<table>
<thead>
<tr>
<th>Standard Operating Procedure:</th>
<th>NEUTROPENIA Management of Adults with Neutropenia</th>
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<td>SOP No:</td>
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<tr>
<td>Version No:</td>
<td>5</td>
</tr>
<tr>
<td>Date this version approved</td>
<td>MARCH 2011</td>
</tr>
<tr>
<td>Approving committee:</td>
<td>INFECTION CONTROL COMMITTEE</td>
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<tr>
<td>Author(s) (Job title)</td>
<td>CONSULTANT HAEMATOLOGIST CONSULTANT MICROBIOLOGIST HAEMATOLOGY NURSE SPECIALIST</td>
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<td>Division/Directorate</td>
<td>CLINICAL SUPPORT SERVICES</td>
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<td>Trust wide SOP (Yes/No)</td>
<td>YES</td>
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<tr>
<td>Links to other Policies, SOP’s, Strategies etc:</td>
<td>SUSPECTED NEUTROPENIC SEPSIS FAST TRACK PATHWAY</td>
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Date(s) previous version(s) approved (if known):  
Version: 4 Date: August 2008

DATE OF NEXT REVIEW:  
February 2013

Manager Responsible for Review:  
Consultant Haematologist
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1. Introduction

Fifty to 60% of febrile neutropenic patients prove to have infections and 16-20% of those with a neutrophil count <0.1 x 10⁹/l has a bacteraemia. Fever is commonly as a result of bacteraemia and usually due to Gram positive cocci (eg coagulase negative staphylococci, Staphylococcus aureus, viridans streptococci) or Gram negative bacilli (eg Escherichia coli, Klebsiella spp, Pseudomonas aeruginosa etc). Fungal infections tend to occur after patients have received broad-spectrum antibiotics and have had prolonged periods of Neutropenia, but may occur as primary infections.

Infections in neutropenic patients typically take 2-7 days to respond to antimicrobial therapy. Acute respiratory viral infections e.g. influenza or respiratory syncytial virus may be associated with severe illness in the immune-compromised host.

Documented Management of Patients with Suspected Neutropenic Sepsis

The documented management of patients presenting with Neutropenic sepsis should be in accordance the Neutropenic Sepsis Fast Track Pathway. The pathway is used alongside this Standard Operating Procedure

2. DEFINITION

Sepsis is defined as a systemic inflammatory response to infection. It is formally characterised by the presence of 2 or more of the following:

- Temperature >38 or <36
- Heart rate >90/min
- Respiratory rate >20/min or PaCO₂ <4.3Pa
- WCC >12x 10⁹/l (in those with normal bone marrow activity)

Neutropenia

in a patient with a neutrophil count of <0.5 x 10⁹/l or <1 x 10⁹/l and expected to fall to <0.5 x 10⁹/l.

The risk of infection is greater the faster the rate of decline of the neutrophil count and the longer the duration of Neutropenia especially if Neutropenia lasts for >10 days.

- Mild Neutropenia (1.0 –1.7 x 10⁹/l) and moderate Neutropenia (0.5 – 1.0 x 10⁹/l) should not be ignored since this may be the consequence of an underlying haematological abnormality.

Note; do not delay administration of antibiotics whilst awaiting WCC result

Fever: temperature >37.5°C

Note; Fever may be absent in some infected patients who are dehydrated, severely shocked, taking steroids or NSAIDS.

- Look for evidence of shock, DIC or acute respiratory failure
NEUTROPENIC SEPSIS ALGORITHM

The ‘Golden Hour’
door to needle in 60 minutes

Patient had chemotherapy in last 3 months or has bone marrow failure due to primary haematological disorder with one of the following:

- Temperature > 37.5 °C
- Rigor or other signs of fever (shivering, cold, sweating)
- Unexplained hypotension, tachycardia, or clinical deterioration

URGENT TRIAGE

ABCD MANAGEMENT

Airway

MONITOR
Respiratory rate
Oxygen saturations >93%

Breathing

Circulation

MONITOR
Heart Rate / BP
Consider fluid resuscitation at the earliest opportunity

Disability/Drug

HISTORY:
When received last chemotherapy?
How are they feeling?
Any specific signs of infection?

EXAMINE:
MEWS, Clinical Assessment

ACTION:
Urgent bloods
Take blood cultures x 2
IV antibiotics to be administered within 60 minutes of presentation

Do not wait for blood results.

Meropenem 1g TDS
(caution for patients with true penicillin allergy- see policy pg12 and consider microbiology advice)

Patient Stable
Transfer ward side room

Investigations must include:
FBC, U+E, LFTs, COAG, Group and Save, Calcium, Mg, CRP, ESR, Blood Glucose
Blood Cultures from central lines (from each lumen)
Also consider; Chest X-Ray
Swab any skin lesions
Blood gases if hypoxic
ECG if hypotensive
4. CLINICAL ASSESSMENT OF SUSPECTED NEUTROPENIC SEPTIC PATIENTS

Early diagnosis will prevent death - treat patients with suspected Neutropenic sepsis within 1 hour of presentation.

Patients must be
- Identified early and triaged immediately
- Reviewed by medical officer
- Initiated on antibiotics within 1 hour of presentation

4a. EARLY TRIAGE

Patients at risk of Neutropenic sepsis include
- Patients whom have had chemotherapy in the last 3 months
- Or has bone marrow failure due to primary haematological disorder.

Post chemotherapy 7-10 days is a classic time for Neutropenia following chemotherapy; however delayed Neutropenia can occur in some regimes.

Those with additional risk are patients which are
- Heavily pre-treated
- Elderly
- Have an indwelling line
- Have co-morbid conditions e.g. advanced cancer
- General poor health

These patients should be triaged looking for common early signs of sepsis: i.e.
- Temperature > 37.5 ºC
- Rigor or other signs of fever (shivering, cold, sweating)
- Unexplained hypotension, tachycardia, or clinical deterioration

4b. INITIAL ASSESSMENT

The initial assessment should be the immediate assessment of airway, breathing and circulation. Monitoring of vital observations and a score for the Modified Early Warning Score (MEWS) for re-contacting the clinical team or critical care outreach.

Record TPR, BP, urine OP and SaO₂

Patients with the following features should be assessed and treated with the utmost urgency:

These patients have severe sepsis – severe sepsis pathway must be followed (Found in clinical guidelines under "Emergency Medicines and Guidelines Policy"

- SBP <90mmHg or MAP < 65mmHg
- Urine OP < 0.5ml/kg/hr for 2 hrs
- INR >1.5 or APTT >60 s
- Bilirubin elevated
- Lactate >2mmol/l
- New need for oxygen to keep SaO₂>90%
- Platelets < 100 x 109/l
- Creatinine >177 mmol/l
4c. FULL HISTORY AND EXAMINATION

Try to identify any focus of infection

It is useful to enquire about whether rigors are associated with the recent use or flushing of a central venous line

Check the patient’s records for alerts such as previous infections with *Clostridium difficile*, allergies etc.

It is important to enquire and look for inflammation/infection at the following sites and sample as appropriate:
- Mouth – teeth, gums, pharynx
- ENT problems especially involving sinuses
- Eyes including fundi
- Upper gastrointestinal symptoms
- Lung – cough, shortness of breath, sputum
- Perineum especially anal area (defer PR examination until antibiotics started)
- Diarrhoea – if present isolation precautions may be advisable – discuss with a member of the infection control team. Consider testing for *Clostridium difficile toxin*
- Skin lesions – (NB think about fungal, Pseudomonas, generalized herpes and varicella zoster infections)
- Look at vascular access sites, especially central venous line insertion sites, bone marrow aspiration sites, nail margins, skin tunnels and at surgical incision sites etc.

Also include a full systems review.

4d. INVESTIGATIONS

- FBC
- Coagulation screen (if applicable) to exclude DIC and possible vitamin K deficiency in patients who have had recent antibiotics
- U+E, glucose
- LFT
- CRP
- Samples from any obvious focus of infection
- Stool microscopy, culture and *C. difficile* toxin detection if diarrhoea - also consider whether virology would be useful
- Blood cultures (x2 sets) peripherally and from indwelling lines (samples from each lumen)
- Coagulation screen (if applicable) to exclude DIC and possible vitamin K deficiency in patients who have had recent antibiotics
Additional Tests to Consider:

- CXR and other imaging as indicated
- Urinalysis and culture - if urinary symptoms present or patient catheterised
- Respiratory secretions for rapid testing for viral antigens e.g. NPA, BAL
- A clotted blood sample should be sent for viral serology and a convalescent sample sent 10-14 days later if appropriate – clinical details and indication for test must be included.
- Blood gases if hypoxic
- If varicella zoster is being considered, vesicle fluid should be sampled with a swab placed into viral transport medium (VTM) and sent for PCR test. It should be labelled and sent to the lab.
  - Bloods for viral PCR and clotted blood (serum) for IgG and IgM
  - Also in VZ - remember infection control precautions are needed to protect both staff and other patients – discuss with a member of the infection control team.
- Fungal

Patients who are not getting better, or are at high risk of a fungal infection, should be discussed with the radiologists regarding appropriateness of additional imaging eg ultrasonography, CT (especially useful for diagnosis of pulmonary aspergillosis), MRI, radionuclide imaging.

If invasive fungal infection is being considered, please discuss investigations with consultant microbiologist.

- CMV infection
  If CMV is being considered e.g. after bone marrow transplantation, please send EDTA blood for CMV PCR.
- Pneumocystis pneumonia (PCP)
  If PCP infection is considered send bronchial washings (or, if these are unobtainable, then sputum or EDTA blood) for PCP PCR.
  If bronchial washings are collected these should be sent for *Pneumocystis jirovecii* and CMV detection as well as being routinely microscopically examined and cultured for bacteria, fungi, and mycobacteria. Please discuss with consultant microbiologist before bronchoscopy.
### DETERMINE RISK STATUS

All patients should be treated as High Risk until the case has been reviewed by a consultant.

<table>
<thead>
<tr>
<th><strong>High Risk</strong></th>
<th><strong>Serious Infections</strong></th>
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<tbody>
<tr>
<td><strong>Cancer and its treatment</strong></td>
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<tr>
<td>- Uncontrolled cancer/leukaemia</td>
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<tr>
<td>- High dose chemotherapy likely to result in Neutropenia (&gt;10 – 14 days) and severe mucositis</td>
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<tr>
<td>- Allogeneic or autologous bone marrow transplantation</td>
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<td><strong>Drugs</strong></td>
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<tr>
<td>- Those on immunosuppressive agents e.g. Cyclosporin A</td>
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<tr>
<td>- Recent fludarabine therapy</td>
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<tr>
<td><strong>Prolonged Neutropenia, cell mediated immune suppression</strong></td>
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<tr>
<td><strong>Haemodynamic instability</strong></td>
<td></td>
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<tr>
<td>- Decrease in blood pressure, tachycardia &gt;100bpm</td>
<td></td>
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<tr>
<td><strong>Specific foci of infection</strong></td>
<td></td>
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<tr>
<td>- e.g. Intravascular catheter, new pulmonary infiltrate</td>
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<tr>
<td><strong>Organ / metabolic dysfunction</strong></td>
<td></td>
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<tr>
<td>- Respiratory failure</td>
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<td>- Renal failure</td>
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<td>- Liver failure</td>
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<td>- Cardiac failure</td>
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<tr>
<td>- Altered mental status</td>
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<tr>
<td>- Profound weakness</td>
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<tr>
<td>- Severe electrolyte imbalance</td>
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<tr>
<td>- Inadequate fluid intake</td>
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<tr>
<td><strong>Haemostatic disorder</strong></td>
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<tr>
<td>- Uncontrolled bleeding and / or severe thrombocytopenia</td>
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| **Low Risk** |  |
| - Neutropenia expected to resolve in 7 – 10 days |  |
| - No haemodynamic instability |  |
| - No abdominal pain |  |
| - No nausea and vomiting |  |
| - No diarrhoea (x 6 loose stools daily) |  |
| - No neurological or mental-state changes |  |
| - No intravascular –catheter infection |  |
| - No catheter-tunnel infection |  |
| - No new pulmonary infiltrate |  |
| - Be able to swallow oral medication |  |

None of the factors listed in the high risk group
RISK-SPECIFIC THERAPY

HIGH RISK

- Reverse barrier nursing is not required but strict adherence to Standard Infection Control Precautions, including hand washing, should be maintained at all times.
- Side room nursing if available
- Limit number of visitors to two at any one time
- Consider nutrition (see section 5)
- Commence antibacterial mouthwash e.g.: corsodyl 5 mls qds
- **Commence empirical IV broad spectrum antibiotics within 1 hour of assessment:**
  
  **Meropenem 1Gram 8 hourly**

4f. MANAGEMENT OF PATIENTS WITH A PENICILLIN ALLERGY

Patients with history of anaphylaxis, urticaria, angioedema or rash immediately after penicillin administration are at risk of immediate hypersensitivity and should not receive any beta-lactams (penicillins, cephalosporins, or carbapenems such as imipenem or meropenem).

**Note Piperacillin / Tazobactam (Tazocin) and co-amoxiclav contain penicillins**

Meropenem is a beta-lactam and therefore contra-indicated in patients with a good history of penicillin allergy (anaphylaxis, urticaria or rash immediately after beta-lactam administration).

Patient with a history of minor rash (non-confluent and restricted to small body area) or a rash that occurred >72hrs after penicillin are probably not allergic to penicillin. In these patients, penicillin or other beta-lactams should not be withheld for serious infections. In the hospital setting using cephalosporins or carbapenems in such patients is not unreasonable.

If patient is unable to receive these antibiotics due to allergy or other contra-indications then seek advice from the on-call microbiologist.

In neutropenic sepsis the risk of withholding Meropenem must be balanced against the clinical risk of allergic reaction. Note the majority of patients with vague symptoms, or symptoms of gastro-intestinal intolerance do not have a true penicillin allergy

**The initial dose of antibiotics may be given based on most recent liver and renal function results. Therapy should not be delayed pending results.**

Subsequent doses of IV antibiotics must be adjusted to patient’s clinical condition, weight, most recent liver and renal function tests.

**Antibiotics should be given through each lumen of an indwelling IV catheter on a rotational basis.**
- Additional therapy for Gram-positive cover (coagulase-negative staphylococci, MRSA or enterococci):

It is acceptable to wait for positive organism identification from blood cultures before adding teicoplanin, unless the following apply:

- Suspected IV catheter-related infection
- Prior prophylaxis with ciprofloxacin
- Likely MRSA or penicillin resistant pneumococci
- Severe mucositis
- High dose cytarabine therapy
- Suspected viridans streptococcus toxic shock.

**Add IV Teicoplanin 400mg 12 hourly for 3 doses then 400mg 24 hourly**

### MEROPENEM 1 Gram TDS
If renal impairment give 1g BD

**Plus TEICOPLANIN if:**

- Severe mucositis
- IV catheter related infection
- MRSA or penicillin resistant pneumococci are likely
- Patient has received prior quinolone as prophylaxis

### IF GENUINE PENICILLIN ALLERGY
Discuss with microbiology

Give:

- TEICOPLANIN 400mg IV 12 hourly for 3 doses then 400mg daily plus
- CIPROFLOXACIN 400mg IV plus
- GENTAMICIN IV

- High-dose of 7mg/kg daily (max 500mg) is suitable for patients with creatinine clearance $\geq 20$ml/min (unless patient received platinum containing chemotherapy within last 7 days). A level should be taken 6 - 14 hours after first dose and interpreted according to the nomogram.
- Patients with a creatinine clearance <20mg/L should receive a lower dose of 3mg/kg and a level should be checked 18 – 24 hours later. Further doses should be withheld until a trough level of <1mg/L is achieved.

### CONSIDER THE ADDITION OF

- IV Metronidazole 500mg TDS If perineal or gingival infection
- IV Aciclovir 5-10mg/kg TDS If herpetic lesions
- IV Fluids

G-CSF may be indicated in post chemotherapy patients and in other patients specified by consultant Haematologist or Oncologist.

**PATIENTS WHO HAVE PREVIOUSLY RECEIVED NEULASTA DO NOT GIVE GCSF WITHOUT PRIOR DISCUSSION WITH A HAEMATOLOGIST/ONCOLOGIST**
4g LOW RISK

- Admit to side ward if possible (* see below)
- Routine reverse barrier nursing not required but strict hand washing is essential
- Limit number of visitors to two at any one time
- Consider nutrition (see section 5)
- Commence antibacterial mouthwash e.g.: corsodyl 5 mls qds

Neutropenic patients with fever should be treated in hospital but may be treated as an outpatient, at the discretion of the responsible clinician.
Low Risk (cont’d)

If low risk hospitalised patients are stable at day 3 of antibiotic therapy, consider discharge home to continue oral antibiotics as an option if:

a) patient is mentally competent,
b) lives near the hospital (within an hour),
c) has someone at home all the time,
d) has access to transport and a telephone, 
e) home conditions are deemed satisfactory.

The patient and family must be aware of the complications of Neutropenia, and the patient’s temperature must be monitored regularly. The patient should be reviewed regularly and should be admitted if there are any problems.

5. CONTINUING MANAGEMENT

- 4 hourly TPR and BP (inpatients)
- Fluid balance chart (inpatients)
- Daily FBC until patient afebrile and neutrophils > 1.0 x 10⁹/l
- Alternate day CRP until episode completed.
- U+E, LFT, and coagulation at regular intervals depending on the clinical features

CONTINUING ANTIBIOTIC THERAPY:

IF AFEBRILE WITHIN 48HOURS OF TREATMENT:

- **Cause identified:**
  adjust antibiotics to most appropriate treatment according to sensitivities and continue for a minimum of 7 days.

- **No cause identified:**
  Continue same antibiotic regime for at least 7 days.
  In a group of low risk patients it may be possible to change to oral antibiotics in discussion with consultant microbiologist or consultant in charge of patient:
  e.g.: oral co-amoxiclav 625 mg tds.

PERSISTENT FEVER AT 48HOURS OF TREATMENT

- **No cause identified**

- Reassess daily with history, examination and investigations as appropriate

- Consider reason:
  - Non-bacterial infection
  - Resistant infection
  - Emergence of second infection
  - Abscess / catheter infection
  - Drug fever

Discuss with Microbiologist if no response in 48 hours of Meropenem.
Investigate according to symptoms, consider:

- CXR
- Sinus XR
- USS / CT scan
- Recultures, including blood cultures
- Investigate for viruses, fungal infection, TB (discuss with consultant microbiologist)
- Consider bronchoscopy and alveolar lavage if respiratory symptoms and signs (discuss with consultant microbiologist in advance).

Add IV Caspofungin where there is a clinical suspicion of fungal infection.
Add oral metronidazole in presence of diarrhoea / mucositis.
Add IV / oral aciclovir when clinical suspicion of Herpes simplex/ Varicella zoster.
Add IV cotrimoxazole when suspecting *Pneumocystis jiroveci*.

Acute typhlitis (combination of acute severe mucositis and neutropenia) should be suspected when there is diarrhoea, abdominal pain and plain radiograph shows dilated small bowel with oedematous walls. Such patients need intensive treatment and are best managed in ICU / HDU.

**DURATION OF THERAPY**

If still febrile at day 4-6
Consider adding an antifungal agent IV (especially if likely to remain neutropenic, clinically unstable, worsening radiology, laboratory investigations) and review antibiotics as at day 3.

Repeat CXR - if pulmonary symptoms / infiltrates are present consider bronchoscopy and BAL along with high resolution CT scan chest. If there are no chest symptoms or signs consider using Caspofungin IV 70mg day 1, followed by 50mg once daily.

If positive BAL for fungi, or Aspergillus PCR or galactomannan assay is positive, consider using Liposomal-amphotericin B (Ambisome).

Doses will vary dependent on the indication, please discuss with a Consultant Microbiologist.

NB. Experienced oncologists/microbiologists may choose to prescribe doses that fall outside the manufacturers license (please consult BNF or respective datasheets and see note on page 11).

Other antifungal therapies are available if there is no response to first line therapy; these should be considered in consultation with the consultant microbiologist and consultant in charge of patient.
6. CENTRAL VENOUS CATHETERS

Where possible the access line should be used for administration of IV antibiotics and antibiotics should be given through each lumen of an indwelling IV catheter on a rotational basis.

Venous access devices must be assessed for signs of infection as the use of these devices increase the risk of infection (Johnson, et al, 2000). Signs of infection can include:

- Inflamed exit site/tunnel
- Pyrexia/rigors post flushing
- Previous history of line infection
- Other soft tissue infection

If a line infection is suspected blood cultures should be taken from each lumen, exit site swabbed for microbiology culture and sensitivity. The patient should be prescribed a 100mg Teicoplanin line lock (for each lumen) and also commenced on IV Teicoplanin 400mgs peripherally 12 hourly, for the first 3 doses and then daily.

Contact Cancer Care Suite to access line and for advice on 2571.

REMOVAL OF CENTRAL VENOUS CATHETERS

This should be considered if there is a sub-cutaneous tunnel or periport infection, septic emboli, hypotension associated with catheter use, or a non-patent catheter.

Specific infections that often require line removal include candidiasis, atypical mycobacteria, *Bacillus* sp, *Ps. aeruginosa*, *Corynebacterium jeikeium*, fungi including aspergillus, *Stenotrophomonas maltophilia* and *Acinetobacter spp.* *S. aureus* and CNS infections may sometimes necessitate line removal too.

Venous access devices must not be removed without discussion with the treating consultant. If it is decided the appropriate action is to remove the line immediately, the on-call surgical team should be contacted.

7. SUPPORTIVE MANAGEMENT FOR THE NEUTROPENIC PATIENT

Prompt early recognition of early features of infection is crucial in the management of these patients so that infectious complications can be diagnosed early and treatment can be initiated immediately (Dellinger, et al, 2004).

1. Monitor full blood count and biochemical profile daily. Depending on chemotherapy regimen coagulation screening may also be required.

2. Assess intravenous sites daily for any signs of infection.

3. Assess the patient’s oral status every 12 hours (minimum) using a recognised oral assessment.

4. Assess the patient’s skin daily for breakdown, lesions and rashes. Assess any wounds for signs of infection and educate patient in the importance of scrupulous personal hygiene.

5. Assess for any change in urinary function including frequency, dysuria and haematuria.

6. Assess any changes in bowel habit.

7. Assess female patients for vaginal candidiasis; instruct patients to avoid the use of tampons.

8. Assess patients for any signs of peri-anal infection.
8. GENERAL GUIDELINES FOR IN-PATIENT CARE OF NEUTROPENIC PATIENTS

Patients should be advised of their increased risk of infection and educated in simple preventive measures. They should seek urgent attention if they develop fever, sweats, rigors or other symptoms to indicate underlying infection.

Prophylactic measures

1. Patients will be cared for in an environment that minimises the risk of infection from other patients, hospital staff and visitors, preferably in a single en-suite room.

2. Protected isolation must be clearly indicated by appropriate signage and protective measures taken in accordance with Infection Control Policy.

3. Educate the patient and relatives about the need to restrict visitors who have transmissible illnesses; e.g. bacterial infections, herpes, colds, influenza, chickenpox, shingles or measles. Patients must also avoid contact with people who have been recently vaccinated with live or attenuated virus vaccines.

4. Careful hand washing is the single most important action for the health professional, patient, the patient’s family and visitors in preventing cross infection (Jonson, et al, 2000).

5. Fresh flowers or plants should not be placed in the patient’s room as pathogens could flourish in stagnant water. Denture mugs and soap dishes should also be removed. Face cloths should be avoided and disposable wipes should be provided.

6. Ensure patients are encouraged/assisted to shower daily (the shower should be cleaned and disinfected before and after use with Chlorclean). Wash bowls must also be cleaned using Chlorclean and dried thoroughly before and after each patient use.

7. Daily damp dusting of patient room area to be maintained using Chlorclean (separate cloths used for cleaning patient tables, beds and equipment, etc in room).

8. Ensure use of equipment e.g. commodes, drip stands, bath, etc cleaned before and after each patient use using Chlorclean.

9. MANAGEMENT OF AFEBRILE/ NON-SEPSIS NEUTROPENIA

Neutrophil count < 0.5 x 10⁹/l

If the patient is well, afebrile and has a good understanding of neutropenic sepsis:

1. Perform initial assessment as in febrile Neutropenia (see sections b and c).
2. If patient is clinically well with no sign of infection, and is well supported at home with good transport, do not admit.
4. Ensure patient has a thermometer at home and monitors temperature daily after 6pm or if feels unwell at any time.
5. Ensure patient has emergency contact number.
10. NEUTROPENIC DIET

The hospital kitchen must be notified as they will provide the required neutropenic diet. Contact kitchen on 2346, inform them the name of ward only requiring the meal.

Certain food stuffs are best avoided;

Salads, pâté, soft cheeses, black pepper.  
Unpasteurised milk and its products.  
Yogurts, Actimel/Yoplait drinks, etc as these contain live bacteria.  
Undercooked or cold meats.  
Raw or undercooked eggs.  
Unpeeled fruit.  
Ice cream.

Water should be boiled and allowed to cool before consumption.

A more detailed update is available from nursing staff on the Cancer Care Suite. Contact on 2571.
REFERENCES


Guidelines for the management of neutropenic sepsis
Greater Manchester and Cheshire cancer network guideline (GMCCN) November
13 CONTACTS

The consultant in charge of the patients care should be notified within 24 hours.

Dr C. Faris:
Consultant Microbiologist
01942 822153
Or via RAEl Switchboard 01942 244000

Dr H. Patel
Consultant Haematologist
01942 822139
Or via RAEl Switchboard 01942 244000

Dr G. Wilson:
Consultant Medical Oncologist
0161 446 8347
Or via Christie Switchboard 0161 446 3000

Dr R. Cowan:
Consultant Medical Oncologist
0161 446 3409
Or via Christie Switchboard 0161 446 3000

Dr. R. Nelson:
Consultant Microbiologist
01942 822943
Or via RAEl Switchboard 01942 244000

Christie Hospital Advice Line
0161 446 3658

For patients of The Christie Hospital (Regional Cancer Centre), this number can be contacted for either advice on how to manage the patient locally or to refer back to The Christie Hospital.

The microbiology laboratory is open 9am to 5pm Mon to Fri, outside these hours contact the on call Microbiology BMS via switchboard.

Cancer Care Suite, 9am to 5pm, Monday to Friday:
Chemotherapy nurses: 01942 822571
Secretary: 01942 822574

Haematology Cancer Nurse Specialist
01942 822057
Or via RAEl Switchboard 01942 244000 bleep 2057

Infection control:
01942 822035
On call via switchboard 01942 244000

Such patients may be under the care of Consultants or departments (e.g. Haematology), or visiting consultants such as Oncologists from The Christie Hospital. Please inform the treating clinician of the patient’s admission by the next working day.

The patient may have been issued with an information card, which will detail information about their chemotherapy regimen.

For patients of the Christie Hospital (regional cancer centre), the Christie Hospital advice line can be contacted on 0161-446-3658 for either advice on how to manage the patient locally or referral back to the Christie.

For Royal Albert Edward Infirmary Haematology patients contact the on-call Haematologist.
## EQUALITY IMPACT ASSESSMENT FORM – STAGE 1
### INITIAL ASSESSMENT (PART 1)
#### POLICY / GUIDELINES

<table>
<thead>
<tr>
<th>Division:</th>
<th>Department:</th>
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<tbody>
<tr>
<td>Title of Person(s) Completing Form</td>
<td>New or Existing Policy?</td>
</tr>
<tr>
<td>Title of Policy being assessed:</td>
<td>Implementation Date (Policy)</td>
</tr>
</tbody>
</table>

**What is the main purpose (aims / objectives) of this policy?**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Public</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Staff</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Will patients, carers, the public or staff be affected by this policy? Please delete as appropriate.**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Public</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Staff</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**If staff, how many individuals / Which Groups of Staff are likely to be affected?**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Public</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Staff</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Have patients, carers, the public or staff been involved in the development of this policy? Please delete as appropriate.**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Public</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Staff</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**If yes, who have you involved and how have they been involved:**

**What consultation method(s) did you use?**

*For example: focus groups, face-to-face meetings, questionnaires etc.*

**How are any changes / amendments to the policy communicated?**

*For example: Meetings / Focus / Email etc.*
QUESTIONS YOU MUST CONSIDER when completing the following Equality Impact Assessment Table:

- Are there any barriers which could impact on how different groups might benefit from this policy?
- Does this policy promote the same choices for different groups as everybody else?
- Could any of the following group’s experience of this policy be different?
- Does this policy address the needs and potential barriers of these groups?

**EQUALITY IMPACT ASSESSMENT TABLE – POLICIES (PART 2)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Younger People (17-25) and Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Older People (60+)</td>
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<td></td>
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<tr>
<td>Race or Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Difficulties</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Hearing Impairment</td>
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</tr>
<tr>
<td>Visual Impairment</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Need</td>
<td></td>
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<tr>
<td>Gay/Lesbian/Bisexual</td>
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<tr>
<td>Transgender</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Faith Groups (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage &amp; Civil Partnership</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Group (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applies to ALL Groups</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**High:** There is significant evidence of a negative impact or potential for a negative impact.

**Low:** Likely to have a minimal impact / There is little evidence to suggest a negative impact.

**None:** A Policy with neither a positive nor a negative impact on any group or groups of people, compared to others.
INITIAL ASSESSMENT (PART 3)

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

(b) How are you going to gather this information?

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following Equality Groups? Delete as appropriate

| Age | YES | NO |
| Gender | YES | NO |
| Race | YES | NO |
| Disability | YES | NO |
| Religion / Belief | YES | NO |
| Sexual Orientation | YES | NO |
| Gender Re-assignment | YES | NO |
| Marriage & Civil Partnership | YES | NO |
| Pregnancy & Maternity | YES | NO |
| Carer | YES | NO |
| Other | YES | NO |

(Please delete as appropriate)

Any Other Comments

Assessment Completed By:

Job Title: .................................. Date Completed:.................................

IF ‘NO IMPACT’ IS IDENTIFIED Action: No further documentation is required.


PLEASE RETURN COMPLETED FORM VIA E-MAIL TO:
DEBBIE JONES, EQUALITY AND DIVERSITY PROJECT LEAD (for Service related policies) debbie.jones@wwl.nhs.uk
EMMA WOOD, EQUALITY AND DIVERSITY PROJECT LEAD (for HR / Staffing related policies) emma.wood@wwl.nhs.uk