.

EXAMINATION

A clinical examination should be guided by the patient's history, and conducted to identify potential causes, exclude life-threatening conditions, and assess potential sequelae, including the patient's level of dehydration. It is important to note that symptoms of severe dehydration and shock are also present in sepsis. Where there is doubt of the cause of acute nausea and vomiting, the severity of dehydration, or the presence of life-threatening conditions, the patient must be referred for medical review.

- **The patient's level of dehydration** should be assessed, in line with the Therapeutic Guidelines: Assessing adults for dehydration, including vital signs as appropriate.
    - **Note**: while moderate to severe dehydration is often associated with low blood pressure (hypotension), high blood pressure (hypertension) in a patient who is pregnant may be a sign of pre-eclampsia.
    - **Note**: In older patients, traditional symptoms and signs of dehydration may be absent, and presentation may be atypical. Symptoms and signs can include increased confusion, functional decline, chest pain, and falls. Assessment of dehydration may be further confounded by comorbidities such as heart, liver or kidney failure.
- A physical examination should be conducted as appropriate (e.g. abdominal examination). Given that nausea and vomiting are non-specific and associated with a wide range of pathologies including life-threatening conditions, there should be a low threshold for referral for medical care where signs and symptoms are unclear.

- A **blood sugar level (BSL)** is recommended for all patients and must be performed on any patient who has a history of diabetes. A high BSL may be a sign of diabetic ketoacidosis, which requires referral to emergency health services for review and management. Patients on SGLT inhibitors may present with euglycemic ketoacidosis. As such, there should be a lower threshold for referral to urgent medical care in this group.

Any patient presenting with signs and symptoms of a life-threatening condition, including severe dehydration, diabetic ketoacidosis, or an acute abdomen, must be referred to an emergency department for urgent review and management.

J. MANAGEMENT AND TREATMENT PLAN

It is important to identify, treat, or remove the cause of acute nausea and vomiting, as well as ensure adequate hydration before starting treatment of symptoms.

- **Managing the cause of acute nausea and vomiting**
  - Refer patients for medical review if they have any red flags or other indications for referral (see tables). Where the cause of acute nausea and vomiting is unclear, patients should also be referred for medical review.
  - For patients who have a history and examination consistent with viral gastroenteritis, it is important to provide advice to minimise the risk of transmission, including hand hygiene, food safety practices, and avoidance of high-risk settings such as aged care facilities until at least 24-48 hours after their diarrhoea or vomiting have resolved.
- **Managing hydration**
  - Managing hydration status is one of the most important aspects of acute nausea and vomiting. Rehydration should be aligned with the Therapeutic Guidelines: Rehydration for acute gastroenteritis in adults.
  - Adults with features of mild to moderate dehydration can usually be adequately managed with oral rehydration (water and/or rehydration drinks). Drinks that are high in sugar may worsen diarrhoea if this is present.
  - Patients should be encouraged to eat as normally as possible, with small, light meals, as guided by their appetite. Fatty, spicy or heavy foods may worsen symptoms.
- **Managing symptoms**
  - Nausea and vomiting can often be effectively managed with non-pharmacological therapy, including dietary changes, appropriate hydration, and rest.
  - If using pharmacotherapy, the choice of antiemetic should be determined by the clinical situation, noting that there are a number of neural pathways implicated in nausea and vomiting.

- Pharmacotherapy for the control of symptoms in acute nausea and vomiting under this Practice Standard must be in accordance with the Therapeutic Guidelines: Nausea and Vomiting, and the following:
    - A maximum of **24-hours' supply of oral preparations of a single approved medicine** may be given to patients. This does not preclude the use of prochlorperazine or promethazine hydrochloride under pre-existing Schedule 3 indications, or any other Schedule 3 anti-emetics, that fall outside of this Practice Standard.
    - **Ondansetron** is currently approved by the TGA for the prevention of nausea and vomiting induced by cytotoxic therapy and radiotherapy, and for the prevention of post-operative nausea and vomiting. Use for nausea and vomiting outside of these indications is considered off-label use. Patients should be advised about reasons for off-label use and counselling to this effect should be documented in the notes.
    - **Metoclopramide** as a dopamine antagonist, metoclopramide is associated with extrapyramidal adverse effects (EPSEs), usually acute dystonic reactions. EPSEs are more common in the elderly, people under 20 years of age, and people with renal failure. Metoclopramide must not be given to patients under 20 years of age, patients with Parkinson's Disease, or patients with suspected gastrointestinal obstruction.
    - **Prochlorperazine** is particularly useful for acute nausea and vomiting associated with migraine, motion sickness, or acute gastroenteritis. It is available as a Schedule 3 medicine for the treatment of acute nausea and vomiting associated with migraine. As a dopamine antagonist, it can also cause EPSEs, including tardive dyskinesia and akathisia. It must not be given to patients who have Parkinson's disease.
    - **Promethazine Hydrochloride** is an antihistamine with antiemetic effects, and available as a Schedule 3 medicine. It can cause sedation, lower the seizure threshold and have anticholinergic effects. It can also cause EPSEs, including tardive dyskinesia; and should not be given to patients who have Parkinson's disease.
- Additional consideration should be taken when managing nausea and vomiting in patients who are pregnant, in line with the NSW Health Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum. This includes appropriate recognition and referral of patients with severe, persistent, or late onset nausea and vomiting, as well as consideration of appropriate non-pharmacological and pharmacological therapies depending by symptom pattern and gestational age.

Counselling

- Comprehensive advice and counselling (including supporting written information when required) as per the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references should be provided to the patient regarding:
    - Individual product and medicine use, including contraindications and precautions
    - How to manage adverse effects
    - Supportive care, including the importance of rehydration
    - The impact of vomiting on the absorption and effectiveness of other regular medications
    - When to seek further care and/or treatment from a medical practitioner, including recognising signs and symptoms of 'red flags' and dehydration. All patients should be advised to seek medical care if their symptoms worsen or do not improve with 24-48 hours.
- The agreed management plan must be documented in the patient electronic clinical record and shared with members of the patient's multidisciplinary team, in accordance with the Authority.
- Where a patient has a My Health Record, the pharmacist must ensure the details of the supply are uploaded to My Health Record, unless requested otherwise by the patient.

FOLLOW-UP CARE AND REVIEW

- Repeat clinical review with the pharmacist is generally not required. Patients should be advised to seek medical care if their symptoms worsen, or do not improve or resolve within 24-48 hours.

K. CLINICAL DOCUMENATION AND COMMUNICATION

- The pharmacist must make an electronic clinical record, and a record in a pharmacy dispensing system regarding the supply of any medications under these services, in accordance with the Authority.
- Where a patient has a My Health Record, the pharmacist must ensure the details of the supply are uploaded to My Health Record, unless requested otherwise by the patient.

L. RESOURCES

Patient information/resources:

- It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients.
- NSW Agency for Clinical Innovation, Emergency Care Institute factsheets:
    i. Gastroenteritis
    ii. Nausea and Vomiting in Pregnancy
- Healthdirect factsheets:
    i. Nausea
    ii. Vomiting

iii. Gastroenteritis
iv. Additional information factsheets specific to the individual patient's cause of acute nausea and vomiting may also be available (e.g. morning sickness, motion sickness, etc.)

- NSW Health: Nausea and Vomiting in Pregnancy and Hyperemesis gravidarum
- Royal Hospital for Women: MotherSafe factsheet: Nausea and Vomiting in Pregnancy
- UpToDate:
    i. Patient Education: Nausea and Vomiting in Adults
    ii. Patient Education: Viral Gastroenteritis in Adults

Pharmacist resources:

- Therapeutic Guidelines: Gastrointestinal
    - Assessment and causes of nausea and vomiting in adults
    - Antiemetic drugs in adults
    - Assessing adults for dehydration
- Australian Medicines Handbook: Nausea and vomiting
- Australian Prescriber:
    - Antiemetic drugs: what to prescribe and when
    - Treatment of nausea and vomiting in pregnancy
- NSW Agency for Clinical Innovation, Emergency Care Institute: Emergency care assessment and treatment (ECAT) protocols:
    - Diarrhoea and/or vomiting
    - Nausea and vomiting in pregnancy
    - Dehydration assessment
- NSW Health: Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum
- Royal Australian College of General Practitioners (RACGP)
    - Nausea and vomiting in adults: A diagnostic approach
    - Managing nausea and vomiting in pregnancy in a primary care setting
- UpToDate: Approach to the adult with nausea and vomiting
- MSD Manual: Nausea and Vomiting
- Society of Obstetric Medicine of Australia and New Zealand (SOMANZ): Guideline for the management of Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum
- To report suspected outbreaks of gastroenteritis, or food safety concerns:
    - NSW Health: Viral Gastroenteritis
    - Service NSW: Report a Food Safety Complaint

M. ACKNOWLEDGEMENTS

NSW Health acknowledges and thanks Queensland Health for consent to use the *Acute Nausea and Vomiting – Clinical Practice Guideline* as the basis for this Practice Standard.

NSW Health emergency care assessment and treatment (ECAT) protocols developed by the ECAT Working Group, led by the Agency for Clinical Innovation, have also been used to inform aspects of this Practice Standard, where relevant.

N. REFERENCES

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Approved

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5 AUGUST 2025