ALGORITHM FOR THE MANAGEMENT OF INFECTION IN PAEDIATRIC HAEMATOLOGY AND ONCOLOGY PATIENTS

Appendix 1 - full details in text

T = 0 hours
Commence Piperacillin with tazobactam (+/- Gentamicin)

T = 48 hours

Blood cultures NEGATIVE          Blood cultures POSITIVE                 Blood cultures NEGATIVE
Fever settling                    Fever persists

Fever settling
Blood cultures NEGATIVE
Consider stopping antibiotics if Blood Cultures negative
OR Continue planned course of antibiotics for positive cultures

Blood cultures POSITIVE
Treat with appropriate antibiotics for 7 – 10 days
Review necessity for nephrotoxic drugs

Blood cultures NEGATIVE
Clinical review
Reculture - repeat CRP
If patient remains stable continue on 1st line antibiotics
Do not discharge unless apyrexial

CLINICAL DETERIORATION

Blood cultures negative
Review cultures and sensitivities. Consider:
  • Changing antibiotics if appropriate
  • line removal in clinically unstable or microbiologically indicated
  • Adding/changing antifungal treatment

Blood cultures positive
REMOVE LINE unless clear alternative source of infection or very good reason not to remove line. Review cultures and sensitivities. Consider:
  • Changing antibiotics if appropriate
  • Adding/changing antifungal therapy

ASSESS A, B, C
MEMO SEPSIS SIX:
- OXYGEN
- FLUIDS
- CULTURES
- IV ANTIBIOTICS
- BLOODS
- URINE OUTPUT

Add Teicoplanin/Vancomycin if line infection

Review necessity for nephrotoxic drugs

Add Teicoplanin/Vancomycin if line infection
Clinical Guideline for the management of infection in Paediatric Haematology and Oncology Patients

1. Aim/Purpose of this guideline
   1.1 This information is a guideline dealing with the management of presumed infection in the immunocompromised child. Children undergoing treatment for cancer are at increased risk of infections as a result of their disease as well as its treatment.
   1.2 This guideline applies to all nursing and medical staff caring for children undergoing treatment for cancer and their families.

2. The Guidance

Definition of Neutropenic sepsis

Diagnose neutropenic sepsis in patients having anticancer treatment where neutrophils $\leq 0.5 \times 10^9/\text{litre}$ and who have either:
- temperature $>38^\circ\text{C}$
- other signs or symptoms consistent with clinically significant sepsis (e.g. unexplained abdominal pain or generally unwell)

2.1 There are several factors which can influence the risk of infection:

- The disease itself
- Presence of an indwelling central venous line
- Duration and severity of neutropenia
- Length of treatment and prolonged immunosuppression
- Presence of chemotherapy-related toxicity e.g. mucositis

Delay in starting antibiotics may prove fatal. Treat suspected neutropenic sepsis as a medical emergency and offer empiric antibiotics immediately. These children must be seen and treated WITHIN 60 MINUTES.

Parents should not administer paracetamol/ibuprofen to their child prior to admission as this may mask a fever.

All patients MUST be managed as in-patients for the first 48 hours until blood culture results are available and it has been established that the child is stable.

2.2 Initial investigation of neutropenic sepsis

Take a brief history, taking note of:

- The diagnosis
- Date and type of last chemotherapy
- Last known blood count
- Duration of fever
- Presence of central line
- Any bleeding/mucositis/pain/local cause for fever
A full clinical examination looking for any site of sepsis must include:

- Examination of central venous access device for exit-site or tunnel infection
- Examination of mouth for mucositis
- ENT examination
- Assessment of nappy area/perineum

Baseline Investigations must include:

- Full blood count (FBC) + differential
- Routine biochemistry and baseline C-reactive protein (CRP) and lactate (if appropriate)
- Blood cultures from each lumen of the central venous line (~5mL), or peripherally (if appropriate)
- Urinalysis in all children < 5 years

If clinically indicated:

- Chest X-ray (CXR) if symptomatic or chest signs present
- Computerised tomography (CT) of chest if suspicion of fungal infection (as more sensitive than CXR)
- Urine microscopy and culture (consider as "routine" in younger children and infants)
- Swabs from sites of clinical infection only
- Clotted blood for viral and atypical serology
- EDTA blood for viral polymerase chain reaction (PCR)
- Throat swab or other respiratory tract sample for viral PCR

For fever with acute diarrhoea and/or vomiting add:

- Stool culture and sensitivities
- Stool virology, *Clostridium difficile* toxin, *cryptosporidia*
- Ensure form has NEUTROPENIC written on it

For fever with possible or definite respiratory tract infection add:

- Sputum (if produced) or
- Nasopharyngeal aspirate (NPA)
- Send one sample for bacterial culture and one sample for direct immunofluorescence and respiratory virus PCR

2.3 Empirical Treatment of neutropenic sepsis

See Appendix 1 Algorithm for the Management of Febrile Neutropenia in a Paediatric Haematology/Oncology patient and Appendix 2 for drug doses

Be cautious when prescribing potentially nephrotoxic antibiotics in children at increased risk of nephrotoxicity secondary to chemotherapy.

**Time (T) = 0 hours**

Commence:

- **Piperacillin with tazobactam (Tazocin)** 90mg/kg (max 4.5 gram per dose) intravenously 4 x per day as monotherapy
  
  If allergy reported to penicillin then see section on patients with a documented penicillin allergy.

- Add **Gentamicin** if haemodynamically compromised or microbiologically indicated.
• **Gentamicin guidance:**
  - After the first dose of gentamicin, check the level prior to subsequent doses and await the result before giving further doses of gentamicin. Liaise with Clinical Chemistry to ensure result timely and doses are not delayed.
  - Seek Consultant/ senior paediatrician advice if there are any concerns about known renal impairment or failure in any of the patients before prescribing aminoglycosides.
  - If gentamicin level > 1.0, do not administer any further aminoglycoside until discussed with Consultant/senior paediatrician. Pharmacist available for advice (Out of hours contact on call Pharmacist).

• Add **Teicoplanin** if there is clinical evidence or suspicion of line sepsis or a tunnel infection.
  - If there is evidence of infection resistant to teicoplanin start Vancomycin (caution in renal impairment).
  - **NOTE:** The first dose of antibiotics can precipitate septic shock

**Patients with documented penicillin allergy:**

<table>
<thead>
<tr>
<th>Non-anaphylactic allergy</th>
<th>IV Ceftazidime +/− gentamicin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaphylactic allergy (anaphylaxis, urticarial or rash immediately after administration of beta-lactam)</td>
<td>IV Ciprofloxacin +/− gentamicin +/− vancomycin</td>
</tr>
<tr>
<td></td>
<td>If patient is on ciprofloxacin prophylaxis discuss with Microbiologist.</td>
</tr>
</tbody>
</table>

**T=48 hours, reassess**

**Gentamicin** - stop unless clinical or microbiological indication to continue.

**Blood cultures positive: fever settling**

- Treat with appropriate antibiotics for a minimum 7-10 days depending on organism isolated and microbiological advice. Confirm that blood cultures are negative before considering stopping IV antibiotics.

**Blood cultures positive: fever persists**

- Clinical review
- Reassess all microbiology results and sensitivities, discuss with a microbiologist
- Repeat blood cultures and CRP
- If patient stable do not change antibiotics
- If patient unstable consider changing 1st line antibiotics or adding Teicoplanin/Vancomycin or antifungal treatment if appropriate.
- In the absence of improvement consider removing the central line, particularly if blood cultures are positive for organisms such as *Staphylococcus aureus, Pseudomonas aeruginosa* or *Candida sp*. Discuss whether to remove the line with Consultant/senior paediatrician if child is clinically unstable.

**Blood cultures negative: fever persists**

- Clinical review, repeat blood cultures and CRP
- Do not change tazocin unless indicated but always try to stop gentamicin at 48 hours if clinically stable even if still febrile
• Review regarding potential viral infection
• If patient well and considered “low risk”, consider if eligible for step down to oral antibiotics

“LOW RISK” PATIENTS – switching from intravenous to oral antibiotic treatment
It may be appropriate to consider switching from intravenous to oral antibiotic therapy in patients whose risk of developing septic complications has been reassessed as low by a healthcare professional with competence in managing complications of anticancer treatment using a Low Risk Stratification Checklist.

The oral antibiotic of choice is coamoxiclav.

This should only be considered if the patient still meets the low risk criteria at T=48 hours and a system is in place for follow-up contact as follows:
24 hours from discharge (T=72 hours) – telephone contact and review if clinically indicated
48 hours from discharge (T=96 hours) – clinical review +/- bloods

IF THERE IS ANY CLINICAL DETERIORATION OR PARENTAL CONCERN THE CHILD MUST BE REVIEWED IMMEDIATELY.

Blood cultures negative: fever settled
• If clinically well stop intravenous antibiotics and arrange discharge.

At T= 96 hours, reassess. If fever persists:

Blood cultures positive:
• Clinical review, repeat blood cultures and CRP
• Review cultures and sensitivities and consider changing antibiotics if appropriate
• Consider adding/changing antifungal therapy
• With persistent evidence of infection that is not responding to treatment it may be necessary to arrange removal of the central venous line. Discuss whether to remove the line with Consultant/senior paediatrician if child is clinically unstable.

Blood cultures negative
• Clinical review, repeat blood cultures and CRP
• Remove line if clinically unstable
• Consider adding/changing antifungal therapy

2.4 Stopping Antibiotics when patients are not following the low risk “step down” strategy.
Patients can usually be discharged after stopping antibiotics. Parents should be warned to bring the child back if she/he becomes febrile or unwell.

Blood Cultures Positive
• Continue minimum of 7-10 days of appropriate intravenous antibiotics from the start of treatment. Once child’s condition is stable and antibiotic sensitivities have been confirmed it may be possible for the course of antibiotics to be completed at home or by attending the ward on a daily basis. Home antibiotics may be administered by a CLIC nurse or by a parent who has been trained in IV drug administration. Such arrangements must always be by prior discussion with Consultant/senior paediatrician.
Certain infections e.g. *Staphylococcus aureus*, *Pseudomonas aeruginosa* or Aspergillus/Candida, will require more prolonged treatment and often removal of central venous line. Discuss with microbiologist as necessary.

Child should be afebrile and well with negative cultures before antibiotics are stopped, preferably with rising neutrophil count and a stable or decreasing CRP.

### Blood Cultures Negative
- Stop antibiotics once afebrile for 48 hours provided child is well.
- Consider stopping antibiotics if alternative cause for fever identified eg RSV.

#### 2.5 Management of Presumed Fungal Sepsis
- If fungal infection is suspected the patient MUST be discussed with the Principal Treatment Centre.
- The most common fungal infections seen are Candidiasis and Aspergillosis.
- Candida may cause skin and or mucosal infection such as oesophagitis, or systemic disease with fever, jaundice and occasionally pulmonary infiltrates.
- Aspergillus usually presents with pulmonary infiltration or rhino-sinusitis and occasionally CNS disease.

Children at greater risk of fungal infection include:
- Children with prolonged periods of neutropenia
- Patients who have received more than one course of intravenous antibiotics
- Children with underlying immunodeficiencies.
- Children on “high risk” protocols e.g. high risk Neuroblastoma, AML or infant ALL.

### Investigations
Fungal infection can be difficult to prove as blood cultures are often negative.
- Cultures of blood, urine, sputum and/or Broncho-alveolar lavage (BAL), serology for Candida and Aspergillus should be performed (discuss with Microbiologist).
- CT scan of chest +/- sinuses plus ultrasound scan of abdomen should be undertaken
- Beta glucan test on serum sample (high negative predictive value, although not for mucormycosis or BAL)
- Aspergillus antigen test on serum sample or BAL
- Aspergillus specific PCR (still investigational so discuss on individual basis)
- For proven infection with Candida consider Ophthalmology assessment

### Treatment
- Treatment is usually with **AmBisome** (do not forget test dose)

### Stopping antifungals
**Where there is no definitive evidence for fungal infection,**
- Stop antifungal therapy when patient has been afebrile for 3 days with a rising neutrophil count and discharge (this is usually 24 hours after stopping antibiotics)

**Where there is clear evidence for fungal infection,**
- Complete a minimum of 14-21 days of antifungal therapy and reassess sites of disease with appropriate investigations to confirm resolution of infection.
2.6 Fevers in non-neutropenic, immunosuppressed patients

- The child should be assessed and should be treated according to clinical findings.
- If the child is unwell first line IV antibiotics must be started immediately.
- The minimum investigations are full blood count, routine biochemistry, CRP and blood cultures from all lumens of the central line.
- If the child is well and no site of infection is found clinically it may be possible to send him/her home pending culture results. If this is any doubt admit the child for observation.
- If line sepsis is suspected start empirical antibiotics irrespective of neutrophil count and await cultures.
- For central venous access device exit site or tunnel infections give 7-10 days of treatment depending on the organism isolated.
- Well, non-neutropenic children with Gram-positive line infections can often be managed at home with IV teicoplanin provided sensitivity demonstrated.
- Consider Pneumocystis jirovecii (previously known as Pneumocystis carinii) in a child with leukaemia or relapsed Hodgkin’s disease who has missed cotrimoxazole prophylaxis. NB patients infected with Pneumocystis jirovecii will give a positive beta-glucan test which can help in diagnosis, although it is non-specific and fungal infections cannot be excluded.

Management of Central Line Tunnel or Exit Site Infections

- Blood cultures should always be taken from all lumens of central venous line irrespective of the clinical status of the child.
- Exit site swab should be taken.
- Ensure that the line is secure to prevent it being accidentally dislodged whilst the area is inflamed and infected.
- When giving intravenous antibiotics through the central lines, ensure that alternate lumens are used.

Management:

If the child is AFEBRILE and NOT Neutropenic with exit site infection:

- Antibiotics may be given orally if the child is well and blood cultures negative and where there is no evidence of tracking along the skin tunnel eg flucloxacillin/clarithromycin.

If the child is FEBRILE and NOT Neutropenic with exit site infection:

- Teicoplanin/vancomycin alone could be used as first line, if this was felt to be clinically appropriate.
- 1st line IV antibiotics should be started plus teicoplanin/vancomycin if the child is clinically unwell.

If the child is FEBRILE and NEUTROPENIC with exit site infection:

- Treatment should be commenced with Piperacillin with tazobactam (e.g. Tazocin) +/- Teicoplanin/vancomycin +/- Gentamicin (if clinically indicated).

If the child is AFEBRILE and NEUTROPENIC with exit site infection:

- Provided the child is well, Teicoplanin alone could be used as first line
- 1st line IV antibiotics should be started plus teicoplanin/vancomycin if the child is clinically unwell
Specific Infections:

**Clostridium difficile and patient with diarrhoea**
- Patients with *Clostridium difficile* toxin positivity should be treated with ORAL metronidazole and subsequently changed to ORAL vancomycin if there is no response.
- If symptoms are severe give ORAL vancomycin first.
- If complicated or life threatening, it may be necessary to give both oral vancomycin and IV metronidazole. Seek appropriate advice.
- Treat for minimum of 10 days.

**Perineal Infection**
- Have a high index of suspicion for Gram negative infection
- Repeat blood cultures and swabs
- Treat with empirical antibiotic regime and consider the addition of metronidazole.
- If still febrile at T=96 hours consider antifungal therapy (discuss with Principle Treatment Centre)

**Mucositis/Stomatitis** – see Mucositis guideline

**Varicella zoster** – see VZ guideline

**Appendices**
- **Appendix 1** Algorithm for suggested management of a haematology or oncology patient presenting with febrile neutropenia
- **Appendix 2** Commonly used drugs with their dosing schedules
## Appendix 2 – commonly used drug doses

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose and frequency</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Piperacillin/tazobactam (Tazocin)</td>
<td>IV</td>
<td>90mg/kg max 4.5 grams 6 hourly</td>
<td></td>
</tr>
<tr>
<td>Gentamicin</td>
<td>IV</td>
<td>3-7mg/kg od (based on renal function as per RCHT Paediatric Antibiotic Guideline)</td>
<td>Based on dosing weight See main guidance for advice on levels</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>IV</td>
<td>10mg/kg 8 hourly Max 400mg 8 hourly</td>
<td></td>
</tr>
<tr>
<td>Teicoplanin</td>
<td>IV</td>
<td>&lt;70kg 10mg/kg 12 hourly for 3 doses then every 24 hours Max 400mg/dose &gt;70kg As per BNF</td>
<td></td>
</tr>
<tr>
<td>Vancomycin</td>
<td>IV</td>
<td>15mg/kg 8 hourly Max total daily dose 2 grams (based on renal function as per RCHT Paediatric Antibiotic Guideline)</td>
<td>Pre dose levels prior to 4th dose unless renal impairment when levels are needed more frequently. Use ideal body weight for obese patients</td>
</tr>
<tr>
<td>Ceftazidime</td>
<td>IV</td>
<td>50mg/kg 8 hourly Max 2 gram/dose</td>
<td></td>
</tr>
<tr>
<td>Ambisome</td>
<td>IV</td>
<td>Treatment dose: 3mg/kg – may be increased to 5mg/kg in severe infection – once daily Memo test dose = 100micrograms/kg up to max 1mg Empirical dose: 1mg/kg (inclusive of test dose) – once daily</td>
<td>Caution in renal impairment – see BNFC</td>
</tr>
</tbody>
</table>
2. Monitoring compliance and effectiveness

| Element to be monitored | Needle to door time  
| CVL infection rates |
| Lead | Dr Katrina Macdonald, Dr Shama Goyal, Sabrina Tierney |
| Tool | Audit |
| Frequency | 3 yearly |
| Reporting arrangements | Child Directorate Audit and Guidelines Meeting |
| Acting on recommendations and Lead(s) | Child Health |
| Change in practice and lessons to be shared | Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders. |

3. Equality and Diversity

3.1 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

3.2 **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Clinical guideline for the management of infection in paediatric haematology and oncology patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>17.03.2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>17.03.2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>March 2019</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Dr Katrina Macdonald, Sabrina Tierney  
<p>| Dr Shama Goyal |
| Contact details: | 01872 252069 |</p>
<table>
<thead>
<tr>
<th>Brief summary of contents</th>
<th>Clinical guideline for the management of infection in paediatric haematology and oncology patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggested Keywords:</td>
<td>Paediatric Haematology Oncology Neutropenic Sepsis</td>
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<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>7.03.2016</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Clinical guideline for the management of infection in paediatric haematology and oncology patients</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Paediatric consultants Child Health Directorate Audit and Guidelines</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td></td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
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</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name:</td>
<td>Child Health Audit and Guidelines Meeting</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
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<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Child Health – Paediatric Policies and Guidelines</td>
</tr>
<tr>
<td>Related Documents:</td>
<td>Bristol Royal Hospital for Children. Clinical guideline – Management of infections in paediatric haematology and oncology patients</td>
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</table>
Training Need Identified? No

**Version Control Table**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>July 2013</td>
<td>V 1.0</td>
<td>Initial Issue</td>
<td>Dr Katrina Macdonald Sabrina Tierney Dr Shama Goyal</td>
</tr>
<tr>
<td>Sept 2013</td>
<td>V2.0</td>
<td>Re format in trust template and addition of governance sheet and EIA</td>
<td>Tabitha Fergus Deputy Ward Manager</td>
</tr>
<tr>
<td>17th March 2016</td>
<td>V3.0</td>
<td>Guideline updated</td>
<td>Dr Katrina Macdonald Sabrina Tierney Dr Shama Goyal</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

**Controlled Document**
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**Appendix 2. Initial Equality Impact Assessment Form**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of strategy / policy / proposal / service function to be assessed (hereafter referred to as policy)</td>
<td>(Provide brief description): Guideline for referring new, relapsed and routine Paediatric Haematology/ Oncology patients to Bristol Royal Hospital for Children</td>
</tr>
<tr>
<td>Directorate and service area</td>
<td>Is this a new or existing Policy? Existing guideline adjusted following suggestions following Paediatric SIM.</td>
</tr>
<tr>
<td>Child Health</td>
<td></td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Telephone: 01872 252069</td>
</tr>
<tr>
<td>Dr K. Macdonald</td>
<td></td>
</tr>
</tbody>
</table>
1. **Policy Aim***
Who is the strategy / policy / proposal / service function aimed at?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>To provide clear guidance and treatment plans for management of infection in paediatric patients in haematology and oncology</td>
</tr>
</tbody>
</table>

2. **Policy Objectives***

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>To provide clear guidance and treatment plans for management of infection in paediatric patients in haematology and oncology</td>
</tr>
</tbody>
</table>

3. **Policy – intended Outcomes***
Standardised care using best evidence.

4. **How will you measure the outcome?**
Audit

5. **Who is intended to benefit from the policy?**
Children and families accessing care in haematology and oncology.

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?
b) If yes, have these *groups been consulted?*  
C). Please list any groups who have been consulted about this procedure.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no</td>
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</tbody>
</table>

7. **The Impact**
Please complete the following table.

Are there concerns that the policy *could* have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
<td>X</td>
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</tr>
<tr>
<td><strong>Disability</strong> - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td><strong>Religion / other beliefs</strong></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. **or**
- Major service redesign or development

<table>
<thead>
<tr>
<th>8. Please indicate if a full equality analysis is recommended.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>X</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. If you are not recommending a Full Impact assessment please explain why.

**No Impact**

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Katrina Macdonald</td>
<td>2016</td>
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<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
</tbody>
</table>

### Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD
A summary of the results will be published on the Trust’s web site.
Signed   Dr Katrina Macdonald
Date 17.3.16