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| Oral Care Guidelines for Cancer Care  | Version: | 2.0 |
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| Document Status |
| This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. |

**Executive Summary**

The incidence of oral mucositis in the cancer setting is very high. It can be expected to occur in at least 50% of patients undergoing chemotherapy to treat a solid tumour (Sonis et al 2004, Elad et al 2014) and as many as 98% of patients undergoing haematopoietic stem cell transplantation (Wardley et al 2000). Kostler et al (2001) estimate that as many as 97% of patients receiving irradiation with or without chemotherapy for head and neck cancers will suffer from some degree of oral mucositis.

**Increased Risk Factors for Mucositis**

* Intensive chemotherapy regimens / bone marrow transplant/ leukaemia
* Elderly and children
* Deficits in self care ability
* Altered fluid or nutritional status (dehydration, malnutrition)
* Receiving certain medications, particularly steroids and other immunosuppressive drugs
* Exposed to additional stressors (alcohol, tobacco, drugs, oxygen therapy)
* Liver / renal impairment
* Previous experience of mucositis
* Graft versus Host Disease
* Cancer of the Head and Neck
* Impaired immunity
* Receiving Stomatotoxic drugs

**List of stomatotoxic drugs**

Amsacrine

Bleomycin

Busulphan Capecitabine

Chlorambucil

Cladrabine

Cyclophosphamide (high dose)

Cytarabine (high dose)

Daunorubicin (all forms) Dactinomycin Docetaxel (Taxotere)

Doxorubicin Epirubicin

Erlotinib

Etoposide

5-Fluorouracil

Melphalan (high dose)

Methotrexate

Mitomycin C

Mitoxantrone

Mitotane

6 Mercaptopurine

Oxaliplatin

Paclitaxel (Taxol)

Panitumumab

Pazopanib

Pemetrexed

Raltitrexed (Tomudex)

Sorafenib

Sunitinib

Streptozocin

Temsirolimus

Temozolomide

Thioguanine

Thiotepa

Topotecan

Vinblastine

Vincristine

Vindesine

Vinorelbine

**1 Scope and Purpose**

## This policy deals with all cancer care inpatients and outpatients who are at risk of developing oral problems due to either receiving chemotherapy or radiotherapy for the control of disease, who are undergoing palliative care, or are having intensive chemotherapy and / or bone marrow / stem cell transplant, who as a result are highly likely to develop mucositis and / or stomatitis.

## The Guidelines are based on an extensive literature search of the available evidence, best practice from similar units and the guidance from the UK Oral Mucositis in Cancer Group formed in 2012, and guidance updated in 2015

**2. Definition of oral mucositis**

Oral mucositis is defined as inflammation of the mucosal membrane, characterised by ulceration, which may result in pain, dysphagia and impairment of the ability to talk (UKOMiC 2015). Mucosal injury provides an opportunity for infection to flourish,placing immunocompromised patients at risk of sepsis and septicaemia. (Ruebenstien et al 2004)

**3 Details of Procedure to be followed**

3.1 All patients should have an oral assessment undertaken by a member of the clinical team on admission to the inpatient unit or commencing treatment on the day units, using the assessment sheet in Appendix 1. The assessment is also undertaken -

1. To identify usual oral care routine
2. To identify the advice/care required to maintain and promote individual oral care.

**Inpatients**

 The Oral Assessment Guide should be implemented for all in patients and assessment undertaken daily, (Appendix 1) Patients who have developed severe mucositis should be assessed each shift. Encourage patients to report any changes in their mouth or any concerns.

**Outpatients**

The oral assessment guide(Appendix 1) should be implemented for all outpatients at the start of treatment, and undertaken on each review visit and treatment visit. Encourage patients to report any changes in their mouth or any concerns.

**All patients**

3.2 Patients should be advised to clean their teeth two-four times a day with a soft toothbrush and fluoride toothpaste (British Dental Health Foundation 2014), some head and neck patients undergoing radiotherapy may require a higher concentration of fluoride in order to protect the teeth. The mouth should be rinsed thoroughly with a sodium chloride 0.9% (Peterson et al 2011, Lalla et al 2014, Elad et al 2014) mouthwash afterwards. Patients should then rinse with 1ml of nystatin suspension and then swallow this. They should avoid drinking and eating for 20 minutes afterwards. Flossing is advised once a day but should be avoided if the patient is thrombocytopaenic or has a clotting disorder. (Quinn 2008, Elad et al 2014). Flossing may also be contraindicated in patients receiving radiotherapy. Check with a member of the clinical team.

3.3. For patients who are unable to undertake their own oral care then a nurse or carer should assist.

3.4 Antifungals and antivirals should be prescribed for those patients at high risk as described in the Cancer Care Infection prevention and therapy protocols 2014 v3.

3.5 Adequate oral fluid intake and self-care measures should be encouraged and the necessary information education and mouthwashes provided to meet their individual requirements.

3.6 The level of care required should be discussed with the patient and any assistance required identified.

3.7 Dentures should be

a. Removed each time the patient undertakes their mouth care and brushed and rinsed with unperfumed soap (The British Dental Health Foundation 2014), prior to putting back into their mouths.

1. Soaked overnight in water (The British Dental Health Foundation 2014, NHS Health Scotland 2013), cleaned with a brush and rinsed prior to putting back into their mouths. It is advisable for patients to leave their dentures out overnight.
2. Removed when uncomfortable due to oral damage.(The British Dental Health Foundation 2014
3. Thoroughly cleaned by soaking in chlorhexidine mouthwash for 15 minutes twice a day. (Scottish Dental Clinical Effectiveness) if a fungal infection of the mouth is present.

3.8 Prior to commencing treatment (where possible)

1. Patients having high dose chemotherapy, head and neck patients, and transplant patients should see a dentist. This should be discussed with their Consultant, as they may need prophylactic antibiotics to be prescribed.
2. Patients identified at increased risk of mucositis should be referred to the dietician.

3.09 Following completion of treatment patients should be encouraged to visit the dentist on a six monthly basis. For transplant patients this needs to be after permission is given from the Consultant in charge of their care.

3.10 Advise patients not to use commercial mouthwashes.

3.11 Encourage patients to stop smoking. Use of alcohol should be minimised. Spicy foods may irritate the mouth, and rough or crunchy food may damage the mucosal lining or gums, so care should be taken and appropriate advice given to patients. (Cooley 2002, Clinical Knowledge Summaries 2010, National Cancer Institute (US) 2013)

**4 Roles and Responsibilities**

**All staff** that are responsible for care of patients undergoing intensive chemotherapy within the ADULT/TYA setting are responsible for following these guidelines.

**Ward and Department Managers**. All managers are responsible for ensuring that these guidelines are implemented in their areas and for ensuring all staff who work within the area adhere to the principles at all times.

**Consultant Medical Staff** are responsible for ensuring their junior staff read and understand these guidelines and adhere to the principles contained within this document at all times.

**Divisional and Care Group Management Teams** are responsible for monitoring implementation of these guidelines and for ensuring action is taken when staff fail to comply with these guidelines.

Non-compliance with a Trust Policy, Procedure, or Protocol **may result in disciplinary action.**

**5 Related Trust Policies**

Screening of adults for malnutrition policy 2012

Cancer Care Infection prevention and therapy protocols 2014

Diarrhoea and/or vomiting: Policy for the management of unexpected /unexplained cases 2010

**6** **Communication Plan**

The updated guidelines will be disseminated to clinical staff by managers of those areas. There is a training DVD on how to inspect the oral cavity which can be viewed on line at [www.ukomic.co.uk](http://www.ukomic.co.uk)

**7 Process for Monitoring Compliance/Effectiveness**

The purpose of monitoring is to provide assurance that the agreed approach is being followed – this ensures we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Key aspects of the procedural document that will be monitored:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **What aspects of compliance with the document will be monitored** | **What will be reviewed to evidence this** | **How and how often will this be done** | **Detail sample size (if applicable)** | **Who will co-ordinate and report findings (1)** | **Which group or report will receive findings** |
| Oral Care assessment sheets in patients notes | Patients notes | Annually | 5 sets of notes per clinical area | Lead Nurse BMT | Cancer Care governance |

1. State post not person.

Where monitoring identifies deficiencies actions plans will be developed to address them.

**8 Arrangements for Review of the Policy**

This policy will be reviewed after 3 years.

**9 References**

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**Appendix 1 - Oral Assessment Guide**

|  |  |  |  |
| --- | --- | --- | --- |
| Category | Normal No changesScore 1 for each response below.  | Mild to moderate changeScore 2 for each response below. | Moderate to severe changeScore 3 for each response below. |
| Voice | Normal (1) | Deeper or raspy (2) | Unable to talk (3) |
| Swallow | Normal swallow (1) | Some pain on swallow (2) | Unable to swallow (3) |
| Lips | Smooth, pink and moist (1) | Dry or cracked (2) | Ulcerated or bleeding (3) |
| Tongue | Pink and moist with papillae present (1) | Coated or loss of papillae with shiny appearance with or without redness (2) | Blistered or cracked (3) |
| Saliva | Watery (1) | Thick or ropey (2) | Absent (3) |
| Mucous membranes | Pink and moist (1) | Reddened or coated without ulceration (2) | Ulcerations with or without bleeding (3) |
| Gingiva | Pink and firm (1) | Oedematous (2) | Spontaneous bleeding (3) |
| Teeth | Clean or no debris (1) | Plaque or debris in localised areas (2) | Generalised plaque or debris along gum line. (3) |

(to be printed off and laminated, a copy of this should be kept in individual patient records folders on the wards so that it can be used at the patient bed side)

|  |  |  |  |  |  |  |  |  |  |  |
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| Date and Time of assessmentOral assessment scoring and monitoring sheet | Voice score | Swallow score | Lips score | Tongue score | Saliva score | Mucous membrane score | Gingiva score | Teeth score | Total score | Signed |
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Patient ID label



Interventions specific to each assessment score – note in patient care plan

|  |  |  |
| --- | --- | --- |
| Assessment | Management | Pain Control |
| Healthy Mouth / no mucositis | Brush teeth with soft tooth brush 4 x day +Use Sodium Chloride 0.9% mouth2 wash 5mls QDS +nystatin suspension 1 ml QDS (best used after meals) |  |
| Mild – ModerateMucositis(WHO grade 1-2) | Continue with the standard mouthcare protocol.If dry mouth consider saliva stimulants, replacement gel / spray and increasing fluid intake (See notes in individual interventions for recommendations)If oral thrush notify Dr and consider increasing nystatin to 3-5 mls QDS Fluconazole p.o. may be required (may be on a systemic antifungal already)Ensure MUST scoring is maintained and dietetic referral made as appropriateCommence food chart  | - Introduce Benzydamine 0.15% mouthwash (Diflam®), 15 mls every 1½-3 hrs. May be diluted 50/50 with water. **NB not to be used in head and neck patients.** Warn patient that it may sting for a few seconds.- If has localised ulcer – consider using orabase® paste or lidocaine 5% ointment - consider use of Caphasol® or Episil®- Try soluble paracetamol gargles. 1gram QDS maximum dose-Add in either Oxetacaine & Antacid suspension 5 ml QDS rinse (5 minutes is the optimum time)14 and then spit out or swallow if needed for oesophageal pain.Or- Add in sucralfate suspension, 5ml QDS– need not be swallowed if patient has sore mouth only.  |
| Moderate to Severe mucositis(WHO grade 3-4) | Continue with standard mouth care protocol. If unable to brush teeth, try using a foam sponge instead. NB not as effective as tooth brushing. Patients should be encouraged to use a brush where possible. Consider using a TePe® brush available from dentists. +Increase sodium chloride 0.9% mouthwashes to 1-2 hourly (5mls) +continue antifungal agents +Ensure fluid balance chart commenced. +Ensure food chart maintained. | - Consider morphine infusion.Ensure adequate fluid intake.Think about using a pain-scoring chart to monitor effectiveness of measures taken. |

**\*\*NB All medications, mouthwashes need to be prescribed by a doctor or by a qualified independent non medical prescriber\*\***

\*Caphasol®, Mugard®, Episil® are not issued by pharmacy but ordered through materials management stores\*

**Appendix 2**

**Individual Interventions**

LIPS/CORNERS OF MOUTH

* Use lubricant jelly as a moisturiser for lips. Ensure that each patient has their own single use sachets for personal use. NB Soft yellow paraffin increases the risk of aspirationand should not therefore be used.
* Observe for herpes simplex and refer to Dr immediately. Commence Aciclovir cream 5% as prescribed (5 x a day for 5-10 days).

CANDIDA/INFECTION

* Observe for white patches or creamy white areas. These could be an indication of infections or thrush (pseudomembranous candidosis is the most common fungal mouth infection where white lesions can be easily removed).
* Observe for any signs of halitosis
* Refer to Dr for appropriate anti-fungal/antibacterial/antiviral agents.

TONGUE

A. COATED

* Very gently brush tongue with soft toothbrush or tongue scraper.
* Encourage good regular mouth care.
* Increase fluid intake – a likely cause is dehydration!
* If drinking plenty it might be due to very sugary drinks, try a low sugar version.
* Check to see if patient’s nose is blocked as mouth breathing makes this worse.
* A ‘hairy’ tongue is associated with smoking and antibiotic use. Encourage patients to stop smoking.
* Ascorbic acid effervescent tablets can be used on the tongue to remove slough – allow quarter if a 1g effervescent tablet to dissolve on the tongue and spit out remainder and rinse mouth when it stops fizzing.

B. BLISTERED/CRACKED

* Increase fluid intake, particularly water
* Initiate mouth care protocol for severe mucositis
* Ensure adequate analgesia given, especially prior to mealtimes.

DRY MOUTH (Xerostomia)

* Drink plenty of water, particularly whilst eating
* Increase use of sauces, gravies
* Consider use of crushed ice (use boiled water or sterile water only), frozen tonic water, artificial saliva, and sugar free chewing gum. Note if ice pops are consumed use sugar free juice. Patients often find sucking boiled sweets helpful. Sucking fruit such as pineapple chunks is not recommended as acid based products are associated with oral discomfort and demineralisation of the teeth.
* Avoid citrus drinks if this causes further pain or discomfort.

In order of most effective

* Salivary stimulation using chewing gum (low sugar) qds. This may be contraindicated in head and neck setting due to thickened secretions or the complete absence of any saliva which may increase the risk of choking.
* Parasympathominetic drugs (pilocarpine), which are effective against Xerostomia induced by drug treatment, salivary gland disease and radiotherapy, however with radiotherapy improvement may not occur for up to 12 weeks. Recommended dose is 5mg t.d.s with meals NB. This will need to be prescribed with caution due to many drug interactions.
* Saliva replacements of which mucin based products are the most effective and gels are thought to be better tolerated than sprays.16 Oral Balance (Biotene ®), or Glandosane® spray.
* Ensure thickened secretions are removed – steam inhalation or saline nebulisers can loosen secretions and help expectoration. Sodium bicarbonate mouthwash (1 teaspoon of sodium bicarbonate in 1 pint of cooled boiled water) made fresh daily and used every 3-4 hours may assist in clearing thickened secretions. There is some evidence to suggest that the use of sodium bicarbonate may affect the pH of the mouth and interfere with mucosal healing; therefore it should be used with caution.

TEETH/DENTURES

* Ensure any patients with loose teeth, ill fitting dentures or caries are referred to the dentist.
* Advise patient to clean dentures 4 times a day, including underneath the dental plate.
* Advise patient to remove dentures overnight and soak in water or if patient has a fungal infection of the mouth a weak chlorhexidine solution.
* NB do not use an ordinary toothpaste as it damages denture surface.

SWALLOWING/CHEWING

* Consider nutritional impact. Complete MUST scoring, Commence nutritional care plan. Ensure referral to dietician.

EATING AND DRINKING

* If any deficits in this area patients should be commenced on a fluid balance chart, a food chart and be referred to the dietician.

DIARRHOEA

* If patients develop diarrhoea this could be due to gut irritation following their treatment. A stool sample should be sent to ensure that there is no infectious cause.
* A fluid balance chart needs to be maintained and all diarrhoea should be measured and recorded. If patient is post an allogeneic transplant this could be caused by graft versus host disease. It is important that frequency, quantity and colour of diarrhoea is recorded so that the progress of the disease can be measured and monitored, as well as any response to treatment. Use Bristol stool chart.
* Fluid loss through diarrhoea can exacerbate the symptoms in the mouth.

SORE THROAT

* Encourage patients to drink plenty as this helps to relieve pain caused by dryness.
* Encourage a soft diet, with plenty of sauces as this makes it easier for patients to swallow.
* If there are white patches on examination of the patients’ throat a swab of the mouth and throat should be sent for both microbiology and virology (virology samples need to go in a special medium pot which should be kept in the fridge).
* If patient is post transplant and has a prolonged sore throat a viral swab should be sent off to check for any unusual viral infections such as HSV or HHV6, adenovirus etc.

PAIN

* Soluble paracetamol mixture (1gram in 20mls) Give half an hour before meals and before bedtime. Do no exceed maximum daily dose and do not take with other medicines containing paracetamol. Please record on the observation chart if paracetamol has been administered as well as the drug chart.
* Oxetacaine and antacid suspension – can be rinsed and spat out or swallowed. Can be especially helpful to swallow in patients with oesophageal pain. Optimum rinsing time is 5 minutes.
* Benzydamine 0.15% (Diflam) mouthwash – has a local anaesthetic effect. Can be used every 11/2 – 3 hours. Can cause stinging and has quite a strong flavour. Gargle the mouthwash as this will lead to numbness. Can be diluted 50/50 with water. If given before meals don’t gargle. Avoid hot food. As tolerance can develop use for 7 consecutive days only. Not to be used instead of Sodium Chloride 0.9%. Not to be used in head and neck patients undergoing radiotherapy.
* Caphosol®, or Episil® - lipid based liquids which spread on the mucosal surface and transform into a bioadhesive film which mechanically protects the damaged mucosa. Caphasol® works best if started at the commencement of treatment and continued afterwards.
* Sucralfate Suspension 1g/5ml (oral tablets to be crushed in water if suspension not available), to be used after meals. May have some prophylactic value and promote healing / reduce severity of mucositis. Use as a mouthwash (swish and spit out) to relieve oral discomfort, if patient has sore mouth only. Can be swallowed if patient also has sore throat.
* Controlled systemic analgesia –
	+ - Morphine Sulphate oral solution or Morphine continuous intravenous infusion.

Monitor bowel function, as aperients may be required.

Needs to be titrated according to pain experienced.

Remember to administer anti-emetics as well.

GRAFT VERSUS HOST DISEASE OF THE MOUTH

* Need to keep mouth moist, use interventions for dry mouth.
* Monitor carefully for infections
* Monitor carefully for soreness and ulceration – can use orabase paste to help with pain control particularly if there are small ulcers. This will provide a protective paste over the ulcers.
* Steroid mouthwashes may have some benefit.
	+ - Prednisolone 5mg soluble tablets in 10mls sterile water four times a day.
		- Or Betamethasone 500micrgrammes in 20mls sterile water four times a day
		- Or hydrocortisone 2.5 mg buccal tablets four times a day.
* Ciclosporin mouthwashes 5ml orally three times a day (Use the 100mg/ml oral solution)

HIGH DOSE METHOTREXATE

* To help reduce the very sore mouth associated with high dose methotrexate patients can be advised to suck ice whilst infusion in progress.

BLEEDING MOUTH.

* Tranexamic acid mouthwashes can be used to help control bleeding in the mouth. Use injection 5 mls diluted with 5 mls of saline q.d.s.
* Not to be used in transplant patients.

**APPENDIX 3**

**EQUALITY IMPACT ASSESSMENT TOOL - To be completed for all new/revised policy, procedural and guideline documents.**

Equality Impact Assessments (EQIAs) are a way of examining new policy\* documents to see whether they have the potential to affect any one group of people more or less favourably than another. Their purpose is to address actual or potential inequalities resulting from policy development. The duty to undertake EQIAs is a requirement of race, gender and disability legislation.

The word ‘policy’ is taken to mean ***all*** *procedural* documents i.e.: Policy, Procedure, and Guideline. (This does *not include Patient Information*)

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| --- | --- | --- |
| **Document Title** | Oral Care Guidelines for Cancer Care | **Version** |
| **Is this a new or revised document?** | Revised Document  |
| **Area to which document relates** Specify whether Trust wide or, Care Group. Name Care Group | Cancer Care |
| **Name of person completing Assessment** | Nikki McKeag |

**STAGE 1 – INITIAL SCREENING**

This stage establishes if the proposed change will have an impact from an **equality perspective** on any particular group(s) of people. See guidance notes on completion.

| **Does the document affect one group more or less favourably than another on the basis of any of the strands of diversity?** | **Positive Impact****Y/N/Neutral** | **Negative Impact****Y/N/Neutral** | **Comments -** Give details of concerns and evidence in the boxes below | **Impact Level**N/L/M/H |
| --- | --- | --- | --- | --- |
| **Age** | Yes |  | Adults  | Low |
| **Disability** | No  | No |  |  |
| **Gender** | No | No |  |  |
| **Sexual Orientation** | No | No |  |  |
| **Race & Ethnicity** | No | No |  |  |
| **Religion or Belief** | No | No |  |  |
| **Culture** | No | No |  |  |
| **Other** e.g. Mental Health, Geographic factors, Economic factors... | No | No |  |  |

**Level of impact:**

Taking into account the impact level for each group, circle one of the words in the boxes below to identify the overall impact level:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **LOW**  |  |  |

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| Target audience: | Cancer Care Staff |
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| Main areas affected: | Cancer Care |
| Summary of most recent changes if applicable: | Summarise most recent changes updated references, update drugs being used,  |
| Consultation: | Cancer Care Clinical Leads, Ward Leaders, Head and Neck CNS’s, Consultant Chemotherapy Nurse, Head of Cancer Nursing, Lead Nurse TYA, BMT team, pharmacy |
| Equality Impact Assessment completion date: | January 2018 |
| Number of pages: | 14 |
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| Should this document be made available on the public website? | No  |
| Is this document to be published in any other format? | No  |

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it, regardless of their individual differences, and the results are available on request.