journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Clostridium Difficile Associated Diarrhoea (CDAD)

Ref: IPC-0001-004-v4.1

Status: Approved
Document type: Procedure
Overarching policy: IPC Policy

Contents

1 Introduction

This procedure is critical to the delivery of OJTC and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us deliver our three strategic goals as follows:

This procedure supports the trust to co- create a great experience for all patients, carers and families from its diverse population by ensuring access to the care that is right for you through controlling and managing any incidence of Clostridium difficile infection.

This policy supports the trust to co-create a great experience for our colleagues by providing advice and support to clinical teams when caring for a patient with suspected or confirmed Clostridium difficile infection.

This policy supports the trust to be a great partner by working across all disciplines of the trust and external organisations

To co-create a great experience for our patients, carers and families, so you will experience:
- **Outstanding** and compassionate care, all of the time.
- **Access** to the care that is right for you.
- **Support** to achieve your goals.
- **Choice** and control.

To co-create a great experience for our colleagues, so you will be:
- **Proud**, because your work is meaningful.
- **Involved** in decisions that affect you.
- **Well led** and managed.
- That your workplace is **fit for purpose**.

To be a great partner, so we will:
- Have a **shared understanding** of the needs and the strengths of our communities
- Be **working innovatively** across organisational boundaries to improve services.
- Be **widely recognised** for what we have achieved together.

2 Purpose

Following this procedure will help the Trust to:-

- Prevent the spread and reduce the level of *Clostridium difficile* infection (CDI)
- Manage a patient with *Clostridium Difficile* infection

3 Who this procedure applies to

This procedure will apply to all patients who are clinically suspected of having clostridium diffcile infection.

Respect
- Listening
- Inclusive
- Working in partnership

Compassion
- Kind
- Supportive
- Recognising and Celebrating

Responsibility
- Honest
- Learning
- Ambitious

4 Related documents

The Standard (Universal) Precautions for Infection Prevention and Control defines the universal standards for IPC which you **must** read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

- Hand Hygiene
- Waste Management Policy
- Outbreak
- Laundering and Safe Handling of Linen and Clothing
- Decontamination of equipment

5 What is Clostridium Difficile

Clostridium difficile is an anaerobic, gram-positive spore forming bacillus. *Clostridium difficile* spores are resistant to exposure to air, drying, and heat and they can survive in the environment without nutrients for long periods of time. They are also resistant to general detergents and higher levels of cleaning must be instigated when dealing with patients who are symptomatic.

Clostridium difficile is a bacterium found in the intestines. *Clostridium difficile* can be found in the gut of healthy people where it causes no symptoms. Statistics illustrate carriage in 3% of adults, 7% of residents in long-term care facilities, 14-20% of older people on hospital wards and 66% of healthy children under 2 years.

Clostridium difficile infection (CDI) occurs when the normal bacterial flora of the bowel is altered this allows *Clostridium difficile* to flourish and produce toxins which attack the intestines and cause diarrhoea

The primary cause of CDI is antibiotic exposure. Gastro-intestinal surgery also increases a person's risk of developing the disease. A long length of stay in healthcare settings and immuno-suppression leads to an increase in patients who are carriers.

All age groups can be affected; however, the elderly and other vulnerable patient groups especially those that have been exposed to antibiotics are most at risk.

Children under the age of 2 years **are not** usually affected but they are frequently asymptomatic carriers.

6 Clinical features of CDI

- The illness ranges from mild self-limiting diarrhoea to explosive watery, green coloured and foul-smelling diarrhoea.
- Other symptoms include abdominal swelling, high temperature, lethargy and loss of appetite.
- Symptoms are usually (but not always) associated with antibiotic therapy.
- The patient may also have fever and abdominal cramps.
- Occasionally *Clostridium difficile* can lead to potentially fatal pseudo membranous colitis and perforation of the bowel.

6.1 Diagnosis in an Inpatient Setting

Clostridium difficile **must** be managed as a diagnosis in its own right

Clinicians (doctors and nurses) should apply the following mnemonic protocol **(SIGHT)** when managing suspected potentially infectious diarrhoea.

Re-testing of cases **should not** be carried out within 28 days of a positive result unless specifically requested by the Physician, Microbiologist. Or Infection Prevention Control team,

S	**Suspect** that a case may be infective where there is no clear alternative cause for diarrhoea for example aperients and laxatives. Refer to the Bristol Stool Chart (Appendix 1).
I	**Isolate** the patient (if practicable) and consult with the infection prevention control team (IPCT) while determining the cause of the diarrhoea
G	**Gloves** and aprons must be used for all contacts with the patient and their environment
H	**Hand** washing with soap and water must be carried out before and after each contact with the patient and the patient's environment. **Alcohol hand gel is not effective in removing spores from staffs' hands.**
T	**Test** the stool for Clostridium difficile, by sending a specimen immediately to the nearest microbiology laboratory.

If the initial test is negative but symptoms persist, discuss with the infection control nurse who will gain further advice from a Consultant microbiologist/Infection control doctor

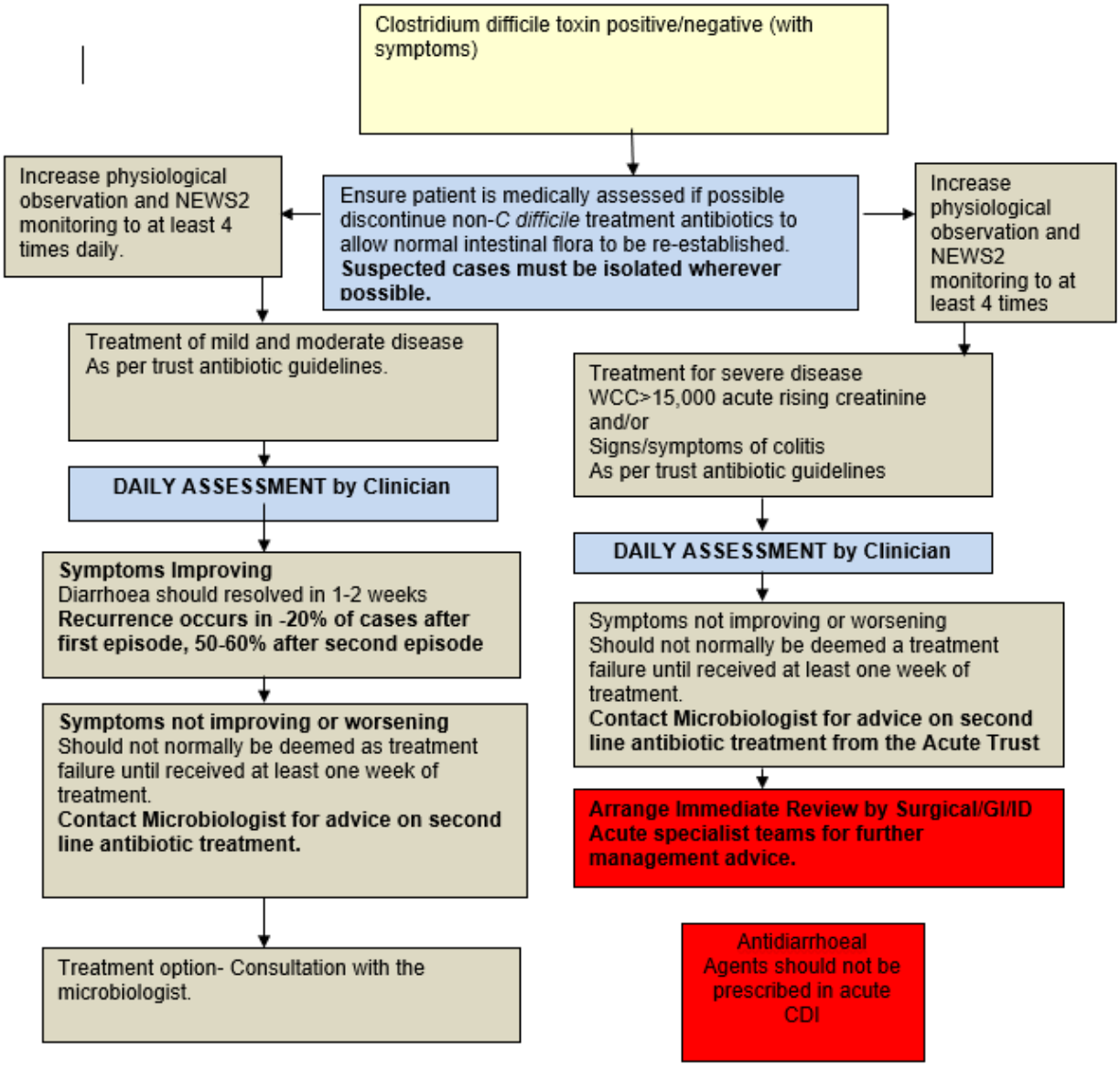
6.2 How the infection is spread

- Transmission can be directly spread from patient to patient by the faecal oral route.
- Indirectly spread via the hands of healthcare workers.
- Or via environmental contamination including health care equipment (physiological monitoring equipment, beds, mattresses, chairs, hoists etc) and toilet facilities.

7 Management of patients with Clostridium Difficile Infection (CDI)

All patients with Clostridium *difficile* infection must be managed using the agreed pathway

C Difficile Pathway



7.1 Assessing the severity level of CDI

The clinician (Physical health practitioner and/or medical staff) **must** assess the severity of CDI **daily** and liaise regularly with the multidisciplinary team including the IPC team to ensure the patient receives holistic care and appropriate treatment.

Severity of CDI			
Mild CDI	**Moderate CDI**	**Severe CDI**	**Life-threatening CDI**
Is not associated with a raised White cell count (WCC).	Associated with a raised WCC that is <15,000.	Associated with a WCC >15,000 or a temperature of >38.5 degrees C or an acute rising serum creatinine (i.e., >50% increase	Includes hypotension, partial or complete ileus or toxic megacolon or CT evidence of severe disease.

		above baseline), or evidence of severe colitis (abdominal or radiological signs)	
Typically associated with 3 or fewer type 5 – 7 stools per day using the Bristol Stool Chart (Appendix 1) as reference.	Typically associated with 3 – 5 type 5-7stools per day	The number of stools may be a less reliable indicator of severe disease but if the patient is passing >5 unformed (type 5-7) stools per day the disease should be classified as severity **The patient does not necessarily have to have all the above criteria to be defined.**	Daily assessment must be documented in the medical notes.

If any patient displays symptoms of severe or life-threatening CDI, medical staff must consult a microbiologist/gastroenterologist/surgeon for immediate advice.

7.2 Treatment of CDI

All medications including antibiotics and other drugs should be reviewed by the patient's medical Doctor or Physical Health Practitioner and stopped if deemed appropriate. (see Appendix 3).

- CDI **must be** managed as a diagnosis.
- Any current antibiotic treatment should be reviewed to ensure it is still required and prescribed in line with the trust's antibiotic guidance/policy.
- Treatment for CDI should follow guidance stated in point 7.3 below
- Each patient **must be** monitored daily for signs of increasing disease severity. Consideration will be given to the requests of the service user with regards to the gender of the staff member who may monitor their symptoms.
- Each patient **must be** reviewed daily by a physical health practitioner and/or medical staff, fluid intake, electrolyte replacement and nutritional status must be included in the daily review.
- All bowel movements must be recorded on the patient's bowel chart Appendix 4
- Clinicians and Infection Prevention and Control Nurses (IPCN) caring for patients in a mental health/learning disability will review patients at least weekly.

7.3 Treating CDI according to severity

Medical staff must consult a microbiologist, infectious diseases physician or gastroenterologist for prescribing advice. The below antibiotics are advised for adults aged 18years and over.

Treatment	Antibiotic, dosage and course length
First line antibiotic for a first episode of mild, moderate or severe *C. diffcile* infection	Vancomycin: 125mg orally four times a day for 10 days
Second-line antibiotic for a first episode of mild, moderate or severe *C. difficile* infection if vancomycin is ineffective	Fidaxomicin: 200mg orally twice a day for 10 days
Antibiotics for *C. difficile* if first- and second-line antibiotics are ineffective – seek specialist advice as the patient may need transferring to acute trust.	Specialist may initially offer: Vancomycin: Up to 500 orally four times a day for 10 days With or without Metronidazole: 500mg intravenously three times a day for 10 days
Antibiotic for a further episode of *C. difficile* infection within 12 weeks of symptoms resolution (relapse)	Fidaxomicin: 200mg orally twice a day for 10 days
Antibiotics for a further episode of *C. difficile* infection more than 12 weeks after symptom resolution (recurrence)	Vancomycin: 125mg orally four times a day for 10 days Or Fidaxomicin: 200mg orally twice a day for 10 days Refer to BNF for appropriate use and dosing in specific population.

8 Responsibilities of the nurse in charge

Who	What
Nurse in charge	Inform the IPCN and commence the *Clostridium difficile* pathway.

	C Difficile Pathway
Nurse in charge	Ensure that the patient is isolated in a single room with en-suite toilet facilities. This may require discussion /review with the infection control team depending on the patient's Mental health diagnosis
Nurse in charge	Make sure the correct Infection Prevention and Control (IPC) measures are implemented.
Nurse in charge	Instigate use of personal protective equipment i.e., disposable gloves and aprons / long sleeved gowns. For all contact with the patient and their immediate environment
Nurse in charge	If the ward does not have single rooms with ensuite facilities, then patients must be allocated their own toilet or commode – these **must** be cleaned after each use with a chlorine releasing agent
Nurse in charge	Inform domestic staff to ensure cleaning of the patient's room and toilet facilities is undertaken using a chlorine releasing agent at least daily
Nurse in charge	Ensure that a Bristol Stool Chart (Appendix 1) is commenced, maintained and monitored to record all bowel movements appendix 4
Nurse in charge	Allocate designated medical equipment for the sole use of the patient that must still be thoroughly cleaned with a chlorine releasing agent / sporicidal wipes following each use. If designated equipment is not available, ensure all staff are informed to clean any multi use medical equipment immediately after use with a chlorine releasing agent / sporicidal wipes (these will be delivered by the infection control team.
Clinician	To review the patient's condition and assess severity daily in collaboration with the Multidisciplinary and Infection Prevention and Control teams.
Clinician	If patient dies complete a death certificate (examples Appendix 5).
IPCN/Nurse in Charge	For individual cases and multiple outbreaks complete a Root Cause Analysis (RCA).

9 Infection Prevention and Control Measures

If the patient is passing formed stools no special measures are necessary.

If symptomatic: **Single room accommodation**	• The patient must be nursed in single room accommodation with en-suite facilities. This may require further discussion with the infection control team. • It is important to physically separate the symptomatic patient from other vulnerable patients in order to prevent the spread of CDI. This will be done in a respectful way that maintains the service users privacy, dignity and confidentiality.

Hand hygiene	• Staff and relatives must observe strict hand hygiene with liquid soap, water and disposable hand towels before and after each patient contact or contact with the patient's immediate environment. • Patients **must** also be encouraged to wash and dry their hands before meals and after using the toilet. • Alcohol hand gel **must not** be used as an alternative to soap, as it is not effective against these bacteria.
Personal protective equipment	• Disposable gloves and aprons / long sleeved gowns must be worn for direct care for the patient, and for contact with the patient's immediate environment and body fluids. • These **must** be removed and disposed of as clinical waste immediately following the episode of care, and then hand hygiene performed using soap and water.
Laundry	• Must be categorised as infected and laundered (see Laundering and safe handling of linen and clothing). • Patient's clothing must be washed separately on the hottest wash the material can withstand.
Environmental cleaning	• This must be completed daily. • Horizontal surfaces **must** be cleaned with Chlorclean solution in line Hotel Services policy. • Attention **must** be paid to all patient contact areas such as tables, chairs, door handles etc. • Toilet seats **must** be thoroughly cleaned with a chlorine releasing agent after each use. • Once the patient has been symptom free for 48 hours the room **must** be terminally cleaned, and curtains changed. • This **must** take place even if the patient will continue to be cared for in this room.

9.1 Length of Isolation

Once the patient has been symptom-free for 48 hours and they are passing formed stools IPC precautions can revert to Standard Precautions. Hotel services staff must then be advised to undertake a terminal clean

9.2 Clostridium difficile relapse

Recurrent disease occurs in about 20% of patients treated initially with either metronidazole or vancomycin (Teasley et al., 1983; Bartlett, 1985; Wenisch et al., 1996). The same antibiotic that had been used initially can be used to treat the first recurrence (Pépin et al., 2006). A variable proportion of recurrences are reinfections (20-50%) as opposed to relapses due to the same strain; relapses tend to occur in the first two weeks after treatment cessation (Wilcox et al., 1998; Figueroa et al., 2012).

After a first recurrence, the risk of another infection increases to 45–60% (McFarland et al., 1999). If Symptoms resolve then recur, repeat testing is justified to diagnose relapse of condition or new infection. Consult with the IPC team for further advice.

Once diagnosis is confirmed no further specimens are required unless another cause of diarrhoea is suspected or requested by the Infection control team or infection control doctor.

9.3 Continue local surveillance

- The Trust will record the number of patients with *Clostridium difficile* in in-patient facilities. This information will be discussed at the Infection Prevention and Control Committee and forms part of the Quarterly Surveillance reports.

10 Definitions

Term	Definition
CDAD	*Clostridium difficile* Associated Diarrhoea.
Clostridium difficile diarrhoea	One or more episodes of diarrhoea, defined either as stool loose enough to take the shape of a container used to sample it or as Bristol Stool chart types 5 – 7 (Appendix 1) that is not attributable to any other cause. This includes medicines (Appendix 4), and that occurs at the same time as a positive toxin assay (with or without a positive C-difficile culture and / or evidence of pseudo membranous colitis.
CDI	*Clostridium difficile* Infection.
IPC	Infection Prevention and Control.
IPCN	Infection Prevention and Control Nurses.
Pseudo membranous colitis	Severe bowel infection which could be life threatening.
QDS	Four times per day.
TDS	Three times per day.
WCC	White Cell Count.

11 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

11.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All health care staff	On-line / Face to face IPCT mandatory training	30mins	Yearly

12 How the implementation of this procedure will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	IPC quarterly report	IPC	IPCC

13 References

Department of Health and HPA (2008) Clostridium difficile infection: How to deal with the problem. London. Department of Health. Available at

http://www.gov.uk/government/publications/clostridium-difficile-infection-how-to-deal-with-the-problem

https://www.nice.org.uk/advice/esmpb1/chapter/full-evidence-summary-medicines-and-prescribing-briefing

Wilcox M (2013) Updated Guidance on the management and treatment of Clostridium difficile infection. Public Health England London

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321891/Clostridium_difficile_management_and_treatment.pdf

Department of Health and HPA (2008) Clostridium difficile infection: How to deal with the problem. London. Department of Health. Available at

http://www.gov.uk/government/publications/clostridium-difficile-infection-how-to-deal-with-the-problem

National Institute for Health and care Excellence 2021. Clostridioides difficile infection: antimicrobial prescribing

Home - Royal Marsden Manual (rmmonline.co.uk) accessed 19 January 2023

14 Document control (external)

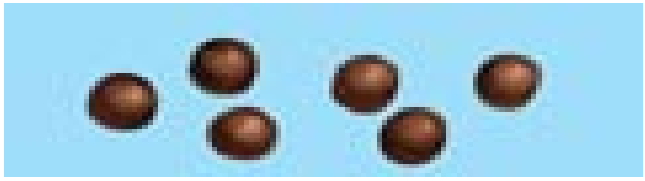
To be recorded on the policy register by Policy Coordinator

Date of approval:	22 October 2021 v4 19 January 2023 v4.1	
Next review date:	22 October 2024	
This document replaces:	IPC-0001-004 v4	
This document was approved by:	Name of committee/group	Date
	IPCC v4 IPCC v4.1	22 October 2021 19 January 2023 (change in principle)
This document was ratified by:	Name of committee/group	Date
	IPCC v4.1 (actual amended document to be retrospectively approved)	20 April 2023 (pending formal retrospective approval)
An equality analysis was completed on this document on:	22 December 2021	
Document type	Public	
FOI Clause (Private documents only)	n/a	

Change record

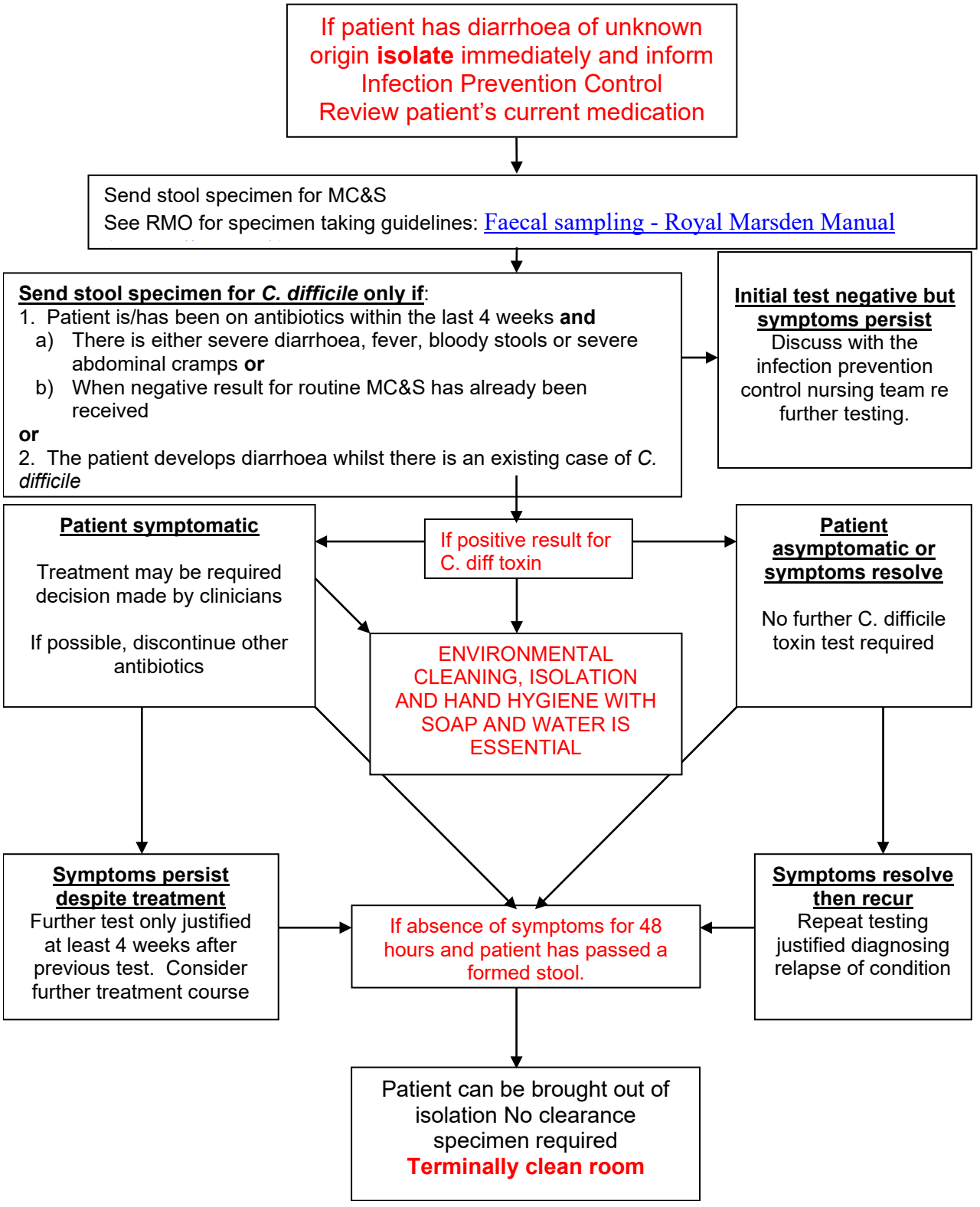
Version	Date	Amendment details	Status
4	22 Oct 2021	Full review with minor changes including transfer to new template and Antimicrobial treatment changes.	Approved
4.1	19 Jan 2023	Information regarding safe labelling and transportation of specimens added to Appendix 2a, due to withdrawal of procedure Ref IPC-0001-015 v3 for specimen collection Link to faecal specimen collection procedure within the Royal Marsden Online Manual added into Appendix 2a Royal Marsden online added to references	Agreed in principle at IPCC 19/01/23, pending retrospective final approval at IPCC April 20th 2023

15 Appendix 1 – The Bristol Stool Chart

Format	Type
	**1.** Separate hard lumps, like nuts (hard to pass).
	**2.** Sausage-shaped but lumpy.
	**3.** Like a sausage but with cracks on surface.
	**4.** Like a sausage or snake, smooth and soft.
	**5.** Soft blobs with clear-cut edges (passed easily).
	**6.** Fluffy pieces with ragged edges, mushy stool.
	**7.** Watery, no solid pieces, **entirely liquid.**

16 Appendix 2 Infection Control Management of Clostridium Difficile

INFECTION CONTROL MANAGEMENT OF *CLOSTRIDIUM DIFFICILE*



17 Appendix 2a Specimen collection and transportation

Follow the Royal Marsden Manual online procedure for specimen taking: Faecal sampling - Royal Marsden Manual (rmmonline.co.uk)

Safe labelling of specimens

Ensure each specimen is clearly labelled with the patient's name, date of birth, NHS number and location eg. ward name.

The pathology request form must also identify the patients details as well as relevant clinical details, reason for the specimen request and any current antibiotic treatment.

Ensure the laboratory request form is also signed by the clinician who has requested the specimen.

The specimen must be secured in the specimen container and placed into a leak proof sealed specimen bag along with the request form.

Any specimens deemed as high risk of infection (e.g. from patients with blood borne viruses or diseases such as Creutzfeldt-Jacob Disease) must be placed into a mini grip plastic bag before being placed into the bag with the pathology request form, they should also be labelled as 'high risk' (high risk stickers can be ordered via cardea).

Unlabelled or incorrectly labelled specimens will be discarded by the receiving laboratory department.

Transportation of laboratory specimens

All pathology specimens must be transported in a leak proof, washable container. The container must be secure and must comply with UN 3373 standards.

Specimen transport containers must not be left unattended in a patient access area.

Specimen transport containers must be cleaned at least weekly, or immediately if they become contaminated.

Where specimens are transported to the laboratory by vehicle, the transport specimen container must be placed into a cardboard transport box labelled with both the destination and senders name and address.

Each specimen container must be in a separate plastic bag with sufficient material to fully absorb any leakage of the specimen

Vehicles used for specimen transportation must be equipped with personal protective equipment and a spill kit. Any spillages must be cleaned immediately, and the specimen requester informed as a further specimen will need to be obtained.

18 Appendix 3 Medicines that can cause diarrhoea

Diarrhoea is a common adverse drug reaction (ADR) with many medicines.

Antimicrobials account for about 25% of drug-induced diarrhoea though most cases are benign (Lee, 2006)

While diarrhoea has been seen with most medicines, the ones that are most commonly implicated are:

- Acarbose
- Antimicrobials
- Bile salts
- Colchicine
- Cytotoxics
- Dipyridamole
- Iron preparations
- Laxatives
- Leflunomide
- Magnesium preparations e.g. antacids
- Metformin
- Metoclopramide
- Misoprostol
- Non-steroidal anti-inflammatory drugs (NSAIDS) e.g. aspirin, ibuprofen
- Olsalazine
- Orlistat
- Proton pump inhibitors
- Sodium Aurothiomalte
- Ticlopidine

Please refer eBNF for up-to-date information.

Clinician to review medication in conjunction with pharmacist and consultant microbiologist.

Careful attention **must be** paid to how much time has passed between the time that the medicine is first taken and when the diarrhoea first appears.

Further information on adverse effects is available from local medicines information centres or by using the 'search by section' at http://emc.medicines.org.uk.

19 Appendix 4 CDI Patient Bowel Movement record chart

Please attach patient sticker here or record: Name: …… Date of Birth: …… PARIS No: …… NHS No: …… Consultant: ……..	Clostridium difficile specimen result date: Toxin positive / toxin negative (please circle)	**Record every bowel movement.** **Also record if bowels are not opened in 24hours.** **Isolation to continue until 48hours symptoms free and a formed stool is passed**

Date	Time	Comments Please state: Blood Mucus Offensive smell Colour Bowels not open	**Type 1** **Separate hard lumps (hard to pass)** 	**Type 2** **Sausage shaped but lumpy** 	**Type 3** **Like a sausage but with cracks on the surface** 	**Type 4** **Like a sausage or snake, smooth and soft** 	**Type 5** **Soft blobs with clear cut edges** 	**Type 6** **Fluffy pieces with ragged edges, a mushy stool** 	**Type 7** **Watery, no solid pieces (entirely liquid**) 	Staff Initials

20 Appendix 5 Example Death certificate for CDI patients

If a healthcare-associated infection (HCAI) was part of the sequence leading to death, it must be in Part 1 of the certificate.

Include all the conditions in the sequence of events back to the original disease being treated.

Examples:

Ia. Clostridium difficile pseudo membranous colitis

Ib. Multiple antibiotic therapy

Ic. Community-acquired pneumonia with severe sepsis

II. Immobility, polymyalgia rheumatica, osteoporosis

If your patient had an HCAI which was not part of the direct sequence, but which you think contributed at all to their death, it must be mentioned in Part 2 of the certificate.

Examples:

Ia. Bronchopneumonia

Ib. Carcinomatosis and renal failure

Ic. Adenocarcinoma of the prostate

II. Clostridium difficile infection secondary to antibiotic therapy for recurrent bronchopneumonia

21 Appendix 6 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Nursing and Governance/IPC and Physical Healthcare					
Policy (document/service) name	IPC-0001-004 v4 Clostridium Difficile					
Is the area being assessed a;	Policy/Strategy		Service/Business plan		Project	
	Procedure/Guidance			√	Code of practice	√
	Other – Please state					
Geographical area	Trustwide					
Aims and objectives	To set standards in practice to ensure the delivery of patient care is carried out safely and effectively by the trust staff. To comply with the HCAI Code of Practice of the Health and Social Care Act 2008.					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	04th October 2021					
End date of Equality Analysis Screening (This is when you have completed the analysis and it is ready to go to EMT to be approved)	04th October 2021					

You must contact the EDHR team as soon as possible where you identify a negative impact.

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

Trust staff and patients

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	Yes/No No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	Yes/No No	**Sex** (Men, women and gender neutral etc.)	Yes/No No
Gender reassignment (Transgender and gender identity)	Yes/No No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	Yes/No No	**Age** (includes, young people, older people – people of all ages)	Yes/No No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	Yes/No No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	Yes/No No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	Yes/No No

Yes – Please describe anticipated negative impact/s
No – Please describe positive impacts/s - No barriers to access or implementing this policy

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.?	**Yes**		**No**	√

If 'No', why not?					
Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)			

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place

No – Please describe future plans that you may have to engage and involve people from different groups
Not relevant to this procedure

5. As part of this equality analysis have any training needs/service needs been identified? Not relevant to this procedure

Yes/No	Please describe the identified training needs/service needs below

A training need has been identified for;

Trust staff	No	Service users	No	Contractors or other outside agencies	No

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so

If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please contact the team

22 Appendix 7 – Approval checklist

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

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
	Have any related documents or documents that are impacted by this change been identified and updated?	N/A	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Y	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
10.	**Publication**		
	Has the document been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	