Trust Policy		NHS Worcestershire Acute Hospitals NHS Trust

Guideline for the management of systemic anti-cancer therapy (SACT) and radiotherapy induced diarrhoea

Department / Service:	Women & Childrens – Paediatric Oncology
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Accountable Director:	Dr B Kamalarajan
Approved by:	Women & Children's Governance
Date of approval:	15th January 2025
First Revision Due: **This is the most current document and should be used until a revised version is in place**	15th January 2028
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Nursing, medical, pharmacy and support staff in paediatrics
Target staff categories	Paediatric Medical/Nursing and SACT trained staff

Policy Overview:
Assist health care professionals to adequately manage differing grades of diarrhoea Minimise morbidity and maximise patient quality of life during treatment Reduce the need for treatment modification and chemotherapy treatment delays Ensure adequate reporting of high-grade toxicity to the multi-disciplinary team meeting and clinical trial managers where appropriate Advise on assessment tools for grading diarrhoea Support staff education and training for managing chemotherapy-induced diarrhoea

Key amendments to this document

Date	Amendment	Approved by:
May 2012	*No amendments*	*Chemo working group (BCH)*
May 2024	*No amendments*	Systemic Anti-Cancer Therapy Review Group

Contents

1. Aim

The aim of this guideline is to:

- Assist health care professionals to adequately manage differing grades of diarrhoea
- Minimise morbidity and maximise patient quality of life during treatment
- Reduce the need for treatment modification and chemotherapy treatment delays
- Ensure adequate reporting of high-grade toxicity to the multi-disciplinary team meeting and clinical trial managers where appropriate
- Advise on assessment tools for grading diarrhoea
- Support staff education and training for managing chemotherapy-induced diarrhoea

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

Diarrhoea is a common side effect of treatment in adult cancer systemic anti-cancer therapy (SACT) regimens 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.

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 SACT. These intestinal functional changes are thought to be a result of direct toxicity of the chemotherapy on the colonic crypt stem cells. **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.

SACT 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 and depression.

2. SACT 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.

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.

SACT may also cause diarrhoea indirectly:

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

3. 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.

3.1 Example grading criteria (From MRC UKALL 20034)

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

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.

4. Patient, Parent and Carer Information & Education

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

Before starting SACT patients and/or parents should be informed that diarrhoea may occur and what action to take should it do so. Verbal Information is supported with relevant literature as well as the Parent/Carer Information Booklet.

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.

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.

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 Haematology and oncology Parent/Carer Information Booklet.

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

				required

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

5. Patient, Parent and Carer advice on management of diarrhoea

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

- If at home contact BCH or their designated POSCU on the numbers provided in the

Parent/Carer Information Booklet, so that diarrhoea can be documented and further support / information given. The Children and Young People Oncology/Haematology Triage Toolkit V2 (2020) should be used by trained staff when triaging patient and parents' concerns in regards to diarrhoea (Appendix II)

- If the 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
- Commence dietary & hydration management and 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
- Stop all laxatives
- Monitor temperature and report pyrexia
- Monitor diarrhoea and report immediately any increase in stool frequency, or signs of dehydration, low urine output, dry mouth, and sunken eyes or, in a baby, sunken fontanel

6. Pre-SACT 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 / History of constipation
- Patient's use of bowel medications, e.g. laxatives

7. Toxicity Management

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

- Ensure toxicity assessment prior to each cycle of chemotherapy

- 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
- Explain likely cause of diarrhoea to patient / carer. Explain treatment plan. Provide reassurance and support. Educate regarding personal care.
- 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
- Educate and ensure care givers wear gloves when providing personal care to prevent the risk of cross-infection
- Ensure anti-diarrhoea agents are given as prescribed or that carers who are self-medicating understand the medicines and treatment plan
- Monitor and record diarrhoea and associated symptoms (report changes) in frequency, volume, colour, consistency or if they notice the presence of fresh blood / melaena or rectal bleeding or a change in smell, abdominal cramping, pain, nausea or vomiting
- Monitor and record effects of anti-diarrhoea agents and other interventions, e.g. skin care, analgesia
- Observe and report signs of dehydration such as 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 or large base deficit
- Observe and report signs of low sodium levels such as tiredness, disorientation, headaches, muscle cramps or nausea. Severely low sodium can lead to seizures or coma and severely low potassium can cause cardiac arrhythmias.

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 until 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 the BCH Guideline for the prevention, recognition and management of fever in children and young people with cancer Commence replacement intravenous fluids 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

9. Specific Drug Management

9.1 Irinotecan

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.

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.

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.

9.2 Loperamide Dosing

>= 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**.**

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

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.

10. Stem cell transplant specific management

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

Management for all patients with SACT -induced diarrhoea in section 6-7 remains relevant.

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.

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.

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

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

Appendix I – Common Terminology Criteria for Adverse Events v3.0 (CTCAE)

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

March 31, 2003, Publish Date: August 9, 2006

Appendix II

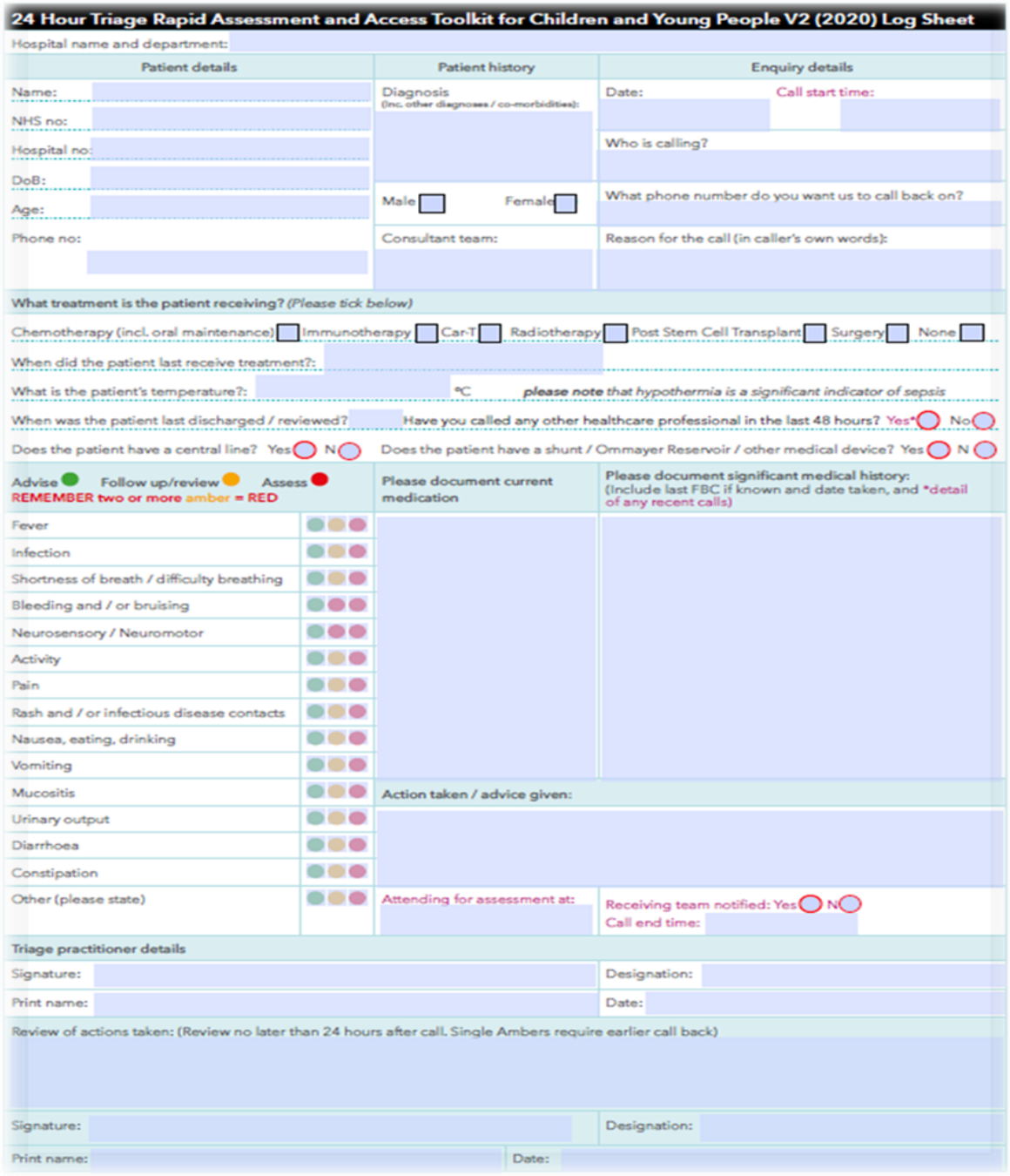
Children and Young People Oncology/Haematology Triage Toolkit V2 (2020)

Children and Young People Oncology / Haematology Triage Tool V2 (2020) Review date: August 2023

Patients may present with problems other than those listed below, these would be captured as "other" on the log sheet checklist. Practitioners are advised to refer to the NCI-CTCAE common toxicity criteria V5.0 to assess the severity of the problem and/or seek further clinical advice regarding management. Caution! Please note patients who are receiving or have received IMMUNOTHERAPY may present with treatment related problems at anytime during treatment or up to 12 months afterwards. If you are unsure about the patient's regimen, be cautious and follow triage symptom assessment.

TOXICITY / SYMPTOM	All green = self care advice	1 Amber = review within 24hrs	2 or more Amber = Escalate to red	Red = Attend for assessment as soon as possible / consider 999	
	0	1	2	3	4
Fever Receiving or has received Systemic Anti Cancer Treatment (SACT) within the last 8 weeks or immunocompromised? Recent Blood count known? On G-CSF? Use Sepsis Six® principles	36ºC – 37.4ºC		37.5ºC-37.9ºC Remain alert and advise to call back if not settling, worsening or additional symptoms	38ºC or above	
	Please note that hypothermia (<36ºC) is a significant indicator of sepsis				
	ALERT: Patients on steroids/analgesia or dehydrated may not present with pyrexia but may still have infection. (If there are signs of sepsis through combination of symptoms in the Tool arrange urgent assessment and review / consider 999)				
Infection Site/ sign of infection? Shivering, chills or shaking episodes- rigor?	None	Site of infection / inflammation, e.g. access device or line, lower abdominal pain. Otherwise generally well. Arrange planned review	Signs of infection e.g. access device or line, abdominal pain, and generally unwell. Arrange for review	Severe symptomatic infection. Arrange urgent assessment and review. Follow sepsis pathway. Consider emergency paramedic support / 999	Potential life threatening sepsis (severe symptoms e.g. difficulty breathing, floppy, altered consciousness, clammy / sweaty skin, extreme discomfort) Arrange paramedic support and emergency care. Discontinue further triage questions
Shortness of breath / difficulty breathing Is it a new symptom? Change in respiratory rate? Accompanied with being pale, ashen, or mottled? Chest pain? Affecting activity level? Cough / wheeze? Choking?	None or no change from normal.		Short of breath on exertion. Arrange for review	Short of breath on normal level of activity. Arrange urgent assessment and review.	Short of breath at rest, agitation, struggling, change of colour, choking, noisy breathing, grunting. Emergency assessment and review. Consider paramedic support.
Bleeding and Bruising Is it a new problem? Is it continuous? Where is it from? Is there any trauma involved? Is the patient on anticoagulants? Blood in urine or stools?	None	Mild, self limiting bleeding controlled by conservative measures. New localised petechiae / bruising. Monitor and arrange planned blood count if on treatment. Escalate to rapid review / blood count if ongoing or less localised.	Non-severe bleeding but not self limiting or keeps restarting. Less localised petechiae / bruising.	Uncontrolled bleeding. Moderate to severe petechiae / purpura / bruising and / or non-blanching spots. Urgent assessment to ward or emergency admissions unit as local policy directs. Consider paramedic support.	
Neurosensory / neuromotor When did the problem start? Is it continuous? Is it getting worse? Is it affecting ability to function? Any constipation or faecal / urinary incontinence? Consider AVPU scoring (Alert, responds to Voice, Responds to Painful Stimulus, Unresponsive)	None	Any new or increased signs of sensory loss, paraesthesia (abnormal sensation, pins & needles), or weakness and / or loss of function, altered gait, or level of consciousness. Any new problems noted with the child's vision. Arrange urgent assessment and review.			
Activity Recent change in activity? Appear or feel generally unwell? Paralysis (consider cord compression) Consider usual levels of activity in assessment, and normal for personal response to stage of current treatment. Consider treatment related fatigue	No change from normal	New mild symptoms. No impact on usual activity. Ensure planned review is scheduled	Symptomatic. Greater restriction on play or normal activities, and less time spent active. Arrange for review	Lying around much of the day. Minimal active play or normal activities. Sleepy, lethargic, floppy. Arrange urgent assessment and review	
Pain Is it a new or worsening problem? Location (consider devices and tumour site)? Intensity? Onset? Triggered by? How long? Patterns, e.g. morning? Pins & Needles? Child's words. Analgesia given and effect? Does patient have shunt, Ommaya Reservoir or other medical devices? Consider with Mucositis symptoms	None or no change from normal. Pain score 0	Mild pain. Not interfering with function or activity. Pain score 1-3 Arrange for review - consider phone review by CNS, ANP or Doctor or next scheduled appt.	Has pain. Pain interfering with function but not activity. Pain score 4-5 Arrange analgesia and review	Severe pain. Pain interfering with function and activity and / or disabling. Repeated Headaches (often worse in the morning) which may or may not affect functioning. Pain score 6-10 Arrange urgent assessment and review. Consider liaising with neuro teams.	
Rash and / or Infectious Disease Contacts Is it localised or generalised? Onset? Duration? Type? Signs of infection? Is it itchy? Close contact with infectious diseases (Chicken Pox, Measles, other) > 15 minutes? Consider post transplant GVHD. Consider increasing petechial rash with low platelets or non-blanching. Consider Burns rule of 9 to assess localised versus widespread as % of body surface area.	No rash or no change from normal. No known infectious contacts or no direct close contact.	Localised rash covering <10% BSA. Otherwise well. Macular: Small, flat spots or blemishes Papular: Small solid bumps rising above the skin. Petechial: flat, pin-prick spots often appearing in clusters. Close contact with infectious disease longer than 15 minutes, but not symptomatic. Arrange planned review, check immune status and consider prophylaxis	Macular or Papular rash covering 10-30% BSA with additional signs and symptoms, e.g. Vesicular: fluid-filled papules often associated with chicken pox Erythema: redness of the skin or mucous membranes Pruritus: severe itching Arrange assessment and review	Generally unwell. Localised or widespread rash >30% BSA and / or sudden onset that does not disappear under pressure i.e. non-blanching. GVHD flare up. Direct infectious disease contact with symptoms. Arrange urgent assessment and review	
Nausea, Eating & Drinking Onset of nausea? Appetite? Duration? Weight loss? Fluid intake in last 48hrs? Thirst? Taking anti-emetics? Impact on wellbeing and activities? Consider against pain grading	No change from normal	Some loss of appetite / mild nausea – still able to eat and drink to near normal intake. Review anti-emetics and dietary advice	Can eat & drink but intake significantly decreased from normal. Moderate nausea impacting activities. Review anti-emetics according to CCLG National Guidelines. Arrange planned review (could include telephone review).	Oral intake significantly decreased, with or without debilitating nausea. Excessive thirst. Prolonged nausea with other concerns from parents e.g. behaviour change, weakness, headache. Arrange urgent assessment and review.	
Vomiting Caution in the case of infants. How many episodes over how many days? Impact on wellbeing and activity? Oral intake? Any particular triggers or patterns, e.g. every morning on waking? Possible infectious causes?	No change from normal	1 episode in 24hr Review anti-emetics as prescribed	2-5 episodes in 24hrs. No change or limited impact on normal activity levels. Normal urinary output. Review anti-emetics according to CCLG National Guidelines for CINV and / or explore infectious causes	Over 6 episodes in 24 hrs. Repeated early morning vomiting; may only be one episode a day. Arrange urgent assessment and review	
Mucositis Onset? Duration? Severity? Mouth ulcers, white patches on mucosa? Coated tongue? Red inflamed gums? Consider mixed symptoms & potential for systemic fungal infections, esp. post haematopoietic stem cell transplantation (HSCT). Consider personal history of post-treatment mucositis.	None	Painless ulcers, mild redness, mild soreness. Patient able to eat, drink and talk as normal. Discuss mild analgesics and mouthcare. Personal history of pattern of severe post-treatment mucositis - escalate to amber	Painful ulcers, redness, sore mouth. Able to maintain some fluids and soft diet. Arrange planned review. Discuss analgesia and mouthcare until reviewed.	Painful, sore mouth. White patches and / or multiple ulcers. Significant decrease in fluids and diet, and / or difficulty talking and swallowing. Arrange urgent assessment and review	
Urinary output **Passing urine / nappies wet? Colour of urine? Are they drinking normally? Pain / discomfort?** Consider urinary obstruction in certain tumour types. Consider infection.	No change from normal Normal urine output. Clear light straw coloured urine		Reduced urine output / nappies less wet. Urine colour dark. Discomfort Arrange planned review. Advise increasing fluid intake.	Poor or absent urine output / dry nappies. Dark urine. Sunken fontanelle in babies. Few or no tears when crying. Dry mouth. Drowsy. Pain. Arrange urgent assessment and review	
Diarrhoea Caution in the case of infants. Onset? Duration? Severity? Abdominal pain / discomfort? Any medication to relieve? Consider post haematopoietic stem cell transplantation (HSCT) N.B. Patients receiving immunotherapy should be managed according to the drug specific pathway and assessment arranged as required.	None or no change from normal	2-3 bowel movements a day above normal pattern. Drink more fluids. Consider stool sample in line with local policy. Consider regimen specific anti-diarrhoeal.	4-6 episodes a day over usual pattern or nocturnal bowel movements and / or moderate cramping. Drink plenty of clear fluids. Consider stool sample in line with local policy. Consider regimen specific anti-diarrhoeal. If diarrhoea persists after taking regimen specific antidiarrhoeal escalate to red. If patient is or has been on immunotherapy escalate to red	7 episodes or more a day above normal pattern or severe cramping and / or bloody diarrhoea. Patient is or has been on immunotherapy. Arrange urgent assessment and review.	
Constipation Is the patient on regular laxatives? Assess change from normal bowel pattern. How long since bowels opened? Does the patient have any abdominal pain/vomiting? Is the patient eating/ drinking normally? Note: Bristol stool chart can be used to assess bowel movement	None	Mild constipation - no bowel movement in the last 24hrs and different from normal pattern. Dietary advice. Increase fluid intake. Review medication.	Moderate - no bowel movement for 48-72 hrs above normal pattern despite active intervention (Medication). If associated with pain / vomiting escalate to red If not, review fluid and dietry intake. Recommend laxatives	Severe- 72 hours or more of no bowel movement with associated symptoms, e.g. Pain and / or nausea / vomiting / headache. Arrange urgent assessment and review.	
Other	None or no change from normal	Mild self limiting concerns able to be managed by non-triage related advice or reminder of existing advice and adherence to advice / medicines	Concerns not otherwise listed above which require non urgent planned review. This could include further telephone review with CNS, ANP or Doctor	Major concern not otherwise covered above. Arrange urgent assessment and review.	

24 Hour Triage Rapid Assessment and Access Toolkit for Children and Young People V2 (2020) Log Sheet



24 Hour Triage Rapid Assessment and Access Toolkit for Children and Young People V2 (2020) Log Sheet

Hospital name and department:

Patient details	Patient history	Enquiry details
Name:	Diagnosis (Inc. other diagnoses / co-morbidities):	Date: Call start time:
NHS no:		Who is calling?
Hospital no:		
DoB:	Male ☐ Female ☐	What phone number do you want us to call back on?
Age:		
Phone no:	Consultant team:	Reason for the call (in caller's own words):

What treatment is the patient receiving? *(Please tick below)*

Chemotherapy (incl. oral maintenance) ☐ Immunotherapy ☐ Car-T ☐ Radiotherapy ☐ Post Stem Cell Transplant ☐ Surgery ☐ None ☐

When did the patient last receive treatment?:

What is the patient's temperature?: °C ***please note*** *that hypothermia is a significant indicator of sepsis*

When was the patient last discharged / reviewed? Have you called any other healthcare professional in the last 48 hours? Yes* ◯ No ◯

Does the patient have a central line? Yes ◯ N ◯ Does the patient have a shunt / Ommayer Reservoir / other medical device? Yes ◯ N ◯

Advise ● Follow up/review ● Assess ● REMEMBER two or more amber = RED		Please document current medication	Please document significant medical history: (Include last FBC if known and date taken, and *detail of any recent calls)
Fever	● ● ●		
Infection	● ● ●		
Shortness of breath / difficulty breathing	● ● ●		
Bleeding and / or bruising	● ● ●		
Neurosensory / Neuromotor	● ● ●		
Activity	● ● ●		
Pain	● ● ●		
Rash and / or infectious disease contacts	● ● ●		
Nausea, eating, drinking	● ● ●		
Vomiting	● ● ●		
Mucositis	● ● ●	Action taken / advice given:	
Urinary output	● ● ●		
Diarrhoea	● ● ●		
Constipation	● ● ●		
Other (please state)	● ● ●	Attending for assessment at:	Receiving team notified: Yes ◯ N ◯ Call end time:

Triage practitioner details

Signature: Designation:

Print name: Date:

Review of actions taken: (Review no later than 24 hours after call. Single Ambers require earlier call back)

Signature: Designation:

Print name: Date:

References

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

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non-compliance)	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
P1	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	Name	Job title	e-mail contact
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title:			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ ❑ ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____

Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age				
Disability				
Gender Reassignment				
Marriage & Civil Partnerships				
Pregnancy & Maternity				
Race including Traveling Communities				

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Religion & Belief				
Sex				
Sexual Orientation				
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		

How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact AssessmenT
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.