1. Aim/Purpose of this Guideline

This guideline applies to all staff caring for children/young people admitted to child health with Cystic Fibrosis.

2. The Guidance

2.1 Record on Admission:

- Weight (Plot on centile chart, needs to be repeated twice weekly, Mondays and Thursdays)
- Temperature
- Blood Pressure
- Heart Rate & Pulse Rate
- SaO₂ (needs to be measured daily and overnight on first night)
- BM 1hr post prandial and staggered over first three days

2.2 Investigations on Admission

**Blood for**
- FBC
- U&E’s
- CRP
- Glucose
- If Pre-op will need in addition;
- LFTs
- Clotting Studies
- Calcium
- X match may be required, check with surgeons

**Sputum for**
- Culture & Sensitivity
- Virology

(In children in whom it is difficult to obtain sputum sample NPA post physiotherapy should be obtained with or without the use of nebulised 7% sodium chloride).

- CXR should only be performed if patient has new localising signs.

2.3 Physiotherapy

On admission the paediatric physiotherapist (or the duty physiotherapist at weekends) should be informed that the patient is in. The physiotherapist will organise the physiotherapy protocol for the duration of the patients stay and spirometry. She/ he will liaise with the nursing and medical staff as to the optimal timing of inhaled medication.
2.4 Dietician

The Cystic Fibrosis dietician should be informed that the patient has been admitted so that a dietetic review can be performed. If the child uses nutritional supplements please ensure that these are prescribed on EPMA (including overnight feeds) and obtained from Pharmacy. Please document food and fluid intake as well as stool charts.

2.5 Infection Control

2.5.1 Isolation

Patients with cystic fibrosis should be admitted to single rooms in order that;

2.5.1.1 Their acquisition or respiratory viruses of pseudomonas from other patients on the wards is prevented

2.5.1.2 Cross infection between patients with different strains of pseudomonas etc. is prevented.

If a patient is found or suspected to be colonised with Cepacia, Atypical mycobacteria or MRSA he/she should be admitted to a single room with private washing and toilet facilities and strict barrier nursing procedures should be adhered to.

2.5.2 Stethoscopes

Each patient should have their own stethoscope for the duration of their stay. These stethoscopes should be thoroughly cleaned with alcohol wipes after discharge.

2.5.3 Spirometry Equipment

The spirometry equipment is cared for by the physiotherapist and CF nurses, a new bacterial/viral filter is used for each patient. Only expiratory measurements are performed. The surface of the spirometer is cleaned with an alcohol wipe between patients. The ward peak flow meters should not be used in patients with CF.

2.6 Antibiotic Therapy

Choice of antibiotic therapy should be guided by the most recent sputum result. Maxims should be checked to ascertain which organisms have grown in the three most recent sputum samples (or cough swabs if no sputum sample results are available, cough swabs being much less reliable than sputum) and the antibiotic sensitivities of these organisms.

2.7 Staph Aureus

For the first two years of life patients with cystic fibrosis are placed on prophylactic Flucloxacillin in order to help limit the damage caused by staph
aureus (primary prevention). In older children chronically colonised with staph aureus Flucloxacillin prophylaxis is continued (secondary prevention).

Dosage schedule for prophylaxis;

**Flucloxacillin**

**Primary prevention:** 125 mg bd 1month – 3yrs

Secondary prevention: 50mg/kg (max 1 gm) bd 1month – 18yrs

### 2.8 Acute Exacerbations

#### 2.8.1 0-2 years (outside the neonatal period)

When patients in the first two years of life are admitted for IV antibiotic therapy the dose of Flucloxacillin is increased and given IV in addition Cefotaxime is added to provide cover for other organisms such as haemophilus influenza.

#### 2.8.2 Dosage schedules for IV therapy;

1. **Flucloxacillin** 25 mg/kg/dose qds as IV bolus over 5 minutes
2. **Cefotaxime** 50 mg/kg/dose tds, up to a maximum dose of 12gm daily.
   Reconstitute as directed in product literature and dilute with sodium chloride 0.9% or glucose 5% to a concentration of 10-50mg/mL
3. **Tobramycin** 10 mg/kg od (max. 660 mg) by infusion over 30 minutes (levels and U&Es need to be performed just prior to the second dose and 9th dose)
   Trough < 1 mcg/ml (1mg/L) Dose should be adjusted in renal impairment, with more frequent level monitoring
   If the dose needs adjusting levels should be performed again before the second or third dose post-adjustment

#### 2.8.3 > 2 years

IF COLONISED WITH STAPH AUREUS BUT NOT COLONISED WITH PSEUDOMONAS;

1. **Flucloxacillin** 25 mg/kg/dose qds po
2. **Cefotaxime** 50 mg/kg/dose (maximum dose 12 g daily) diluted 10 times with 5% Dextrose or 0.9% sodium chloride and given as an IV infusion over 30 minutes
3. **Tobramycin** 10 mg/kg od (max. 660 mg) by infusion over 30 minutes (levels and U&Es need to be performed just prior to the second and 9th dose)
   Trough < 1 mcg/ml(1mg/L) Dose should be adjusted in renal impairment, with more frequent level monitoring
   If the dose needs adjusting levels should be performed again before the second or third dose post-adjustment.
Or if staphylococcus resistant to Tobramycin
Use

a) Clindamycin 7 mg/kg/dose qds (max 600 mg) by IV infusion over 30 minutes (diluted to at least 18 mg/ml in 0.9% sodium chloride or 5% Dextrose)
(Clindamycin should be discontinued if patient develops diarrhoea.)
LFTs and FBC should be performed on 9th day of treatment.

or

b) Fusidic Acid (suspension) po
Child 1 month-1 year 15mg/kg tds
Child 1-4 year’s 250mgs tds
Child 5-11 year’s 500mgs tds
Child 12-18 year’s 750mgs tds

or

Sodium fusidate (tablets) po
Child 12-18 years 500mg tds

Avoid or reduce dose in patients with liver disease.
Fusidic acid/Sodium fusidate must not be used as a single agent due to the risk of resistance developing

IF NOT COLONISED WITH STAPH AUREUS OR PSEUDOMONAS
>2 years
1. **Cefotaxime** 50 mg/kg/dose tds, up to a maximum dose of 12 gm daily. Reconstitute as directed in product literature and dilute with sodium chloride 0.9% or glucose 5% to a concentration of 10-50mg/mL
2. **Tobramycin** 10 mg/kg od (max. 660 mg) by infusion over 30 minutes (levels and U&Es need to be performed just prior to the second and 9th dose)

Trough < 1 mcg/ml (1mg/L) Dose should be adjusted in renal impairment, with more frequent level monitoring
If the dose needs adjusting levels should be performed again before the second or third dose post-adjustment

Adjust antibiotics as required when sputum result is available.

2.9 **Treatment of Exacerbations in patients chronically colonised with pseudomonas**

Patients are often admitted for the first few days of IV antibiotic therapy and intensive physiotherapy. If the patient would like to continue with IV antibiotics at home these are ordered via the current homecare provider (speak to the homecare pharmacy team). IV antibiotic courses last for two weeks but can be extended if necessary. During exacerbations patients increase their physiotherapy sessions at least to twice daily. (Please ensure that the patient/parent is aware that if a hospital supply is used to start home treatment then the homecare supply, when it arrives, should be used instead and not in addition). Oral macrolides should be discontinued during courses of IV antibiotic therapy. Nebulised Tobi, if used, may be continued but needs to be given in the morning and evening and the trough tobramycin levels taken predose in the afternoon (these should not be taken from the Port or long line).
Nebulised hypertonic sodium chloride (7 or 6%) 4 mls bd may be required to aid sputum retrieval but the first dose needs to be carefully supervised and many patients require pre-treatment with salbutamol therapy (normally given via spacer device)

2.10 Choice of Antibiotics

Two IV anti-pseudomonal agents are administered. If the organism is sensitive Ceftazidime and Tobramycin are the first choice combination. If the pseudomonas is resistant or the patient is allergic to either of these antibiotics please discuss the optimal antibiotic combination with the CF consultant or, if not available, the medical microbiologist on call. Other antibiotics which can be used include Amikacin, Aztreonam, Imipenem, Meropenem and Ticarcillin. Piperacillin with tazobactam and/or colistimethate can also be used but only if the organism is multi-resistant as Piperacillin is associated with a high incidence of drug hypersensitivity reactions and IV colistimethate is associated with neuro and nephro toxicity. In vivo sensitivity to antibiotics may differ from laboratory test results.

2.10.1 Dosages

2.10.1.1 1st line

1. **Ceftazidime** 50 mg/kg/dose tds as an infusion over 30 minutes and
2. **Tobramycin** 10 mg/kg od (max. 660 mg) by infusion over 30 minutes (levels and U&E need to be performed just prior to the second and 9th doses)

Trough < 1 mcg/ml (1mg/L) Dose should be adjusted in renal impairment, with more frequent level monitoring

If the dose needs adjusting levels should be performed again before the second or third dose post-adjustment.

If the dose needs adjusting levels should be performed again before the third dose post-adjustment. Levels should be performed again on the 9th day. If the levels are high then U&E’s and creatinine should be measured.

2.10.1.2 2nd choice anti-pseudomonal agents

**Amikacin** 10 mg/kg/dose tds by slow IV bolus over 3-5 minutes. (Up to a maximum of 500 mg every 8 hours)

Monitor levels and U&E’s before and one hour after the second or third dose if used tds. Peak 15-30 mg/L

Trough < 10 mg/L

If it is difficult for the family to administer 8hrly amikacin once daily administration could be considered, but this is not the preferred option. The dose of once daily Amikacin:

15 mg/kg od diluted to 50 ml with 0.9% sodium chloride and infused over 30 min.

Trough < 5 mg/L 24 hours post second dose
Aim for the higher end of the therapeutic range when adjusting the dose if using tds. If the dose needs to be adjusted levels need to be performed again on the third dose post adjustment. Levels and U&E’s are again performed on the ninth day.

**Imipenem with cilastatin** 25 mg/kg/dose (max 1gm) qds by IV infusion over 20 minutes. Reconstitute each 500 mg vial with 100 ml 0.9% sodium chloride or 5% Dextrose and give over 20-30 minutes.

**Meropenem** 1 month-11years body weight under 50 kg 40 mg/kg/dose tds, body weight over 50 kg 2g tds. 12-18years 2g tds by IV infusion over 20 minutes.

Reconstitute each vial as per manufacturers instructions and then dilute further with sodium chloride 0.9% or glucose 5%, to a final concentration of between 1mg in 1mL and 20mg in 1mL

**Ticarcillin with clavulanic acid**
1 month-18 years body weight under 40 kg 80 mg/kg/dose tds  
Adult or body weight over 40 kg 3.2 gm qds  
given as an IV infusion over 30 minutes Reconstitute vial as per manufacturers instruction and dilute reconstituted solution further to a concentration of 16–32 mg/mL with glucose 5%. (Clavulanic Acid can be associated with cholestatic jaundice)

**2.10.1.3 3rd choice anti-pseudomonal agent**

**Colistimethate**  
< 60 kg 25,000 units/kg tds  
> 60 kg 2 million units tds  
by IV infusion over 30 minutes [dilute to concentration of 40,000 units/ml with 0.9% NaCl]

**Piperacillin** with tazobactam  
1 month-11years 90mg/kg tds (max dose 4.5 gm tds) diluted to 15-90 mg/ml with 0.9% sodium chloride and give IV infusion over 30 minutes  
12-17 years of age 4.5gm tds (Should be given with an aminoglycoside if organism is sensitive as they have a synergistic effect).

**2.11 Patients growing Pseudomonas in their sputum for the first time**

Our current procedure is to give patients who have grown pseudomonas in their sputum for the first time a four week course of oral ciprofloxacin 20mg/kg bd and nebulised colistimethate sodium 1 million units bd if under two years of age and 2 million units bd over two years of age. (for a second pseudomonas isolate a 3 month course of Ciprofloxacin and a three month course of nebulised colistimethate (as Colomycin or Promixin) is the treatment of choice). The paediatric Cystic fibrosis outreach nurse will organise the nebuliser if requested. If the patient is unwell a two week course of intensive physiotherapy and IV antibiotics is advisable especially if we do not feel that their treatment at home is optimal Two IV antipseudomonal agents are used and the usual combination of choice is
Ceftazidime and Tobramycin but this choice is influenced by sputum sensitivities. Whilst in hospital physiotherapy techniques are reviewed and nebulised antibiotic therapy is commenced, i.e., Colomycin or Promixin. Sputum is obtained for culture and sensitivity at the end of the course of IV antibiotics and if pseudomonas is no longer present in the sputum all the old spacehalers and nebuliser tubing are replaced.

Sputum or cough swabs are sent fortnightly from home. If three consecutive samples have been clear of pseudomonas nebulised antibiotics are discontinued at the end of the three month period.

Sputum samples or cough swabs are sent monthly thereafter and if pseudomonas is isolated again a further 2 week course of IV Ceftazidime and Tobramycin is considered. These cycles are continued until the patient becomes chronically colonised.

Nebulised Tobramycin therapy is used in subjects who continue to deteriorate (see separate TOBI guideline).

2.11.1 Nebulised Therapy Antibiotics

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>Age Group</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colistimethate as Colistin</td>
<td>1 month - 2 years</td>
<td>1,000,000 units bd</td>
</tr>
<tr>
<td>Injection solution used for nebulisation</td>
<td>2 – 18 years</td>
<td>2,000,000 units bd</td>
</tr>
<tr>
<td>Tobi (Tobramycin)</td>
<td>300 mg bd alternate months</td>
<td></td>
</tr>
</tbody>
</table>

2.12 Bronchodilators

β adenergic responsiveness should be tested in patients with cystic fibrosis on a regular basis both during and between exacerbations. Some patients with cystic fibrosis may show a deterioration in FEV₁ post treatment due to airway damage and these patients should not be given β adenergic agents. If an improvement in FEV₁ is seen even if this improvement is modest (e.g., 5-10% improvement) but reproducible then a β adenergic agent should be administered approximately 15 minutes prior to physiotherapy.

### Bronchodilators

<table>
<thead>
<tr>
<th>Age</th>
<th>Bronchodilator</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;2½ years</td>
<td>Salbutamol 200 mcg Aerochamber &amp; mask</td>
</tr>
<tr>
<td>2½ - 5 years</td>
<td>Salbutamol 200 mcg Volumatic + mask</td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td>Salbutamol 200 mcg Accuhaler or Volumatic</td>
</tr>
</tbody>
</table>

**Note:**
1. Dry powder devices should not be given to pre-school children.
2. Children of 2½ to 5 years of age who can use the mouthpiece of the spacer device without a mask when not in respiratory distress may not be able to do so when unwell, therefore all children of 2½ to 5 years of age should be issued with a suitable mask.

3. Only single doses of aerosol should be administered into the spacer device at a time, followed by 5 tidal breaths and then the dose repeated.

4. The MDI should not be actuated before the face mask or mouthpiece of the spacer device has been applied correctly.

Long acting β-adenergic drugs such as salmeterol are prescribed for all patients of over 5 years of age with cystic fibrosis who also have asthma or exhibit β-adenergic responsiveness. They are given via the same devices as salbutamol and administered after physiotherapy unless the patient is not using a short acting β-adenergic agent, when they are administered 15-20 minutes before physiotherapy.

2.13 Pulmozyme

Pulmozyme or DNase is a nebulised therapy given to break down the DNA in sputum. It should be administered at least two hours before chest physiotherapy at a dose of 2.5 mgs.

2.14 Hypertonic sodium chloride nebulised 6 or 7%

Nebulised hypertonic sodium chloride draws water into the airway and helps to hydrate the airway. It is an airway irritant and causes cough and wheeze. It helps mobilise airway secretions but if it causes wheeze salbutamol should be administered prior to the dose. It should be given prior to chest physiotherapy, usually twice daily but can be administered up to four times a day.

2.15 Vitamins as prescribed on most recent treatment sheet attached to clinic letter. Standard doses are as follows

- < 5 years Dalivit /Abidec as prescribed.  
  + Vitamin E 50 mg/day

- ≥ 5 years Multivitamins (BPC) 1 per day  
  + vitamin E 100 mg/day

- ≥ 12 years Multivitamins 2 per day  
  + vitamin E 200 mg/day

Vitamin A, E and D levels are measured yearly and dose is adjusted according to response.

Many children will also be taking vitamin K.
2.16 Discharge planning

The CF nurse, community CF physiotherapists and GP need to be informed at least 24 hrs prior to a planned discharge and if the patient is going home on IV antibiotics the CF nurse, or her nominated deputy, needs to make sure that the patient has all of the equipment required for therapy. Medical staff are required to ensure that the patient has all the medications they require. If the child has been started on nutritional supplements they will also need to be provided on the TTO’s.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Compliance with admission procedure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>CF team</td>
</tr>
<tr>
<td>Tool</td>
<td>Peer review and patient notes audit</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually or as required</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Via audit and guidelines And dissemination to CF team</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Required actions will be identified and completed in a specified timeframe</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

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

4.2 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>Admission of a Child/Young Person with Cystic Fibrosis Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>15 May 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>15 May 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>15 May 2021</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr. A. Prendiville Paediatric consultant</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252017</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Clear guidance on admission procedures for children/young people with Cystic Fibrosis</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Cystic Fibrosis Child</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>15 May 2018</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Clinical Guideline for the admission of a child or young person with cystic fibrosis V2.0</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Audit and guidelines CF team Pharmacy</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Tunde Adewopo</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed} Name: Caroline Amukusana</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Date</td>
<td>Version No</td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>July 2011</td>
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</tr>
<tr>
<td>October 2013</td>
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<td>May 2018</td>
<td>V3.0</td>
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</tr>
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</table>

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This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

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Appendix 2. Initial Equality Impact Assessment Form

*This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.*

<table>
<thead>
<tr>
<th>Name of strategy / policy / proposal / service function to be assessed</th>
<th>Admission of a Child/Young Person with Cystic Fibrosis Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td><strong>Is this a new or existing Policy?</strong></td>
</tr>
<tr>
<td>Child Health</td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td><strong>Telephone:</strong></td>
</tr>
<tr>
<td>Chris Warren</td>
<td></td>
</tr>
<tr>
<td><strong>1. Policy Aim</strong></td>
<td><strong>Who is the strategy / policy / proposal / service function aimed at?</strong></td>
</tr>
<tr>
<td>To provide clear guidance on care of a child or young person with Cystic Fibrosis when admitted to hospital.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Policy Objectives</strong></td>
<td><strong>Evidence based, standardised care.</strong></td>
</tr>
<tr>
<td><strong>3. Policy – intended Outcomes</strong></td>
<td><strong>As above</strong></td>
</tr>
<tr>
<td>*<em>4. <em>How will you measure the outcome?</em></em></td>
<td><strong>Audit and case note inspection</strong></td>
</tr>
<tr>
<td><strong>5. Who is intended to benefit from the policy?</strong></td>
<td><strong>Children and families.</strong></td>
</tr>
<tr>
<td><strong>6a Who did you consult with</strong></td>
<td><strong>Workforce</strong></td>
</tr>
<tr>
<td>b). Please identify the groups who have been consulted about this procedure.</td>
<td>X</td>
</tr>
<tr>
<td><strong>Please record specific names of groups</strong></td>
<td><strong>Child Health Directorate Meeting</strong></td>
</tr>
<tr>
<td><strong>What was the outcome of the consultation?</strong></td>
<td><strong>Guideline agreed</strong></td>
</tr>
</tbody>
</table>
7. The Impact

Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>X</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
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<td>X</td>
<td></td>
<td>No areas indicated</td>
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<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
<td>X</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions</td>
<td></td>
<td>X</td>
<td></td>
<td>No areas indicated</td>
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<tr>
<td>Religion / other beliefs</td>
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<td>No areas indicated</td>
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<tr>
<td>Marriage and Civil partnership</td>
<td></td>
<td>X</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>X</td>
<td></td>
<td>No areas indicated</td>
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<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td>X</td>
<td></td>
<td>No areas indicated</td>
</tr>
</tbody>
</table>

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

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

9. If you are not recommending a Full Impact assessment please explain why.

   No areas indicated
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed Chris Warren

Date __15/5/2018____________