CLINICAL GUIDELINE FOR THE ADMINISTRATION OF DRUGS VIA ENTERAL FEEDING TUBES

Summary

Key:

<table>
<thead>
<tr>
<th>General Notes</th>
<th>GP/SWASFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED/MAU/SRU/Acute GP/Amb-Care</td>
<td>In-patient wards</td>
</tr>
</tbody>
</table>

Start

Switch off feed if running

Immediately flush the tube with water (at least 30mL)

Check if a break is needed before drug administration

Prepare medicine as instructed (see full guidance)

Give medicine via feeding tube

Draw up 15mL of water into the same syringe and flush down feeding tube to remove any residual drug

Are there more medicines to be given?

Yes

No

Flush tube slowly with 30mL water, ensuring the tube is clean

Check if a break is needed after drug administration

Restart feed if necessary

End
1. **Aim/Purpose of this Guideline**

1.1. The purpose of this policy is to inform all practitioners of their responsibility in the safe and effective administration of medicines via enteral feeding tubes.

1.2. This document specifies the minimum standard procedure that should be applied to prescribing, preparation and administration of medicines via enteral feeding tubes to minimise risks to both healthcare personnel and patients.

2. **Introduction**

2.1. Due to individual patient requirements, it is often necessary to administer medicines via enteral feeding tubes.

2.2. Crushing tablets, opening capsules and administration via feeding tubes usually falls outside a drug’s product licence and presents an increased risk for patients compared to other routes of administration. In these circumstances, the prescriber and practitioner accept liability for any adverse effects resulting from this route of administration.

2.3. Bioavailability cannot be guaranteed when medications have been modified via crushing or opening of capsules, or when drugs are administered via enteral feeding tubes. Changes to pharmacokinetic or pharmacodynamic properties following crushing tablets or opening capsules have rarely been studied.

3. **Main types of feeding tubes**

3.1. Nasogastric (NG), a tube passed through the nose into the stomach. They come in two main types:

   3.1.1. Wide bore – Short term tube not sited specifically for enteral feeding (they are used for stomach aspiration and drainage). These tubes are usually made of polyvinyl chloride with a bore size of 9-22 French Gauge (FG), e.g. Ryle’s tube. These tubes should not be used for feeding or administration of medicines.

   3.1.2. Fine bore – These tubes are used for enteral feeding and may be left in situ for 7 days to 6 weeks. They have a bore size of 6-12 FG and are usually made of polyurethane, making them softer than large bore tubes. There are two types of fine bore tube, those with a guide wire (stylet) and those that are weighted.

3.2. Nasojejunal (NJ), a tube passed through the nose into the jejunum. They come in two main types:

   3.2.1. Single lumen

   3.2.2. Double lumen (the second lumen is used as a gastric aspiration port)

3.3. Gastrostomy tube, a tube inserted through the abdominal wall into the stomach

   3.3.1. There are a number of different types of gastrostomy tube based on size (9-24 FG), internal fixator (flange, balloon) and material.
3.3.2. Gastrostomy tubes may be inserted endoscopically (percutaneous endoscopic gastrostomy or PEG), radiologically (radiologically inserted gastrostomy tube, or RIG) or surgically inserted.

3.3.3. These tubes are used for longer term feeding.

3.4. Surgical or percutaneous endoscopic jejunalostomy (PEJ), a tube inserted through the abdominal wall into the jejunum
3.4.1. These tubes are used for longer term feeding.

3.5. Percutaneous endoscopic gastro-jejunalostomy (PEGJ), a jejunostomy tube inserted via a PEG tube through the abdominal wall into the jejunum
3.5.1. These tubes are used for longer term feeding.

4. **Considerations before administering drugs via a feeding tube**

4.1. Can the patient still take their medicines orally?
   4.1.1. Liquid preparations are often available
   4.1.2. Some tablets and capsules can be crushed/opened and administered orally with water

4.2. Review all medication. Is it all really necessary?

4.3. Can an alternative route be used?
   4.3.1. Rectal (aspirin, diclofenac, paracetamol)
   4.3.2. Parenteral (IV, SC, IM)
   4.3.3. Transdermal (hyoscine, GTN, HRT)
   4.3.4. Sublingual/buccal (prochlorperazine)

4.4. Can an alternative drug be substituted which can be given by a more suitable method of administration?

4.5. Is the patient fluid restricted or a paediatric patient? Flushing volumes may need reducing.

4.6. Where is the end of the tube situated?
   4.6.1. Some drugs may have reduced absorption when administered to the jejunum. This is especially important for drugs with a narrow therapeutic index.

4.7. What type of tube is being used?
   4.7.1. Bore size and tube length can affect the chances of tube blockage. Some tubes have multi-lumens.
   4.7.2. Medication must not be administered down an aspiration/gastric decompression port.
4.8. Is the tube still correctly placed for fine bore tube feeding?
   4.8.1. Tube markings and pH indicator strips should be used to confirm correct placement prior to administration of medicines (NPSA/2011/PSA002).

5. Choosing a formulation

5.1. Can the drug be given via another route that is licensed?

5.2. Is there a commercial oral solution/suspension or dispersible tablet available?
   5.2.1. Liquids may contain sorbitol, which can cause diarrhoea and cramps. Large doses of sorbitol should be avoided.
   5.2.2. Liquids with high osmolality can cause osmotic diarrhoea. The risk of diarrhoea can be reduced by diluting the preparation.
   5.2.3. Bio-availability may vary between solid and liquid forms of a drug, and therefore dose adjustments may be required (citalopram, phenytoin, digoxin, levothyroxine).
   5.2.4. Large volumes may be required, especially if only paediatric preparations with low concentrations are available. This may increase cost.
   5.2.5. Some suspensions may block feeding tubes.
   5.2.6. Some liquids have a high alcohol content. These liquids may be unsuitable for alcohol-dependants, epileptics, patients on metronidazole, warfarin etc. This is especially a problem when given by PEJ/NJ.
   5.2.7. Viscous liquids may require dilution, but this can affect stability.
   5.2.8. Dispersible and effervescent tablets may be used down feeding tubes, but many contain sodium – caution in sodium-restricted patients.
   5.2.9. Converting modified-release formulations to immediate release liquid may require a dose or frequency change.

5.3. Will crushed tablet/capsule contents disperse fully/form a fine suspension that will not block the tube? Is the tablet suitable for crushing?
   5.3.1. Enteric coated, modified-release, cytotoxic, antibiotic and hormonal drugs should not be crushed unless otherwise advised due to the risk of toxic side effects or staff exposure to the drug.
   5.3.2. Sublingual or buccal tablets should not be crushed as this may result in reduced bio-availability. They may be used sublingually in place of oral preparations only if the patient is producing normal amounts of saliva.
   5.3.3. Fractional dosing from dispersed tablets is not recommended due to inaccuracy.
   5.3.4. Many chewable tablets should not be crushed. Some preparations (e.g. Tegretol chewtabs) are designed so that some of the drug is absorbed in the mouth.

5.4. Is the injection suitable for enteral use?
   5.4.1. Some injections contain excipients that are not suitable for oral administration e.g. polyethylene glycol.
5.4.2. Many injections are hypertonic or have a high osmolality, and are unsuitable for oral administration as they may cause osmotic diarrhoea.
5.4.3. Formulations may have an unsuitable pH or may degrade in the acidic stomach environment
5.4.4. If suitable, all injections should be diluted with 30-60ml water before enteral administration.

5.5. Can the drug be substituted for another with similar pharmacology but which can be put down the tube?
5.5.1. Liquids or soluble tablets are the preferred formulation to be administered via feeding tubes, and should be used unless such formulations are deemed unsuitable. This may be because of large volumes or large doses of sorbitol. Some liquids may contain alcohol or may become unstable when diluted. Several injections can be given via a feeding tube, but this can be quite expensive.

6. Drug related problems and preventative measures when giving medication by feeding tubes

6.1. When administering drugs via feeding tubes the drug’s effects on the patient can be unpredictable, and therefore careful monitoring is usually required. Factors that may alter drug availability include:

6.2. Binding of drugs to tubes
   6.2.1. E.g. carbamazepine, diazepam, phenytoin
   6.2.2. Dilute the drug with an equal volume of water and flush with 15 - 30ml post dose. Monitor clinical response

6.3. Direct interaction of drug and feed → Tube blockage
   6.3.1. E.g. Acidic solutions (chlorphenamine, promethazine)
   6.3.2. Find alternative route/drug if possible
   6.3.3. Dilute drug as much as possible to minimise contact. Flush well.

6.4. Interaction between drug and feed → Reduced drug absorption
   6.4.1. E.g. carbamazepine, ciprofloxacin, phenytoin, theophylline, warfarin and other highly protein bound drugs
   6.4.2. Stop feed for 2 hours before and 2 hours after administration.
   6.4.3. Flush with 15 - 30ml pre and post dose.

6.5. Drugs requiring administration on an empty stomach
   6.5.1. E.g. penicillin, ketoconazole, tetracyclines
   6.5.2. Stop feed 1 hour before and after each dose
   6.5.3. Consider alternative route/drug
   6.5.4. Not applicable in jejunal feeding as the stomach is bypassed. Just ensure tube is flushed well before administration.
   6.5.5. Ensure adequate flushing with at least 50mls of water.
6.6. Drug-drug interactions
   6.6.1. Alter drug timings
   6.6.2. Many liquid preparations may cause osmotic diarrhoea when given by feeding tubes that by-pass the stomach.
   6.6.3. Dilute the liquid if possible to reduce its osmolality

7. **Crushing tablets**
   7.1. Crushing tablets or opening capsules should be considered as a last resort.

   7.2. There is no ideal way to crush tablets.

   7.3. Tablets may be crushed:
      7.3.1. Between two spoons
      7.3.2. Using a tablet crusher
      7.3.3. Using a pestle and mortar (NB some drug may be lost in this way – rinse the mortar out and flush the rinse down the tube to reduce drug loss.)

   7.4. Mix crushed tablet with 15-30ml water (use sterile water if administering directly to the jejunum e.g. NJ or PEJ).

   7.5. Draw up the solution into a syringe suitable for attaching to the tube.

   7.6. Administer via the tube.

   7.7. Rinse container with 15ml water and draw up into the same syringe. Flush down the tube.

8. **Using Dispersible tablets**
   8.1. Place the tablet in the barrel of a syringe suitable for attaching to the tube.

   8.2. Replace the plunger and draw up 10-15ml of water (use sterile water if administering directly to the jejunum e.g. NJ or PEJ).

   8.3. Replace cap and allow tablet to dissolve.

   8.4. Shake well and administer via the tube.

   8.5. Flush tube with 15ml water using the same syringe.

9. **Using effervescent tablets**
   9.1. Add tablet to 50ml water (use sterile water if administering directly to the jejunum e.g. NJ or PEJ).

   9.2. Wait for tablet to disperse and stop ‘fizzing’.
9.3. Swirl the solution and draw it up into a syringe suitable for attaching to the tube.

9.4. Administer via the tube.

9.5. Rinse container with 15ml water and draw up into the same syringe. Flush down the tube.

10. Using hard gelatine capsules

10.1. Gently open capsule and add powder to a container.

10.2. Mix capsule contents with 15-30ml water. (Use sterile water if administering directly to the jejunum e.g. NJ or PEJ).

10.3. Draw up the solution into a syringe suitable for attaching to the tube.

10.4. Administer via the tube.

10.5. Rinse container with 15ml water and draw up into the same syringe. Flush down the tube.

11. General points

11.1. **DO** ensure when administering crushed tablets or capsules that the drug is completely dispersed with no sediment.

11.2. **DO** flush tube with at least 30ml of water following administration of the last drug.

11.3. **DO NOT** use hot water as this may alter bio-availability of the drug.

11.4. **DO NOT** use syringes for intravenous drug administration to measure and administer liquid oral medicines.

11.5. **DO NOT** leave unlabelled oral medicines unattended in syringes – they may accidentally be given parenterally.

11.6. **DO NOT** add drugs to the patient’s feed. Medication should not be added directly to the feed, due to the risks of incompatibility.

11.7. **DO NOT** administer any medicine that you have not prepared yourself via any route.
12. Administering drugs by feeding tube

Clearly identified purple oral / enteral syringes (i.e. syringes where a needle cannot be attached) must be used to avoid oral medication being given intravenously in error (NPSA 2007 Alert No 19). Ensure the appropriate oral syringe for the connector is used.

12.1. 50ml catheter tipped oral / enteral syringes should be used for flushes, as the strong pressure generated by smaller syringes may rupture the tube.

12.2. Only one medicine should be administered at a time, flushing the feeding tube with 15ml water between medications. Some medicines may interact if mixed and if a tube becomes blocked it may be difficult to determine how much of any drug has been given.

12.3. Use sterile water when dispersing tablets and flushing a jejunal tube, as the acidic stomach is bypassed. This means that there is an increased risk of infection.

12.4. Wherever possible, a once daily preparation should be used.

12.5. Total volumes given with drugs should be documented on the fluid balance chart.

12.6. Narrow lumen tubes are more likely to block.

12.7. Drugs should not be administered in tubes used for free draining or suction.

12.8. DO NOT give bulk-forming laxatives by tube – use high fibre feeds instead.

12.9. Monitor clinical response if:
   12.9.1. Changing from MR to standard release
   12.9.2. Using a narrow therapeutic range drug
   12.9.3. Bio-availability is altered when changing from tablet to liquid

13. Tube Blockage

13.1. Inadequate flushing is the most common cause of tube blockage.

13.2. Using the wrong formulation of medication may also result in blockage.

13.3. There are numerous products available to unblock feeding tubes, but there is limited evidence to suggest that these are any more effective than water alone.

13.4. Acidic substances, e.g. orange juice, may increase feed coagulation, and therefore increase the risk of blockage.
13.5. If blockage occurs aspiration to remove particulate matter followed by flushing with warm water should be tried. Minimal pressure should be used as excessive force may increase the risk of tube fracture. In these cases, further surgical intervention may be necessary.

13.6. The contents of pancreatin capsules dissolved in sodium bicarbonate have been used to unblock tubes.

14. Discharge Planning

14.1. Ensure the agreed feed and drug regimen are practical in a community setting.

14.2. Ensure all necessary information is given to the community pharmacist and GP.

15. Further information/guidance

15.1. For further information or guidance on specific medications, contact the Medicines Information department on extension 2587.

16. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The prescribing, preparation and administration of medicines via enteral feeding tubes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Medications Safety Pharmacist</td>
</tr>
<tr>
<td>Tool</td>
<td>The NPSA audit tool - Promoting safer measurement and administration of liquid medicines via oral and other enteral routes</td>
</tr>
<tr>
<td></td>
<td>Datix for clinical incidents</td>
</tr>
<tr>
<td>Frequency</td>
<td>The policy will be monitored every three years or sooner as clinical incidents dictate</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The audit results will be reported to the Medication Practice Committee (MPC) and the individual areas audited</td>
</tr>
<tr>
<td></td>
<td>Clinical incidents on Datix will be reported to the senior nurse/manager in that area and will also be reported to the Medication Safety Group</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The MPC will co-ordinate the actions to the audit results. Actions from incident reports will be at a local level and may also resulting broader actions, co-ordinated by the Medication Safety Group.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within the time frame specified in the action plan</td>
</tr>
</tbody>
</table>

17. Equality and Diversity

17.1. This document complies with the Royal Cornwall Hospitals NHS Trust
service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

**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>Clinical guideline for the administration of drugs via enteral feeding tubes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>October 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>October 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>October 2019</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Pharmacy Department, Chief Pharmacist</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252593</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>The standards required to ensure the safe prescribing, preparation and administration of medicines via enteral feeding tubes within the hospitals of Royal Cornwall Hospitals Trust.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Enteral Feeding, Drug Administration</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>October 2016</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Guidance on the administration of drugs via enteral feeding tubes</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Medication Practice Committee</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Karen Jarvill</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}</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>Document Library Folder/Sub Folder</td>
<td>Clinical / Pharmacy</td>
</tr>
<tr>
<td>-----------------------------------</td>
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</tr>
<tr>
<td>Links to key external standards</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handbook of Drug Administration via Enteral Feeding Tubes. Accessible via <a href="http://www.medicinescomplete.com">www.medicinescomplete.com</a></td>
</tr>
<tr>
<td>Kemp A. Medication administration in patients with swallowing difficulties or enteral tubes. Nottingham City Hospital, June 2004</td>
</tr>
<tr>
<td>National Patient Safety Agency (NPSA) (2005) Alert no 9, Reducing the harm caused by misplaced naso and gastric feeding tubes in babies under the care of neonatal units, London NPSA</td>
</tr>
<tr>
<td>Thomson F, Naysmith M, Lindsey A. Managing drug therapy in patients receiving enteral and parenteral nutrition. Hospital Pharmacist 2000; 7; 155-64</td>
</tr>
<tr>
<td>Twycross R, Wilcock A, Charlesworth S. Palliative Care Formulary. Accessible via <a href="http://www.palliativedrugs.com">www.palliativedrugs.com</a></td>
</tr>
<tr>
<td>BAPEN Guidance on Drug Administration via Enteral feeding tubes. Accessible via <a href="http://www.bapen.org.uk">www.bapen.org.uk</a></td>
</tr>
<tr>
<td>The NEWT Guidelines for administration of medication to patients with enteral feeding tubes or swallowing difficulties. Accessible via <a href="http://www.newtguidelines.com">www.newtguidelines.com</a></td>
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| Training Need Identified? | Yes |
**Version Control Table**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>June 2007</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Maggie Fitzgerald Senior Pharmacist Medicines Information</td>
</tr>
<tr>
<td>September 2010</td>
<td>V2.0</td>
<td>Review with minor amendments and reformatted into Trust policy format</td>
<td>Maggie Fitzgerald Senior Pharmacist Medicines Information</td>
</tr>
<tr>
<td>June 2013</td>
<td>V3.0</td>
<td>Review with minor amendments and reformatted into Trust policy format</td>
<td>Maggie Fitzgerald Senior Pharmacist Medicines Information</td>
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<tr>
<td>October 2016</td>
<td>V4.0</td>
<td>Review with minor amendments and reformatted into Trust policy format</td>
<td>Liam Kelly Medicines Information Pharmacist</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 Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy /proposal / service function to be assessed (hereafter referred to as policy)</th>
<th>Guidance on the Administration of Drugs via Enteral Feeding Tubes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: All clinical areas</td>
<td>Is this a new or existing Policy? Update to existing</td>
</tr>
<tr>
<td>Name of individual completing assessment: Liam Kelly</td>
<td>Telephone: 01872 252587</td>
</tr>
</tbody>
</table>

#### 1. Policy Aim* 
Who is the strategy / policy / proposal / service function aimed at? 
To promote safer measurement and administration of medicines via enteral feeding tubes

#### 2. Policy Objectives* 
To ensure RCHT complies with the requirements of NPSA Alert No 19

#### 3. Policy – intended Outcomes* 
Activities related to the administration of medicines via enteral feeding tubes comply with standards set out in the alert

#### 4. *How will you measure the outcome? 
On-going audit

#### 5. Who is intended to benefit from the policy? 
Patients receiving medicines via enteral feeding tubes

#### 6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? 
No

#### 6b) If yes, have these *groups been consulted? 
National Patient Safety Alert No 19 Working Group; Senior Medical, Nursing and Pharmacy Staff; Practice Development

#### 6c) Please list any groups who have been consulted about this procedure. 

7. The Impact

Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td>Policy for all patients</td>
</tr>
<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
<td>✓</td>
<td></td>
<td>Policy for all patients</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>✓</td>
<td></td>
<td>Policy for all patients</td>
</tr>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>✓</td>
<td>Policy for all patients</td>
<td></td>
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<tr>
<td>Religion / other beliefs</td>
<td>✓</td>
<td>Policy for all patients</td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>✓</td>
<td>Policy for all patients</td>
<td></td>
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<tr>
<td>Pregnancy and maternity</td>
<td>✓</td>
<td>Policy for all patients</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>✓</td>
<td>Policy for all patients</td>
<td></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 service redesign or development

8. Please indicate if a full equality analysis is recommended.  Yes  No ✓

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

Policy for all patients

Signature of policy developer / lead manager / director

Date of completion and submission

October 2016

Names and signatures of members carrying out the Screening Assessment

1. Liam Kelly
2. 

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

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

Signed ______________________

Date __________________________