1. Aim/Purpose of this Guideline
   1.1. Guidance for all clinical staff at RCHT for the treatment of alcohol withdrawal and administration of chlordiazepoxide.

2. The Guidance
ALCOHOL DETOXIFICATION AND CHLORDIAZEPOXIDE (CDZ) ADMINISTRATION GUIDELINES

For first 24 hours only: Prescribe CDZ 20-50mg prn to be administered as per CIWA score (alcohol withdrawal scale). Maximum CDZ 250mg in 24 hours. Senior medical staff should be consulted if this limit is to be exceeded.

Do not prescribe Phenytoin for alcohol withdrawal seizures.

Do not prescribe any regular CDZ or other regular sedatives for first 24 hours

Commence Pabrinex 1&2 (one pair) IV daily for 3 days ASAP. Use IM Pabrinex 1 pair OD if unable to gain IV access. Note Alcohol dependent hypoglycaemic patients should be given Pabrinex with or prior to IV glucose

If patient has any one of following symptoms: Acute confusion, Decreased consciousness level, Memory disturbance, Ataxia/unsteadiness, Ophthalmoplegia, Nystagmus, unexplained hypotension with hypothermia commence Pabrinex 3 pairs TDS for 3 days then 1 pair daily for 3 days or until clinical improvement stops. Use IM Pabrinex 1 pair BD if no IV access.

Check Magnesium levels (if low patient will not uptake Pabrinex)

If problems of disturbed behaviour occur prescribe prn lorazepam 1-2mg oral/im (tablets may be administered sublingually if IM preparation unavailable) (maximum 4mg in 24 hours) in addition to CDZ. Lorazepam 1mg = CDZ 30mg therefore nurses and doctors should add this to CDZ given to ensure maximum CDZ 250mg in 24 hours is not exceeded.

If patient requires IV sedation discuss with Critical Care

On Day 2 calculate the total CDZ dose given in initial 24 hours. Divide this dose (including equivalent CDZ dose of any lorazepam given) into equal qds doses and prescribe for Day 2 of detoxification regimen.

Reduce CDZ by approx 20% or10mg QDS daily after Day 2

Prn CDZ/sedation should not be required from Day 2 onwards, however if withdrawal symptoms worsen recommence CIWA scoring and prn administration.

Contact RCHT Alcohol Liaison Team 8am - 4pm 7 days a week for Brief Intervention and referral to Community Alcohol Services. For advice regarding management of detoxification/Wernickes Encephalopathy contact Psychiatric Liaison via bleep through Bodmin Switchboard on ext: 1300 8am - 8pm 7 days a week. Please read accompanying guidelines for CIWA scoring information and further alcohol detoxification care.
CHART OF THE CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL (CIWA) SCORE & CHLORDIAZEPOXIDE ADMINISTERED DURING THE FIRST 24 HOURS OF THE ALCOHOL DETOXIFICATION REGIME

**Name of Patient**..............................
**or affix patient label**
**Address**..........................................  
**Date of birth**.................................
**CR Number**.................................

**Day/Date/Time Commenced:**

.............day ....../....../........

**Consultant**

.................................................

The administration of chlordiazepoxide & continuing monitoring for the first 24hrs should follow this table

Maximum 250 mg chlordiazepoxide in 24 hours.

Lorazepam 1mg = Chlordiazepoxide 30mg

<table>
<thead>
<tr>
<th>CIWA Score (see reverse)</th>
<th>Frequency of CIWA observations</th>
<th>Administration of chlordiazepoxide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before first dose of chlordiazepoxide is required</td>
<td>After first and subsequent doses of chlordiazepoxide</td>
</tr>
<tr>
<td>0-10</td>
<td>Hourly</td>
<td>Two hourly</td>
</tr>
<tr>
<td>11 or greater</td>
<td>Two hourly</td>
<td>20 – 50 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE &amp; TIME</th>
<th>CIWA SCORE</th>
<th>CHLORDIAZEPOXIDE DOSE (INCLUDE LORAZEPAM)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Calculate total chlordiazepoxide dose administered in the first 24 hours. Divide into equal QDS doses. Prescribe on day two of detoxification regime. From day three reduce chlordiazepoxide by approximately 20% daily over five to seven days then stop. PRN chlordiazepoxide or other
sedative should not usually be required from day two onwards. See guidelines for vitamin supplementation.
<table>
<thead>
<tr>
<th>Clinical Institute Withdrawal Assessment for Alcohol (CIWA-AR) (Sullivan et al., 1989)</th>
</tr>
</thead>
</table>
| **Nausea and Vomiting**  
Ask “do you feel sick to your stomach? Have you vomited?”  
**Observation**  
0 No nausea.  
1 Mild nausea with no vomiting.  
2  
3  
4 Intermittent nausea with dry heaves.  
5  
6  
7 Constant nausea, frequent dry heaves and vomiting.  
| **Tactile Disturbances**  
Ask “have you any itching, pins and needles, any burning or numbness or do you feel bugs crawling under your skin?”  
**Observation**  
0 None.  
1 Very mild itching, pins ad needles, burning or numbness.  
2 Mild itching, pins and needles, burning or numbness.  
3 Moderate itching, pins and needles, burning or numbness.  
4 Moderately severe hallucinations.  
5 Severe hallucinations.  
6 Extremely severe hallucinations.  
7 Continuous hallucinations.  |
| **Tremor – arms extended and fingers spread apart**  
**Observation**  
0 No tremor.  
1 Not visible, but can be felt fingertip to fingertip.  
2  
3  
4 Moderate, with patient’s arms extended.  
5  
6  
7 Severe, even with arms not extended.  | **Auditory Disturbances**  
Ask “are you more aware of sounds around you? Are they harsh? Do they frighten you?”  
**Observation**  
0 Not present.  
1 Very mild sensitivity.  
2 Mild harshness or ability to frighten.  
3 Moderate harshness or ability to frighten.  
4 Moderately severe hallucinations.  
5 Severe hallucinations.  
6 Extremely severe hallucinations.  
7 Continuous hallucinations.  |
| **Paroxysmal Sweats**  
**Observation**  
0 No sweat visible.  
1 Barely perceptible sweating, palms moist.  
2  
3  
4 Beads of sweat obvious on forehead.  
5  
6  
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.  | **Visual Disturbances**  
Ask “does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there?”  
**Observation**  
0 Not present.  
1 Very mild sensitivity.  
2 Mild sensitivity.  
3 Moderate sensitivity.  
4 Moderately severe hallucinations.  
5 Severe hallucinations.  
6 Extremely severe hallucinations.  
7 Continuous hallucinations.  |
| **Anxiety**  
Ask “do you feel nervous?”  
**Observation**  
0 No anxiety.  
1 Mildly anxious.  
2  
3  
4 Moderately anxious or guarded so anxiety is inferred.  
5  
6  
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.  | **Headache, Fullness in Head**  
Ask “does your head feel different? Does it feel like there is a band around your head?”  
Do not rate for dizziness or light-headedness. Otherwise rate severity.  
**Observation**  
0 Not present.  
1 Very mild.  
2 Mild.  
3 Moderate.  
4 Moderately severe.  
5 Severe.  
6 Very severe.  
7 Extremely severe.  |
| **Agitation**  
**Observation**  
0 Normal activity.  
1 Somewhat more than normal activity.  
2  
3  
4 Moderately fidgety and restless.  
5  
6  
7 Paces back and forth during most of the interview or constantly thrashes out.  | **Orientation and Clouding of Sensorium**  
Ask “what day is this? Where are you? Who am I?”  
**Observation**  
0 Orientated and can do serial additions.  
1 Cannot do serial additions or is uncertain about date.  
2 Disorientated for date by no more than 2 calendar days.  
3 Disorientated for date by more than 2 calendar days.  
4 Disorientated for place and/or person.  |
**Ongoing Vitamin Supplementation**

- Pabrinex 1&2 (1pair) IV daily for 3 days (Use IM Pabrinex if no IV access)
- Thiamine PO 300mg tablets od or 100mg tds (To be given alongside Pabrinex)
- Vitamin B co strong PO 2 tablets od (To be given alongside Pabrinex)

**Monitoring**

- CIWA score for 1st 24 hours
- BP & TPR with CIWA for 1st 24 hours then BD for days 2-6
- GCS in patients with reduced GCS

**Presentations of note**

**Head Injury** – In most cases patients that are admitted with a head injury can be managed with the above guidelines but if you are concerned about the effect of benzodiazepines on a serious head injury then seek senior advice or advice from specialist neurosurgical team at Derriford. Alcohol withdrawal cannot be ignored in these patients.

**Impaired Hepatic Function** – If you are concerned about the effect of chlordiazepoxide in a patient with acute hepatic impairment change to Lorazepam oral as this is less likely to accumulate and cause encephalopathy and seek advice from the Gastroenterology Team.

**Opiate Dependant and Alcohol Dependant Patients** – If the patient has a community Opiate prescription then this should be confirmed and continued and assessment for alcohol withdrawal symptoms with benzodiazepines titrated on top of Opiate prescription. If the patient is dependant on street opiates then alcohol withdrawal symptoms should take priority and assess using CIWA but do not give opiates to treat opiate withdrawal symptoms.
GUIDELINES FOR TREATMENT OF ALCOHOL WITHDRAWAL
The approach advocated here is to prescribe chlordiazepoxide according to a flexible regimen over the first 24 hours, with dosage titrated against the rated severity of withdrawal symptoms. This is followed by a fixed 5-7 day reducing regimen, based upon the dosage requirement estimated during the first 24 hours.
The intention of the flexible protocol for the first 24 hours is to titrate the dosage of chlordiazepoxide against the severity of alcohol withdrawal symptoms. It is necessary to avoid under-treatment (associated with patient discomfort and a higher incidence of complications such as fits or DTs) or over-treatment (associated with excessive sedation and risk of toxicity/interaction with alcohol consumed prior to admission).

Important points to note when evaluating the patient
- Drinking history – describe amount and type of alcohol and calculate units.
- Past history of alcohol withdrawal
- Complications associated with previous withdrawal episodes such as seizures or delirium.
- Time elapsed since last alcoholic drink

This information can then be used to anticipate the severity, timing and possible complications of withdrawal symptoms. Advice can be given to nursing staff on patient management and dose ranges to be used. Medication such as Diazepam PR can be prescribed if patients are at risk of withdrawal seizure.

Prescribing of chlordiazepoxide

First 24 hours (day 1)

Dose range
A flexible dose range for the first 24 hours only should be prescribed and administered as per the CIWA score. Chlordiazepoxide should be administered when withdrawal symptoms are considered significant (usually CIWA score more than 11). See enclosed table and administration chart. A dose range of 20-50mg will cover almost all circumstances.

Delirium & Disturbed Behaviour
Consider use of Lorazepam 1 – 2 mg Oral / IM for disturbed behaviour (due to the shortage of parental Lorazepam, consider Clonazepam IV, Lorazepam 1mg = Clonazepam 2mg)
Maximum dose in 24 hours
The maximum cumulative dose which may be given during the first 24 hours must be stated. This should usually be a maximum of 250mg chlordiazepoxide unless discussed with Consultant, Senior Registrar or Psychiatric Liaison.
Lorazepam 1 mg = Chlordiazepoxide 30 mg and should therefore be included in this maximum dose.

Days 2-5
The total cumulative dose administered during the initial 24 hrs is the baseline dose. This baseline dose should be divided into equal QDS doses and prescribed as Day 2 of the detoxification regime. Then reduce the doses by approximately 20% or 10mg QDS daily over the following 5 - 7 days.

Withdrawal Seizures
Patient’s at risk of seizures should be prescribed Diazepam 5mg pr prn.
Do not prescribe Phenytoin for alcohol withdrawal seizures

Intravenous sedation
Intravenous sedation should only be given if agreed by a medical consultant and if there is one to one nursing available, in general this means the patient should be cared for on Critical Care.

Vitamin Supplementation – Prevention and Treatment of Wernicke’s encephalopathy
- Commence Pabrinex 1&2 (1 pair) iv daily for 3 days ASAP (usually given with 100mls 5% glucose) as slow infusion. Patients with any one of the following symptoms: Acute confusion, Decreased conscious level, Memory Disturbance, Ataxia/unsteadiness, ophthalmoplegia, nystagmus, Unexplained hypotension with hypothermia may have Wernicke’s encephalopathy (WE) or if patients are at high risk of developing WE (Homeless, Malnourished, IV drug use or previous WE) and should be prescribed Pabrinex 3 pairs TDS for 3 days followed by 1 pair for 3 to 5 days or until clinical improvement stops. Note alcohol dependent hypoglycaemic patients should be given Pabrinex with or prior to the administration of IV glucose to prevent precipitating Wernicke’s encephalophathy..
- Thiamine 100mg tablet tds orally or 300mg od
- Vitamin B Co Strong two tablets tds orally

Monitor
CIWA Score, Pulse, Blood Pressure, Respiration, Temperature &GCS in patients with a reduced GCS
Use of CIWA rating scale

The CIWA scale is a guide to assessing the severity of withdrawal symptoms. **If the patient is asleep the CIWA score is nil.** It is not always necessary to ask the patient all of the questions listed each time a CIWA assessment is completed. The usual medical or nursing observations of a patient’s emotional or mental state will often be sufficient to rate symptoms without asking all the questions suggested on the rating scale. The CIWA score is a guide to the amount of sedative to be given. Factors such as the age, weight and physical condition of the patient should also influence the dose of chlordiazepoxide given.

Maintain a safe environment

**Sedated patients are at risk of dehydration. Observations can be recorded twice daily from days 2-6**

Consider one to one nursing for disturbed patients, refer to RCHT Safe and Supportive Observation Policy.

Contact

Contact RCHT Alcohol Liaison Team 8am - 4pm 7 days a week for Brief Intervention and referral to Community Alcohol Services. For advice regarding management of detoxification/Wernickes Encephalopathy contact Psychiatric Liaison via bleep through Bodmin Switchboard on ext: 1300 8am - 8pm 7 days a week. Please read accompanying guidelines for CIWA scoring information and further alcohol detoxification care.

Discharge

Patients who discharge against medical advice should not be prescribed benzodiazepines as TTO’s. Planned discharges should usually have completed the detoxification regimen prior to discharge.
PABRINEX ADMINISTRATION

**DOES THE PATIENT HAVE SYMPTOMS OF WERNICKE'S? (PLEASE REFER TO ALCOHOL DETOXIFICATION GUIDELINES)**

- **YES**: PX IV PABRINEX 2 to 3 PAIRS TDS FOR 3-5 DAYS
  - **PX IM (HIGH POTENCY) PABRINEX 2 PAIRS TDS FOR 2 DAYS; IF NO RESPONSE, DISCONTINUE:** IF SYMPTOMS RESOLVE AFTER 2 DAYS GIVE 1 PAIR OD FOR 5 DAYS OR FOR AS LONG AS IMPROVEMENT CONTINUES
  - **NO**: PX IV PABRINEX 1 PAIR OD FOR 3 DAYS

- **NO**
  - **YES**
  - **NO**

**ARE YOU ABLE TO OBTAIN IV ACCESS?**

- **YES**
  - **YES**
  - **NO**

**PLEASE NOTE WHEN GIVING IM PABRINEX:** DUE TO THE AMOUNT OF FLUID IN ONE DOSE (7MLS) IT IS BEST PRACTICE TO GIVE IN TWO INJECTION SITES. IE; MIX BOTH AMPULES ADMINISTER HALF, CHANGE NEEDLES AND ADMINISTER OTHER HALF IN TO A DIFFERENT SITE.
**Monitoring compliance and effectiveness**

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Appropriate use of CIWA, chlordiazepoxide prescription and prescribing of Pabrinex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Substance Misuse Liaison Nurse</td>
</tr>
<tr>
<td>Tool</td>
<td>No specific tool will be used the Psychiatric Liaison Team to Audit</td>
</tr>
<tr>
<td>Frequency</td>
<td>Audit should be done 6 months after introduction of the guidelines</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The Psychiatric Liaison Team is responsible for updating and Auditing the guidelines</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The Psychiatric Liaison Team is responsible for updating and Auditing the guidelines</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Identified changes will be identified and actioned within 3 months by the Psychiatric Liaison Team following discussion with appropriate clinical ream (ie, Gastroenterology, Pharmacy)</td>
</tr>
</tbody>
</table>

3. **Equality and Diversity**

3.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

3.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Guidelines for Alcohol Detoxification and Chlordiazepoxide Administration at RCHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td><em>Date signed</em></td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>8&lt;sup&gt;th&lt;/sup&gt; December 2015</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>8&lt;sup&gt;th&lt;/sup&gt; December 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Medical Directorate Andy Brooking, Psychiatric Liaison Nurse (Alcohol/Delirium Lead)</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 253477</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Guidelines for the treatment of alcohol withdrawal and the administration of chlordiazepoxide</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Alcohol, Detoxification, Chlordiazepoxide, Delirium Tremens</td>
</tr>
<tr>
<td>Target Audience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Job Title</td>
</tr>
<tr>
<td>Date revised:</td>
<td></td>
</tr>
</tbody>
</table>

This document replaces (exact title of previous version): Guidelines for Alcohol Detoxification and Chlordiazepoxide Administration at RCHT

Approval route (names of committees)/consultation:
- Senior Medical staff and Pharmacy representative
- Addaction Specialist Substance Misuse Consultant

Divisional Manager confirming approval processes

Name and Post Title of additional signatories: None

Signature of Executive Director giving approval: {Original Copy Signed}

Publication Location (refer to Policy on Policies – Approvals and Ratification):
- Internet & Intranet
- Intranet Only

Document Library Folder/Sub Folder: Clinical

Links to key external standards: Care Quality Commission Outcomes 4 & 9
Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No.</th>
<th>Summary of Changes</th>
<th>Changes by</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2002</td>
<td>1</td>
<td>Original ratification</td>
<td>Bob Taylor &amp; Joanna Lawrence</td>
</tr>
<tr>
<td>August 2009</td>
<td>2</td>
<td>Full review Changes made to prescribing advice for Pabrinex</td>
<td>Andy Brooking</td>
</tr>
<tr>
<td>September 2012</td>
<td>3</td>
<td>Full review Advice not to give Phenytoin for alcohol withdrawal seizures, monitor magnesium levels and alternative medication to lorazepam for Delirium tremens</td>
<td>Andy Brooking</td>
</tr>
<tr>
<td>December 2015</td>
<td>4</td>
<td>Full review Changes made to Psychiatric Liaison hours of working</td>
<td>Andy Brooking</td>
</tr>
</tbody>
</table>

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

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

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Screening Form

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Procedure? Update of existing guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of individual completing assessment: Andy Brooking</td>
<td>Telephone: 01872 253477</td>
</tr>
<tr>
<td>1. Policy Aim*</td>
<td>Guidance on the treatment of Alcohol Detoxification and the Administration of chlordiazepoxide</td>
</tr>
<tr>
<td>2. Policy Objectives*</td>
<td>Safe treatment of patients with alcohol withdrawal symptoms at RCHT</td>
</tr>
<tr>
<td>3. Policy – intended Outcomes*</td>
<td>Safe treatment of patients with alcohol withdrawal symptoms at RCHT</td>
</tr>
<tr>
<td>4. How will you measure the outcome?</td>
<td>Audit</td>
</tr>
<tr>
<td>5. Who is intended to benefit from the Policy?</td>
<td>All patients admitted to RCHT that experience alcohol withdrawal symptoms</td>
</tr>
<tr>
<td>6a. Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</td>
<td>No</td>
</tr>
<tr>
<td>b. If yes, have these groups been consulted?</td>
<td></td>
</tr>
<tr>
<td>c. Please list any groups who have been consulted about this procedure.</td>
<td></td>
</tr>
</tbody>
</table>

*Please see Glossary*
7. The Impact

Please complete the following table using ticks. You should refer to the EA guidance notes for areas of possible impact and also the Glossary if needed.

- Where you think that the policy could have a **positive** impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, tick the ‘Positive impact’ box.
- Where you think that the policy could have a **negative** impact on any of the equality group(s) i.e. it could disadvantage them, tick the ‘Negative impact’ box.
- Where you think that the policy has no impact on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, tick the ‘No impact’ box.

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>No Impact</th>
<th>Reasons for decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<tr>
<td>Disability</td>
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<tr>
<td>Religion or belief</td>
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<td>Transgender</td>
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<td>Pregnancy/ Maternity</td>
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<td>Race</td>
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<td>Sexual Orientation</td>
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<tr>
<td>Marriage / Civil Partnership</td>
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</tbody>
</table>

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

- A negative impact and
- No consultation (this excludes any policies which have been identified as not requiring consultation).

8. If there is no evidence that the policy promotes equality, equal opportunities or improved relations - could it be adapted so that it does? How?

Full statement of commitment to policy of equal opportunities is included in the policy

Please sign and date this form.

Keep one copy and send a copy to Matron, Equality, Diversity and Human Rights, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Chyvean House, Penventinnie Lane, Truro, Cornwall, TR1 3LJ
A summary of the results will be published on the Trust’s web site.

Signed ________________________________

Date ________________________________