Laxative Policy

This is a working document and any changes that become necessary to this policy must be notified in writing to the Medicine Management Group via the Chief Pharmacist, East Cheshire Trust

THIS POLICY MUST BE READILY ACCESSIBLE AT ALL TIMES AND AT THE POINT WHERE MEDICINES ARE USED.
<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>East Cheshire NHS Trust Laxative Policy</th>
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<tbody>
<tr>
<td>Executive Summary:</td>
<td>Overview of the policy and its aims This policy provides guidance to all staff in East Cheshire NHS Trust regarding laxative prescribing for the treatment of constipation in adults</td>
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<tr>
<td>Supersedes:</td>
<td>Laxative Policy Version Number 4</td>
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</tbody>
</table>
| Description of Amendment(s):Version 5 | - Naloxegol and methylnatrexone used for 2nd line palliative patients  
- Linaclotide, Lubiprostone and prucalopride used as 3rd line for chronic idiopathic constipation (CIC/IBS-C pathway) |
| Description of Amendments Version 4 | Reviewed and updated laxative policy as per new NICE Clinical Knowledge Summary (CKS) – revised January 2013.  
- Macrogols now used first line for faecal impaction and opioid induced constipation and now an option in addition to ispaghula husk for hard stools in chronic constipation.  
- Stimulant laxative of choice for chronic constipation (including constipation in IBS) now bisacodyl.  
- Bisacodyl now 3rd line option in pregnancy.  
- Complete acute supply of senna and docusate to be supplied on discharge for acute constipation.  
- Separate advice on management of constipation in IBS patients, critical care patients added to the policy. |
| This policy will impact on: | All health professionals involved in the prescribing of laxatives |
| Financial Implications: | Bisacodyl more expensive than senna in hospital setting but to be used in chronic constipation community. Bisacodyl is cheaper in the community than senna therefore this change will help continuity of care on discharge. |
| Policy Area: | Laxative Policy |
| Version Number: | 5 |
| Document Reference: | ECT002529 |
| Effective Date: | June 2016 |
| Issued By: | Chair of Medicines Management Group |
| Review Date: | June 2019 |
| Author: | Jabeen Razzaq-Sheikh (Lead Pharmacist for Acute Services) |
| Impact Assessment Date: | July 2016 |

**APPROVAL RECORD**

<table>
<thead>
<tr>
<th>Committees / Group</th>
<th>Date</th>
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<tbody>
<tr>
<td>Consultation:</td>
<td>Management June 2016</td>
</tr>
<tr>
<td>All Gastroenterology consultants</td>
<td>Other (please specify) Medicines Management Group June 2016</td>
</tr>
<tr>
<td>Approved by Director:</td>
<td>Trust SQS Committee June 2016</td>
</tr>
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<td>Received for information:</td>
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</table>
For patients admitted on laxative therapy

1. Review the need for a laxative (Consider precipitating factors – medicines (e.g. opioids, anticholinergics, aluminium – containing antacids, tricyclic antidepressants, iron, calcium channel blockers); endocrine or metabolic disease (hypothyroidism); bowel disease; pregnancy).

2. If appropriate educate the patient – increase dietary fibre; ensure adequate fluid intake; increase activity. (Note that a high fibre diet may not be practical or may be unethical in certain patient groups e.g. palliative care where anorexia may be an issue, in squashed stomach syndrome due to mass or ascites (where a high fibre diet is generally contraindicated) and in patients at risk of bowel obstruction.

3. If laxative is still indicated – prescribe from the appropriate regime below

For patients complaining of constipation or at risk of becoming constipated

1. Identify the nature and duration of the constipation.

   Educate the patient – increase dietary fibre; ensure adequate fluid intake; increase activity. (Note that a high fibre diet may not be practical or may be unethical in certain patient groups e.g. palliative care where anorexia may be an issue, in squashed stomach syndrome due to mass or ascites (where a high fibre diet is generally contraindicated) and in patients at risk of bowel obstruction.

2. Consider precipitating factors – medicines (e.g. opioids, anticholinergics, aluminium – containing antacids, tricyclic antidepressants, iron, calcium salts, channel blockers); endocrine or metabolic disease (hypothyroidism); bowel disease; pregnancy.

   A) Short term acute constipation of 5 days or less (a laxative is not always required).

   • Ensure adequate fluid intake

   • Mobilise as soon as possible and encourage exercise where possible.

   Senna 2 tablets at night (effective in 8 – 12 hours). If hard stools in rectum add docusate sodium 200mg twice a day

   Or

   • Glycerin suppository (if hard stool) ONE daily (effective 15 – 30 minutes)

   • For patients post haemorrhoidectomy use lactulose 15ml twice daily and for post major surgery use ispaghula husk ONE sachet twice a day

Review the continuing need for laxatives as patient recovers from the acute episode. ONLY prescribe laxatives on discharge if need continues e.g. prior usage or continuing precipitant. If laxatives are prescribed on discharge a complete acute course should be supplied e.g. approximately 5 days treatment. Note - if on admission patient has history of prior usage consider regime C (long term chronic constipation) or regime D (if chronic opioid induced constipation).
B) Faecal impaction

i) Faecal impaction with hard faeces
- For faecal impaction with hard faeces prescribe macrogol oral powder 8 sachets daily dissolved in 1 litre of water and given over 6 hours (See BNF cautions and dosing). This can be given for 3 days ONLY or until bowels are open (whichever is sooner).

- If the response to oral laxatives is not quick enough consider using a glycerine suppository +/- bisacodyl suppository (10mg mane).
- Other regular laxatives as per Regime C (for long term chronic constipation) or E (if opioid induced constipation) should also be given so that they can continue to work once impaction is cleared.

ii) Faecal impaction with soft faeces
Start bisacodyl 5-10mg nocte. If poor response to oral therapy consider a 10mg bisacodyl suppository.

If faecal impaction inadequate for soft/ hard stools use a Micro-enema Or Phosphate enema

C) Long term chronic constipation
(Avoid long term prescription where possible)

- Relieve faecal/loading impaction if present

- High fibre diet, exercise and adequate hydration may be all that is required (Note that a high fibre diet may not be practical or may be unethical in certain patient groups e.g. palliative care where anorexia may be an issue, in squashed stomach syndrome due to mass or ascites (where a high fibre diet is generally contraindicated) and in patients at risk of bowel obstruction.

- Adjust any constipating medications if possible e.g. Aluminium antacids, antimuscarinics, tricyclics, sedating antihistamines, antipsychotics, antispasmodics, diuretics, calcium supplements, iron supplements, opioids, verapamil and some antiepileptics e.g carbamazepine, gabapentin, pregabalin, phenytoin.

- Where non-drug treatment fails or is impractical, ispaghula husk ONE sachet twice a day - afternoon dose not later than 1600. Advise patient to drink plenty of water (effective 1 – 2 days)

- If stool remains hard add in a macrogol e.g. Movicol ONE to THREE sachets daily in divided doses usually for up to 2 weeks; maintenance ONE to TWO sachets daily (as per BNF dosing).

- If stools are soft but the person finds them difficult to pass or complains of inadequate emptying add bisacodyl 5-10mg nocte (maximum 20mg in 24 hours)
D) Intractable constipation

Senna TWO tablets at night and docusate sodium 200mg twice a day

OR

Macrogol oral powder ONE sachet three times a day for up to 2 weeks ONLY may be considered

E) Patients on regular opioids
Note: for palliative patients see regime G

(DO NOT wait for them to become constipated, consider initiating regular laxative simultaneously with opioid)

• Ensure adequate fluids

• High fibre diet
  (Note that a high fibre diet may not be practical or may be unethical in certain patient groups e.g. palliative care where anorexia may be an issue, in squashed stomach syndrome due to mass or ascites (where a high fibre diet is generally contraindicated) and in patients at risk of bowel obstruction.

First line

• Macrogol – ONE to THREE sachets daily in divided doses usually for up to 2 weeks; maintenance ONE to TWO sachets daily (as per BNF dosing).

Second line

• If first line ineffective add bisacodyl 5-10mg nocte

Please note: bulk-forming laxatives e.g. ispaghula husk should be avoided in opioid-induced constipation.

F) Palliative care


• Lactulose should be avoided in all patients with abdominal distension associated with malignancy (e.g. due to tumour or malignant ascites) and is contraindicated in patients with bowel obstruction

• Co-danthramer 25/200mg *Palliative patients ONLY* Take 1 or 2 capsules daily at bedtime and titrate dose as necessary. There are different formulations as per table below. Please note the liquid formulation is very expensive.
Dose equivalence and conversion

<table>
<thead>
<tr>
<th></th>
<th>Dantron</th>
<th>Poloxamer</th>
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<tbody>
<tr>
<td>Co-danthraper (standard strength) 200mg capsules</td>
<td>25 mg</td>
<td>200 mg</td>
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<tr>
<td>Co-danthraper 200 mg per 5 mL.</td>
<td>25 mg</td>
<td>200 mg</td>
</tr>
<tr>
<td>Co-danthraper strong capsules</td>
<td>37.5 mg</td>
<td>500 mg</td>
</tr>
<tr>
<td>Co-danthraper strong oral suspension</td>
<td>75 mg</td>
<td>1g</td>
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Please note

Co-danthraper suspension 5 mL = one co-danthraper capsule, but strong co-danthraper suspension 5 mL = two strong co-danthraper capsules.

Second line following a trial of at least one other laxative.

- **Naloxegol** 25mg daily

Naloxegol (Moventig, AstraZeneca) is a form of naloxegol which has been pegylated (that is, attached to a molecule of polyethylene glycol, or PEG). In this form, it selectively antagonises peripheral opioid receptors to relieve constipation. It has a marketing authorisation for treating opioid-induced constipation (OIC) in adults whose constipation has had an inadequate response to laxative(s). The summary of product characteristics defines an inadequate response to laxatives as concurrent symptoms of OIC of at least moderate severity while taking at least 1 laxative class for a minimum of 4 days during the last 2 weeks. The European public assessment report for naloxegol provides further clarification regarding the definition of an inadequate response to laxatives. It states that a person must have been taking 1 laxative class for a minimum of 4 days out of the 14 days prior to the screening visit and report moderate, severe, or very severe symptoms in at least 1 of the 4 stool symptom domains.

- **Methylnatrexone** *Palliative patients ONLY.* Can only be initiated by a specialist consultant

For opioid induced constipation. 8-12 mg subcutaneous according to weight, nocte every alternate days. (See SPC). Please review its effectiveness before it is sent to primary care.
G) Pregnancy

**First Line**
- Ispaghula husk 1 sachet twice a day (effective 1 – 2 days).

**Second Line**
- Glycerin suppositories – one daily (effective 15 – 30 minutes)
  **Or**
  - Lactulose 10-20ml twice a day

**Third Line**
- Bisacodyl 5-10mg nocte

H) Constipation in irritable bowel syndrome (IBS)

**First line**
- Ispaghula husk ONE sachet twice a day

**Second line**
- If first line not tolerated or where an additional laxative is required add a macrogol **OR** bisacodyl 5-10mg nocte (short-term use only)

Lactulose is **not** recommended.

Please note - non-laxative treatment not covered in this policy should be considered in the management of IBS. For example, dietary and lifestyle advice, antispasmodics (e.g. mebeverine) and low dose tricyclic antidepressants (e.g. amitriptyline). See NICE Clinical Knowledge Summary on IBS (revised Feb 2013) for further information.

I) Chronic Idiopathic Constipation (CIC/IBS-C pathway).

**If first line and second line fail (H) then review pathway**

- **Prucalopride** can be an option in both **female and male** patients with chronic constipation who fail on treatment with at least 2 laxatives from different classes, at the highest tolerated recommended doses for least 6 months and invasive treatment is being considered.

The dose of **Prucalopride** is 2mg orally ONCE a day. Elderly patients, and those with severe renal or hepatic impairment, should start on 1mg ONCE a day. Review treatment if no response after 4 weeks. See product information for more details.

Prucalopride is a selective, high affinity, serotonin(5HT4) receptor agonist with gastrointestinal prokinetic effects.

**NOTE:** To be initiated by a gastroenterology consultant ONLY, as per NICE technology appraisal 211 (www.nice.org.uk/ta211) *
Linaclotide (Constella) is a first-in-class, oral, once-daily guanylate cyclase-C receptor agonist (GCCA), licensed for the symptomatic treatment of moderate-to-severe irritable bowel syndrome with constipation (IBS-C) in adults. It has visceral analgesic and secretory activities.

-Linaclotide 290 micrograms daily

Lubiprostone is recommended as an option for treating chronic idiopathic constipation, that is, for adults in whom treatment with at least 2 laxatives from different classes, at the highest tolerated recommended doses for at least 6 months, has failed to provide adequate relief and for whom invasive treatment for constipation is being considered.

-Lubiprostone 24 microgram daily
J) Constipation in the critical care setting

See Appendix 2 for guidelines on management.

References:


5. Medical Information. Comparison of the laxative effects of bisacodyl and senna, Boehringer Ingelheim; 2014 Jan 29.


8. NICE Technology Appraisal Guidance 211: Prucalopride for the symptomatic treatment of chronic constipation in women.

Appendix 1: Laxative Guideline - Treatment of Constipation in Adults

1. Identify nature and duration of the constipation (a laxative is not always required)

2. Is there abnormal bowel function or altered routine?

3. Alarm symptoms present? (anaemia, blood in the stool, weight loss)

4. YES
   - Investigate

5. NO
   - Advise patient about normal bowel function
   - Dietary & lifestyle advice as appropriate
     - Increase Fluid intake
     - Increase Dietary fibre
       (see main policy)
     - Increase exercise

6. Underlying cause? (e.g. neurological, bowel disorder or drug treatment)
   - YES
     - Treat underlying cause:
       - Surgical post op
       - Review drug therapy e.g. opioids/iron
       - Dehydration
       See Regimes below for drug management
   - NO

7. Ineffective
   - Initiate laxative therapy

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**Regime A - Short term acute constipation/Post op (5 days or less)**

- Senna TWO tablets at night (if hard stools in rectum add docusate sodium 200mg twice a day)
- OR
- Glycerin suppositoryONE daily

**For patients post haemorrhoidectomy use lactulose 15ml twice daily and for patients post major bowel surgery use fybogel ONE sachet twice a day**

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**Regime B - Faecal impaction with hard faeces**

- Macrogol oral powder EIGHT sachets daily dissolved in 1 litre of water and given over 6 hours for 3 days only or until bowels are open, whichever is sooner (See BNF CAUTIONS AND DOSING).
- If the response to oral laxatives is not quick enough consider using a glycerine suppository +/- bisacodyl suppository (10mg mane). Other regular laxatives (i.e. as per Regime B or D (if opioid induced constipation)) should also be given so that they can continue to work once impaction is cleared.

**Bisacodyl 5-10mg nocte.** If poor response use a bisacodyl suppository (10mg mane)

2nd line - if faecal impaction inadequate for soft/ hard stools use a Micro-enema Or Phosphate enema

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**Regime C - Chronic constipation**

- Note: see life style advice in full policy
- Ispaghula husk ONE sachet twice a day **(Afternoon dose not later than 1600 hours. Advise patient to drink with plenty of water)**
- If hard stools consider macrogols as per BNF dosing. If ineffective add bisacodyl 5-10mg nocte.

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**Regime D - Intractable Constipation**

- Senna TWO tablets at night and docusate sodium 200mg twice a day
- OR
- Macrogol oral powder ONE sachet three times a day for up to 2 weeks ONLY may be considered

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**Regime E - Patients taking regular opiates**

- (Note: for palliative patients see Regime F)
- DO NOT wait for patient to become constipated, consider regular laxative simultaneously with opiate.
- 1st line - Macrogol as per BNF dosing
- 2nd line - if 1st line ineffective add bisacodyl 5-10mg nocte
- (Note: avoid bulk forming laxatives)

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**Regime F - Palliative Care**

- Consider Co-danthramer ONE to TWO capsules at night and then titrate for opioid induced constipation or See Network Guidelines on intranet (can be found under P in Trust policies)
- **Naloxegol 25mg OD** -second line following a trial of at least one other laxative:
- **Methylnaltrexone 8-12mg SC**(as per weight nocte alternate days)-- indicated on specialist recommendation for patients who fail first line laxative (Macrogols +/- Bisacodyl) and Naloxegol, or when here is no oral access

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**Regime G - Pregnancy**

- 1st line - Ispaghula husk ONE sachet twice a day
  - (Last dose no later than 1600 hours, to be drank with plenty of water)
- 2nd line - Glycerin suppository ONE daily OR
- Lactulose 10-20mls twice a day
- 3rd Line - Bisacodyl oral 5-10mg nocte

Contd.
Appendix 1: Laxative Guideline - Treatment of Constipation in Adults (contd)

Regime H - Constipation in Irritable Bowel Syndrome (IBS)

- Consider Regime C-chronic constipation initially

2nd line – Add macrogol (short-term use only)

If inadequate response to laxative after 3 months refer to gastroenterology specialist.

Lactulose is not recommended. Non-laxative treatment not covered in this policy should be considered in the management of IBS e.g. dietary and lifestyle advice, antispasmodics (e.g. mebeverine), low dose tricyclic antidepressant (e.g. amitriptyline) - see NICE Clinical Knowledge Summary on IBS (revised Feb 2013).

3rd Line- See pathway below for Chronic Idiopathic Constipation (CIC/IBS-C pathway). Treatments in the pathway include praculopride, linaclotide, lubiprostone. (See BNF for doses)

Regime J – Constipation in the critical care setting - See Appendix 2 in full guideline

Lactulose should only be used in the treatment of hepatic encephalopathy, in post haemorrhoidectomy patients and 2nd line in pregnancy. Its use should be restricted to these patients.
Appendix 2:

Critical Care Bowel Protocol

- Enteral nutrition commenced as per protocol
  - Commence senna 10mls bd

Bowels opened in last 24-48 hours

Commence docusate 20mls bd (50mg/5ml)
- Bowels opened in 24 hours
  - PR faeces present
    - Continue senna + docusate for 48 hours
      - PR faeces present
        - Consider AXR
          - Refer to medical ICU team
        - If no result in 4 hours
          - Bisocodyl 1 x1
            - If no result in 4 hours
              - Microlax enema
                - If no result in 4 hours
                  - Phosphate enema (NOT in RENAL FAILURE)
                    - If no result in 4 hours

  - Is stool...
    - Hard/soft
      - Continue laxatives
    - Loose >2x day
      - Omit docusate if px + continue senna
      - Loose stools >2x day >24-48 hours Stop senna
        - Loose stools >2x day >48 hours after all laxatives stopped
          - Do not send stool sample
          - Check other medication
          - Refer to medical ICU team
ECT Joint Care
Chronic Idiopathic Constipation-CIC/IBS-c Pathway

Chronic constipation for more than 3-6 months / longstanding

**PRIMARY CARE**
Initial investigations: FBC, U&E’s, TSH, calcium, coeliac serology

- **No red flag signs**
  - Trial of at least 2 laxatives/antispasmodics for 6 months
- **Red flag signs**
  - Weight loss / Rectal bleeding / Vomiting / Abdo pain (significant)
  - Refer under appropriate pathway
  - Urgent / 2ww etc

**Good response:**
GP follow up

**Partial response / No response**

**REFERRAL TO SECONDARY CARE**

- **Assessment / investigations as appropriate**
  - Colonoscopy / colonic transit study / defecating proctogram studies as appropriate or proceed to treatment / other anorectal

- **Medical management**
- **Bio feedback**
- **Surgery**

**Constipation predominant IBS-C/CC**

- **Prucalopride CIC**
- **Linaclotide IBS-C**
- **Lubiprostone CIC**

GI clinic follow up / As per shared care policy

- 8 weeks prescribing by secondary care and thereafter primary care prescribing (GP)
- NB 4 weeks prescribing by secondary care for lubiprostone

Stable patients with good response - Consider discharge to GP-GP to review medication on a 3-6 monthly basis

Prepared/Approved: June 2016  Review: June 2019
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.
Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

East Cheshire NHS Laxative Policy

Details of person responsible for completing the assessment:
- Name: Jabeen Razzaq-Sheikh
- Position: Lead Pharmacist for Surgical Specialities, Clinical Support & Diagnostics
- Team/service: Pharmacy Department

State main purpose or aim of the policy, procedure, proposal, strategy or service:
This policy provides guidance to all staff in East Cheshire NHS Trust regarding laxative prescribing for the treatment of constipation in adults

2. Consideration of Data and Research
To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document
Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.
Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia.
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE: In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC: In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% in 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- None: 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

Carers: In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)
No

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?
No

3. Assessment of Impact
Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

Prepared/Approved: June 2016   Review: June 2019
RACE:
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, racial groups differently?  
Yes ☑ No ✗

**Explain your response:**
Policy applies to all adult patients equally within scope of the policy. Where a person’s first language is not English, staff will follow the Trust’s interpretation and translation policy where necessary for patient consultation & counselling.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, different gender groups differently?  
Yes ☑ No ✗

**Explain your response:**
Policy applies to all patients equally within scope of policy. Note: the trust has a transgender policy and staff will be mindful of this.

DISABILITY
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, disabled people differently?  
Yes ☑ No ✗

**Explain your response:**
Policy applies to all patients equally within scope of policy. Use of an interpreter may be employed where necessary for Deaf patients or deaf blind to facilitate consultation & counselling. The Trust is also implementing Sign translate which is an online BSL interpretation system using a webcam, which may help with patients and carers. Information can be provided in a variety of formats such as large print, audio, Braille and easy read. For patients with learning difficulties, picture communication books are available in ward communication boxes and staff have access to learning disabilities awareness training including Makaton.

AGE:
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, age groups differently?  
Yes ☑ No ✗

**Explain your response:**
There is a reduced dose of prucalopride in elderly patients as per BNF recommendations (see regimen H – treatment failure). All other doses in this policy are the same regardless of age.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  
Yes ☑ No ✗

**Explain your response:**
Policy applies to all patients equally within the scope of the policy

RELIGION/BELIEF:
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, religious belief groups differently?  
Yes ☑ No ✗

**Explain your response:**
Policy applies to all patients equally within scope of policy. Staff will check at the time if any drug contains ingredients that are not acceptable to a person’s faith e.g. porcine or bovine products and would discuss this along with the alternatives with the patient and prescriber if requested.
**CARERS:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?  
Yes [ ] No [✓]

**Explain your response:**

Carers would be involved in discussions, particularly with regard to eliciting information regarding current medications and regarding improving compliance on discharge__________________________

**OTHER:**  
EG Pregnant women, people in civil partnerships, human rights issues.  
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently?  
Yes [✓]  No [ ]

**Explain your response:**

There is a separate section of the policy that covers management of constipation in pregnancy (see regime G). This is included as to ensure appropriate therapies with the best safety evidence for use in pregnancy are advised.

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<thead>
<tr>
<th>4. Safeguarding Assessment - CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is there a direct or indirect impact upon children?  Yes [ ]  No [✓]</td>
</tr>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing/conflicting impact between different groups of children and young people:</td>
</tr>
<tr>
<td>c. If no please describe why there is considered to be no impact / significant impact on children</td>
</tr>
<tr>
<td>Policy applies to adult patients only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Relevant consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?</td>
</tr>
<tr>
<td>No. Policy applies equally to all patients within the scope of the policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Date completed:</th>
<th>June 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Date:</td>
<td>June 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Any actions identified:</th>
<th>Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>Lead</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead <a href="mailto:lynbailey@nhs.net">lynbailey@nhs.net</a></th>
</tr>
</thead>
</table>

Approved on behalf of Trust Equality and Diversity Lead:  

Head of Integrated Governance  
Date: 05 July 2016