Birmingham Children's Hospital NHS
NHS Foundation Trust

GUIDELINES FOR THE PREVENTION AND MANAGEMENT OF CHEMOTHERAPY AND RADIOTHERAPY INDUCED DIARRHOEA

Version:	2.0
Ratified by:	Head of Chemotherapy (HoC) / Lead cancer clinician (LCC) / Lead cancer nurse (LCN)
Date ratified:	May 2010
Name of originator/author:	Nigel Ballantine (Rtrd), Jeanette Hawkins
Name of responsible committee/individual:	Reviewed by Chemo Working Group July 2012
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Target audience:	Nursing, medical, pharmacy and support staff within the Haematology Oncology Specialty

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1 Introduction

Diarrhoea is an increase in stool volume and liquidity, resulting in an increase in bowel movements above the patient's baseline frequency.

Chemotherapy-induced diarrhoea is a common side effect of treatment in adult cancer chemotherapy regimes, but is experienced less often in children for reasons that are not established. However, when experienced it can be debilitating and even life threatening due to fluid loss and electrolyte imbalance. The impact of severe diarrhoea should not be underestimated.[1]

Information is limited on the mechanism(s) by which cytotoxic drugs produce diarrhoea in patients, but two mechanisms by which treatment may induce this symptom are proposed. Firstly, through changes in intestinal absorption which may or may not be accompanied by excessive electrolyte and fluid secretion and, secondly, as consequence of a combination of mechanical and biochemical changes caused by chemotherapy. These intestinal functional changes are thought to be a result of direct toxicity of the chemotherapy on the colonic crypt stem cells[8]

2 Purpose

- To assist health care professionals to adequately manage differing grades of diarrhoea.
- To minimise morbidity and maximise patient quality of life while on treatment
- To reduce the need for treatment modification and chemotherapy treatment delays.
- To ensure adequate reporting of high grade toxicity to Multi-Disciplinary Team Meetings and where appropriate to Clinical Trial data managers.
- To advise on assessment tools for grading diarrhoea
- To support staff education & training for managing chemotherapy-induced diarrhoea.

N.B. New agents, monoclonal antibodies or therapies used in Phase I & II clinical trials may have potential side effects and specific monitoring requirements that are not covered in this guidance document. Staff should contact the trial principal investigator, oncology research nurses and or oncology specialist pharmacists in such instances.

3 Duties

3.1 Duties within the Organisation

The BCH Chemotherapy Working Group chaired by Nigel Ballantine (Lead Cancer Pharmacist) is responsible for reviewing this guideline bi-annually in line with the National Cancer Peer Review Programme. Updated versions will be forwarded to the Information and Quality Compliance Manager to present to the Integrated Governance Committee to be ratified.

The BCH ratified document will then be presented to the West Midlands Children's Cancer Supra-Network Group with a Pan Birmingham Cancer Network Cover Sheet for Network approval and dissemination across the West Midlands Paediatric Oncology Managed Care Network.

Nursing staff are responsible for supportive care & patient / parent education outlined in the document. They are responsible for accurate reporting and recording of information given, symptoms, assessments, care given and response to care and treatment.

Medical staff are responsible for assessing reported symptoms, treatment planning and ongoing evaluation of the treatment plan.

3.2 Identification of Stakeholders

BCH Chemotherapy Working Group
BCH Drugs & Therapeutics Committee
BCH Haematology Oncology Programme Meeting
BCH Pharmacy Department
West Midlands Children's Cancer Supra-Regional Network Co-ordinating Group

4 Method for development

4.1 Consultation and Communication with Stakeholders

The policy has been developed by the Chemotherapy Working Group after identifying a gap in guidance around this aspect of treatment toxicity while reviewing evidence for National Cancer Peer Review in 2010.

Evidence was gathered following requests for similar policies in the Pan Birmingham Cancer Network for Adult Cancers and from the Royal College of Nursing Children & Young People Cancer Nurses group – see references. A literature search was also conducted with support from the BCH Ben Wood Library

Advice was sought from the Trust Equality & Diversity Leads to establish whether there were any dietary or cleansing practices for any particular ethnic, religious, cultural groups that needed to be taken into account in developing this policy.

The policy was circulated in draft form to Consultants and Senior Nurses within the BCH Cancer Service for comment. Opinion was also sought from the BCH Gastroenterology Service and BCH Infection Control Team. Revisions were made accordingly and a final draft was circulated to the Haematology Oncology Programme Meeting and Cancer Locality Group.

A final version was presented to the BCH Integrated Governance Committee and to the Children's Cancer Network Coordinating Group hosted by Pan Birmingham Cancer Network for acceptance as a West Midlands Children's Cancer Network Policy.

4.2 The policy was reviewed as still accurate & valid by the Chemotherapy Working Group July 2012, and subsequently re-issued

5 Content

Chemotherapy and radiotherapy-induced diarrhoea may have a dramatic impact on a patient's quality of life, physical and emotional wellbeing, and invariably increases patient costs. There may be associated abdominal pain, cramping, proctitis, and anal or peri-anal skin breakdown. These in turn can lead to weight loss, malnutrition, sleep disturbance & depression.

5.1 Chemotherapy agents associated with diarrhoea in paediatric oncology

In the literature 5-fluorouracil (5-FU), Methotrexate, Irinotecan and Taxanes (Docetaxel, Paclitaxel) are cited as commonly producing diarrhoea, although a wide range of cytotoxic drugs, including monoclonal antibodies and hormonal treatments are reported to produce this effect[3, 8]

Other medicines used in supportive care may also cause diarrhoea, including antibiotics and ciclosporin, although it should be noted that the manufacturer's Summary of Product Characteristics for almost all drugs will include diarrhoea as a potential side effect.

Cancer treatment may also cause diarrhoea indirectly:

- Infections associated with neutropenia
- Graft versus host disease of the gut following stem cell transplantation.
- Radiotherapy

5.2 Common Toxicity Criteria for Grading Diarrhoea

Most clinical trial protocols and national treatment guidelines for children's cancers provide toxicity grading charts, including diarrhoea, within the protocol or guideline. It is essential that any reported diarrhoea is assessed against the trial grading criteria and that Grade 3 - 4 toxicity is reported to the trial coordinators.

Example grading criteria (From MRC UKALL 2003[4])

Grade 0	Grade 1	Grade 2	Grade 3	Grade 4
None	2 - 3 stools a day	4 - 6 stools a day or mod. cramps	7 -9 stools a day or severe cramps	≥ 10 stools a day, bloody, parenteral support required

In the absence of a diarrhoea grading chart specific to the clinical trial or national treatment guideline the CTCAE v3.0 grading can be used – See Appendix I.

5.3 Patient / Parent / Carer Information & Education

5.3.1 Patient / carer information is central to the management of chemotherapy-induced diarrhoea, including the possible causes (infection or chemotherapy side effect) and the potential for life threatening dehydration, particularly in babies and young children.

5.3.2 Before starting chemotherapy patients and/or parents should be informed that diarrhoea may occur and what action to take should it do so. Verbal Information is supported by a section in the BCH Oncology Department Parent Held Record.

5.3.3 Patients / carers will require fluid and nutrition advice in order to maintain satisfactory hydration and nutritional status. A low residue diet with high fluid intake may be appropriate.

5.3.4 Patients / carers must be informed that children with poor fluid intake and diarrhoea must be presented to BCH or their designated Paediatric Oncology Shared Care Unit (POSCU) for assessment.

5.4 Patient / Carer advice prior to starting treatment

5.4.1 Their doctor or nurse should be informed of the onset of diarrhoea. If at home telephone BCH or the designated POSCU, on the numbers provided in the Parent Held Record, for advice.

5.4.2 Continue to monitor bowel movements and report immediately if any of the following are present;

- Fever associated with diarrhoea
- Abdominal cramps / pain / bloating (especially if receiving vinca-alkaloids as the diarrhoea may relate to constipation overflow)
- Dizziness
- Blood in faeces
- Inability to drink adequate amounts of fluid

- Low urine output, dry mouth, sunken eyes or sunken fontanel in a baby

5.5 Patient / Carer advice on management of diarrhoea

If patients experience diarrhoea they, or their parent/carer, should:

5.5.1 If at home contact BCH or their designated POSCU on the numbers provided in the Parent Held Record, so that diarrhoea can be documented and further support / information given.

5.5.2 If patient has a fever / suspected neutropenia to attend for urgent FBC, stool specimen and medical review in order to rule out infection prior to starting any anti-diarrhoeal medication.

5.5.3 **Commence dietary & hydration management.**

- Drink plenty of fluids (Clear fluids are best. Avoid milk based drinks).
- Eat small amounts of bland low fibre foods (e.g. Bananas, rice, noodles, white bread, skinned chicken, turkey or white fish) until diarrhoea resolves.
- Avoid greasy / fried foods, raw vegetables, fruit, whole grain breads & cereals, lactose containing products, caffeine, spicy foods, and gas-forming foods including beans, cabbage, broccoli or carbonated drinks until diarrhoea resolves.

5.5.4 Stop all laxatives.

5.5.5 Monitor temperature and report pyrexia.

5.5.6 Monitor diarrhoea and report immediately any increase in stool frequency, or signs of dehydration, low urine output, dry mouth, sunken eyes or, in a baby, sunken fontanel.

5.6 Pre-Chemotherapy Treatment Assessments

Accurate pre-chemotherapy assessment is essential to enable variation from the patient's baseline to be detected. The following should be recorded for all patients:

- Weight in kilograms
- FBC and biochemistry
- Usual bowel habit
- Patient's use of bowel medications, e.g. laxatives

5.7 Toxicity Management

Medical and nursing management of all patients with chemotherapy induced diarrhoea should:

5.7.1 Ensure toxicity assessment prior to each cycle of chemotherapy

5.7.2 Eliminate other potential causes of diarrhoea where possible without delaying treatment, such as:

- infection
- use of laxatives
- constipation overflow
- concurrent drugs, such as antibiotics
- progressive disease.

5.7.3 Explain likely cause of diarrhoea to patient / carer. Explain treatment plan. Provide reassurance and support. Educate regarding personal care.

5.7.4 Ensure optimum hygiene care to anal and peri-anal areas (and / or stoma site). Collaborate with tissue viability service if the patient's skin becomes excoriated particularly for babies still in nappies. Follow the Trust standard care plan for nappy care.

5.7.5 Ensure care givers wear gloves when providing personal care to prevent the risk of cross-infection.

5.7.6 Ensure anti-diarrhoea agents are given as prescribed or that carers who are self medicating understand the medicines and treatment plan.

5.7.7 Monitor and record diarrhoea & associated symptoms (report changes):

- Frequency
- Volume
- Colour
- ConsistencyPresence of fresh blood / melaena
- Change in smell
- Abdominal cramping / pain
- Rectal bleeding
- Nausea / vomiting

5.7.8 Monitor and record effects of anti-diarrhoea agents and other interventions, e.g. skin care, analgesia.

5.7.9 Observe and report signs of dehydration:

- Low urine output
- Dry mucous membranes
- Sunken eyes / fontanel, absence of tears
- Poor tissue turgor
- Negative fluid balance
- Decreased peripheral perfusion
- Deep breathing
- High urea
- Low pH
- Large base deficit

5.7.10 Observe and report signs of low sodium levels:

- Tiredness
- Disorientation
- Headache
- Muscle Cramps
- Nausea

Severely low sodium can lead to seizures or coma.
Severely low potassium can cause cardiac arrhythmias.

5.8 Grade specific management

See patients' clinical trial protocol or national treatment guideline for grading criteria (or Appendix I if no relevant protocol / guideline)

GRADE	MANAGEMENT
1	Commence loperamide (Imodium): Child 4–8 years: 1 mg 3–4 times daily for *up to 3 days only* Child 8–12 years: 2 mg 4 times daily for up to 5 days Child 12–18 years: initially 4 mg, then 2 mg after each loose stool for up to 5 days (usual dose 6–8 mg daily; max. 16 mg daily) • Commence dietary management • Report any changes / unresolved or increase in diarrhoea / pyrexia
2	As Grade 1 • Withhold chemotherapy till settled • If diarrhoea has not resolved after 24 hours, consider adding antibiotics on an individual patient basis following consultant / Microbiology advice • Report any changes / pyrexia / unresolved diarrhoea – medical review of patient – FBC / U&Es / stool culture / vital signs
3	Withhold chemotherapy • Admit – medical review - check FBC / U+Es / stool culture / vital signs • If neutropenic follow neutropenia policy • Start iv fluids (Oncology Handbook – Fluid Prescription[7]), correct electrolyte imbalance • Consider antibiotics
4	Urgent medical review • As Grade 3 + abdominal x-ray • Consider second line treatment (e.g. octreotide) according to specialist advice

5.9 Chemotherapy drug specific management – Irinotecan

5.9.1 Early diarrhoea starts during or within 24hrs of receiving Irinotecan and is cholinergic in nature. It is associated with symptoms of sweating, stomach cramps, watering eyes, blurred vision, dizziness, feeling unwell, and excessive mouth watering.

5.9.2 Experience to date suggests that early diarrhoea is not a major problem. Should treatment be necessary – of diarrhoea, or other cholinergic symptoms – atropine is recommended, and a regime can be found in the ET 2003 04 protocol.

5.9.3 Late onset diarrhoea – starts more than 24hrs after starting an Irinotecan infusion. Loperamide should be given according to the following schedule until a normal pattern of bowel movement returns. Oral rehydration should be given in addition throughout the episode of diarrhoea

>= 43kg: 4mg. after first loose stool. Subsequently 2mg. every 2 hours (2mg. every 4H at night)

30 - 43kg: 2mg. after first loose stool. Subsequently 1mg. every 2 hours (2mg. every 4H at night)

20 - 30kg: 2mg. after first loose stool. Subsequently 1mg. every 3 hours (2mg. every 4H at night)

13 - 20kg: 1mg. after first loose stool. Subsequently 1mg. every 3 hours (1mg. every 4H at night)

< 13kg: 0.5mg. after first loose stool. Subsequently 0.5mg. every 3 hours (0.5mg. every 4H at night)

If a patient needs to take Loperamide they and/or their carers should be counselled to maintain close contact with their treatment centre – BCH or POSCU – and certainly to report if the diarrhoea has not resolved within 48 hours.

5.9.4 Loperamide should not be given prophylactically, even in patients who experienced delayed diarrhoea in previous cycles.

5.9.5. Where the delayed diarrhoea is unresponsive to Loperamide, a trial of Cefixime may be appropriate. Cefixime reduces bowel colonisation by organisms that may reactivate the active metabolite of Irinotecan excreted in the bile, leading to local toxicity. The dose is 8mg/kg/day (Max: 400mg) for five days before Irinotecan and through the course – typically five days per week in two consecutive weeks.

5.10 Stem cell transplant-specific management

5.10.1 All patients presenting with diarrhoea post transplant must be reviewed by medical staff and considered for admission. Admission may require transfer to the transplant / Principal Treatment Centre, depending on severity of symptoms and / or concomitant symptoms.

5.10.2 Management for all patients with chemotherapy-induced diarrhoea in section 5.7.1.to 5.7.10 remains relevant.

5.10.3 Patients with gut GvHD may also experience presence of tissue fragments in the stool, green offensive “mincemeat” diarrhoea, nocturnal diarrhoea and co-existing upper GI symptoms.

5.10.4 Infection screen should include stool specimens for microscopy, culture & sensitivity and virology. If adenovirus is detected, send EDTA blood for adenovirus PCR testing. If *Clostridium difficile* infection is suspected, send two liquid stool specimens 48 hours apart.

Giardia & Cryptosporidium should be considered. Discuss severe cases with a microbiologist.

5.10.5 If diarrhoea is thought to be related to mucositis, Loperamide may be used until engraftment occurs, which usually resolves symptoms.

5.10.6 Patients may require biopsy, but negative biopsies can be a result of “skip” lesions. Positive gut GvHD is managed via a separate policy.

6 References

Sandwell & West Birmingham Hospitals NHS Trust (2007) Management of Chemotherapy Induced Diarrhoea (CID) Guidelines *Chemotherapy Executive Group*

University Hospitals Bristol NHS Foundation Trust (2008) Diagnosis and Management of Patients with Diarrhoea post-transplant *Stem Cell Transplant Programme*

Maloney, A. (2005) Gastrointestinal tract: Diarrhoea Ch.15 pp. 263-266 in *Tomlinson D. & Kline N. (2005) Pediatric Oncology Nursing: Advanced Clinical Handbook* Springer Berlin Heidelberg New York

Medical Research Council (2003) UKALL 2003 UK National randomised trial for children and young adults with acute lymphoblastic leukaemia (A.L.L.) Version 7 August 2009

Cancer Therapy Evaluation Program (2003) Common Terminology Criteria for Adverse Events, Version 3.0, DCTD, NCI, NIH, DHHS March 31, 2003 (http://ctep.cancer.gov), Publish Date: August 9, 2006

Arden Cancer Network (2008) Policy for the Management of Chemotherapy Induced Diarrhoea (Adults) V1

Birmingham Children’s Hospital Oncology Department (2010) Fluid Prescription Oncology Handbook P:\Oncology Department\HANDBOOKS\Specialty Handbook, 3-2010.doc

Gibson R J, Keefe D M K Cancer chemotherapy-induced diarrhoea and constipation: mechanisms of damage and prevention strategies. Support Care Cancer 2006; 14: 890 - 900

7 Equality Impact Assessment

See Appendix

8 Approval, Dissemination and Implementation

8.1 Approval of document

8.2 Dissemination

8.3 Implementation

9 Monitoring Compliance With and the Effectiveness of the policy

9.1 Process for Monitoring Compliance and Effectiveness

9.2 Standards/Key Performance Indicators

10 Associated Documentation

Procedure for the management of body waste and clinical samples from patients receiving cytotoxic drugs

Appendix I

Common Terminology Criteria for Adverse Events v3.0 (CTCAE) March 31, 2003, Publish Date: August 9, 2006

Toxicity	Grade 0	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
Diarrhoea (without stoma)	None	Increase of < 4 stools per day	Increase of < 4 – 6 stools/day or nocturnal stools	Increase of >7 stools/day or incontinence +/- parenteral support	Requires intensive support of haemodynamic collapse	Death
Diarrhoea (with Stoma)	None (normal emptying times)	Mild increase in loose watery output (>1 – 2)	Moderate increase in loose watery output (> 3 – 4)	Severe increase in output, interfering with normal activity	Requires intensive support of haemodynamic collapse	Death

http://ctep.cancer.gov/protocoldevelopment/electronic_applications/docs/ctcaev3.pdf

Appendix D - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		Checklist used for 2012 review
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Unsure	See para. 9.1.
	Is there a plan to review or audit compliance with the document?	No	See para. 9.1.
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date.			
Name		Date	
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Dr Martin English Representing the Chemotherapy Working Group	Date	July 2012
Signature			

Appendix F – Equality Impact Assessment

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

EQUALITY IMPACT ASSESSMENT FORM

SECTION 1:

Department: Haematology Oncology Cancer Service	**Assessor: Jeanette Hawkins Lead Cancer Nurse**
Policy/ Service Title: Guidelines for the prevention and management of chemotherapy and radiotherapy-induced diarrhoea	**Date of assessment: 20th. May 2010**
1. Describe the purpose of this policy or function	• To assist health care professionals to adequately manage differing grades of diarrhoea. • To prevent death • To minimise morbidity and maximise patient quality of life while on treatment • To reduce the need for treatment modification and chemotherapy treatment delays. • To ensure adequate reporting of high grade toxicity to Multi-Disciplinary Team Meetings and where appropriate to Clinical Trial data managers. • To implement a standard assessment tool for grading diarrhoea • To support staff education & training for managing CID N.B. New agents, monoclonal antibodies or therapies used in phase 1 & 2 Clinical trials may have specific monitoring and potential side effects which are not covered in this Guidance document. Personnel should contact the trial principal investigator, oncology research nurses and or oncology specialist pharmacists in such instances.
2. Who is affected by this policy?	Patients referred to BCH Cancer Service for treatment
3. What are the outcomes or intended outcomes of this policy/ function?	• Safe, effective & equitable management of Chemotherapy Induced Diarrhoea • Adequate reporting mechanism particularly for patients treated within Clinical Trials
4. What consultation has been undertaken during the development of this policy/function?	The policy has been developed by the Chemotherapy Working Group after identifying a gap in guidance around this aspect of treatment toxicity while reviewing evidence for National Cancer Peer Review in 2010. Evidence was drawn from request for similar policies in the Pan Birmingham Cancer Network for Adult Cancers and from the Royal College of Nursing Children & Young People Cancer Nurses group. Two policies which are referenced provided a starting point. A literature search was also conducted with support from the BCH Ben Wood Library.

	Advice was sought from the Trust Equality & Diversity Leads to establish whether there were any dietary or cleansing practices for any particular ethnic, religious, cultural groups that needed to be taken into account in developing this policy. The policy was circulated in draft form to Consultants and Senior Nurses within the BCH Cancer Service for comment. Opinion was also sought from the BCH Gastroenterology Service and BCH Infection Control Team. Revisions were made accordingly and a final draft was circulated to the Haematology Oncology Programme Meeting and Cancer Locality Group. A final version was presented to the BCH Integrated Governance Committee and to the Children's Cancer Network Coordinating Group hosted by Pan Birmingham Cancer Network for acceptance as a West Midlands Children's cancer network Policy.
5. What information or evidence has been used to assess the potential impact across the equality strands?	Advice was sought from the Trust Equality & Diversity Leads to establish whether there were any dietary or cleansing practices for any particular ethnic, religious, cultural groups that needed to be taken into account in developing this policy.

IMPACT		
1. What is the impact or likely impact, either positive or negative, of the initiative on individuals, staff, or the public at large? The aim of the policy is to ensure equitable, safe and effective care is provided to all patients referred to BCH Cancer Services who experience this side effect of treatment regardless of race, ethnicity, colour, nationality or national origin.		
2. Please complete the following list and identify if there is, or likely to be, an impact on a group		
a) Grounds of race, ethnicity, colour, nationality or national origins.	Yes ☐ No ☐	Adverse? ☐ Provide further details:
b) Grounds of sexuality or marital status	~~Yes ☐~~ No ☐	Adverse? ☐ Provide further details:

c) Grounds of gender	~~Yes~~ ☐ No ☐	Adverse? ☐ Provide further details:
d) Grounds of religion or belief	Yes ☐ No ☐	Adverse? ☐ Provide further details:
e) Grounds of disability	Yes ☐ ~~No~~ ☐	Adverse? ☐ No Provide further details: Special consideration is given in the policy to patients with disability who may need additional support in managing chemotherapy-induced diarrhoea
f) Grounds of age	Yes ☐ ~~No~~ ☐	Adverse? ☐ No Provide further details: Special consideration is given in the policy in regard to age as babies and children will require additional support in managing chemotherapy-induced diarrhoea, and children and teenagers may feel embarrassed discussing symptoms or requesting support with personal care.
If you have stated that there is an adverse impact a Full Impact Assessment is Required. Complete Section 2.		

SECTION 2:

Modifications
1. If you stated that the policy/ function has or could have an adverse impact on any group, how could you modify it to reduce or eliminate any identified negative impacts?

2. If you make these modifications, would there be an impact on other groups, or on the ability of the policy to achieve its purpose?

Consultation

Under the Race Relations (Amendment) Act 2000 you are required to consult on the impact of new policies, functions and service change.

3. How do you plan to consult on these modifications?

   Specify who would be involved, timescales and methods.

Decision Making

1. Who will make the decision?
2. What is the decision?
   - ☐ Reject the policy/ function
   - ☐ Introduce the policy/ function
   - ☐ Amend the policy/ function
   - ☐ Other (Please explain)

Monitoring and Review

1. How will the implementation of the policy/ function and its impact be monitored?

2. What are the overall learning points from this assessment?
3. What actions are recommended from this assessment?
4. When is the review date?

For advice in respect of answering the above questions, please contact the Equality and Diversity Officer on Ext: 8611. A completed form must be returned with your procedural document.

Appendix G - Version Control Sheet

Version	Date	Author	Comment (Identify any significant changes to the procedural document)
1.0.2	15.02.2011	Jeanette Hawkins – Lead Cancer Nurse	Changes to section 5.10 SCT infection screen section on Page 11 following recommendations by Ursula Nusgen after policy sent to D&TC for ratification.
2.0	July 2012	J.Hawkins	Discussed at Chemo Working Group meeting on 21st June. No revisions required. Amend review dates and re-issue

Appendix H - Plan for Dissemination of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Procedure for the management of spillage of cytotoxic drugs		
Date finalised:	July 2012	**Dissemination lead: Print name and contact details:** Julia Bottle	BCH email Ext: 9143
Previous document already being used?	**Yes / ~~No~~** (Please delete as appropriate)		
If yes, in what format and where?	Paper copies in policy files in key clinical areas within the Specialty		
Proposed action to retrieve out-of-date copies of the document:	Review of all policy files		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
HaemOnc Policy files	JB	P	
Speciality policies'p' drive	JH	E	

Dissemination Record – to be used once document is approved.

Date put on register / library of procedural documents		**Date due to be reviewed**	

Disseminated to: (either directly or via meetings, etc)	**Format (i.e. paper or electronic)**	**Date Disseminated**	**No. of Copies Sent**	**Contact Details / Comments**