Procedure for Patient or Carer Administration of Subcutaneous Medication in Community Setting (Palliative Care)

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0	June 2018	HDFT Initial Publication	June 2020
2.0	June 2020	HDFT Local Review	June 2023
3.0	September 2025	Updated Guidance and creation of joint procedure across organisations - Refreshed Consent Form to ensure clarity in completion of consent and role of signatory - Improved definition on roles and responsibilities of all members of Multi-disciplinary team - Reviewed all aspects of SOP following recent incidents reported taking into account learning - Clarified managing incidents and escalation process if concerns - Defined monitoring, auditing and compliance responsibilities	**September 2028**
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Clinical Guideline/Protocol Lead (Job Title)		**HDFT**: Charlotte Rock, Macmillan Lead Nurse for Palliative and End of Life Care. Sara Moore, Deputy Chief Pharmacist **Humber NHS Trust:** Debi Adams, Professional Lead for Palliative and End of Life Care **York & Scarborough NHS Trust:** Debbie Bayes, Lead Nurse – Palliative and End of Life Care (PEoLC) Jane Crewe, Pharmacist	
Author ***(if different to above)***			
Governance Group ***(that will oversee effectiveness of implementation)***		**HDFT: LTUCC Quality, Safety and Learning group, End of life and Mortality Committee**	
Approval and/or Ratification Body		**Medicines Therapeutic Group (MTG)** **LTUCC Quality, Safety and Learning group** **End of life and Mortality Committee**	**October 2025**
Review date ***(Usually 3 years from approval date)***		**September 2028**	

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1. INTRODUCTION

This procedure provides the guidance and associated documentation for healthcare professionals to support patients and carers in the safe administration of prescribed medication by the subcutaneous route.

This procedure should not be considered as standard care and should only be considered if initially requested for by patient or carer.

This procedure has been developed in response to rare but important requests from patients and carers to be able to administer subcutaneous medication in a palliative care situation. Regional experience supports that use of this procedure may:

- Reduce patient distress
- Facilitate effective symptom control and offer greater patient choice and informal carer involvement
- Support patients to remain in their preferred place of care or expedite discharge from hospital to their preferred place of care
- Improve patient/carer understanding of medication, their indications, actions, and side effects
- Assist healthcare professionals in the training and assessment of patients and carers in a consistent and safe manner

The practice of supporting patient and carer administration of subcutaneous medication in adult palliative care have been developed across the United Kingdon[1-5]. Benefits of implementing this practice have been reported in the UK and Australia, particularly with rural populations.[6-8]. The benefits include timely symptom relief and enabling patients to remain in their own homes at end of life. Carers also valued the role and felt it gave them a sense of empowerment, pride and achievement as opposed to feelings of helplessness and hopelessness[6-8].

Studies support that with appropriate education, support and boundary setting carers can safely and competently administer subcutaneous medications. This includes being able to document appropriately, providing the right drug for the indicated symptom and monitor effectiveness [7,8]. In a survey by Dying Matters, six out of ten people said they would feel comfortable giving a pain relief injection to someone who was dying and wanted to stay at home[9].

Carers have a significant role in symptom management and commonly administer or assist with the administration of oral medication. It is not uncommon for carers to administer subcutaneous medications such as insulin and low molecular weight heparin.
In palliative care there are occasions following patient and carer request when it may be helpful to train them to give palliative subcutaneous medication including:

- Regular medication that cannot be taken by less invasive route
- As required medication for symptom management during the patient's last days of life.

2. SCOPE

This procedure relates to palliative patients or their carers 18yrs or older giving medication via a subcutaneous injection or subcutaneous cannula in the patient's home. This procedure must align with national and local policies on medicine storage and administration[10].

Use of this procedure is the exception and should not be considered as standard practice. The motivation to implement this procedure should be led by the needs and wishes of the patient or carer and must not be imposed by healthcare professionals.

The procedure may also be initiated in a hospital or hospice setting, including by a different organisation, to support people being discharged home. Each individual organisation supporting the patient with this procedure will complete their own risk assessment and training as required by this procedure.

This process will not be suitable for all patients or carers, depending on meeting suitability criteria and individual risk assessment. It must be made clear that the patient or carer can stop the procedure at any time or that a healthcare professional may recommend that it is no longer appropriate.

Implementation of this procedure is a partnership between patient, family and health care professional. Regular and frequent health care professional reviews will be planned, and the patient and family carer are positively encouraged to request support from health care professionals to review and administer palliative injectable medication when appropriate.

3. DEFINITIONS

The term **'carer'** is a person who is either providing or intending to provide a substantial amount of unpaid care on a regular basis for someone who is disabled, ill or frail. Carers are usually family members, friends or neighbours and are not paid care workers.

'Subcutaneous' injection refers to the bolus administration of medication into the tissue layer between the skin and the muscle.

'Anticipatory medication' refers to injectable medication to manage common symptoms that may occur in patients in the last days of life e.g. pain, breathlessness, agitation, nausea and vomiting and secretions.

4. DUTIES AND RESPONSIBILITIES

Chief Executive

The chief executive is required to ensure the organisation has systems and processes in place to implement this procedure.

Director of Nursing / Executive Nurse

Director of nursing has devolved responsibility for the overall management of this procedure within the organisation.

Matrons and Clinical Leads

Will ensure dissemination and implementation of this procedure within the sphere of their responsibility. They should ensure staff are supported with relevant training and support to understand and develop competence to implement this procedure, as required

Clinical Leads and Team Leads
Will disseminate and implement the agreed procedure as required. Will ensure mechanisms and systems are in place to facilitate staff to understand this procedure as part of their Appraisal and supervision as required.

Registered Nurses (RN)
RNs supporting and coordinating Patient or carer administration of palliative subcutaneous medications must be competent in administering subcutaneous palliative medications. RN's implementing this procedure must have read and understood this procedure, received appropriate training and support and be deemed competent to implement this procedure. Will use approved documentation and complete relevant paperwork as per this procedure and relevant trust documents.

All clinical staff employed by the Trust
Will familiarise themselves and follow the agreed procedure and associated resources. Will make their line managers aware of barriers to implementation and completion.

Family Carers who are also Health Care Professionals
Family carers who are health care professionals are advised to inform their employing organisation of the possibility that they will be administering SC injections to a family member. It is the responsibility of any doctor or registered nurse who is considering the administration of subcutaneous medication in these circumstances to seek advice from their governing body and/or defence union[11,12].

5. PROCEDURE

5.1. Patient and Carer Selection Criteria

Inclusion Criteria	Exclusion Criteria
• The patient is referred to this organisation. • The patient is over 18 years old with a palliative diagnosis. • The patient has symptoms where *As Required* (PRN) subcutaneous medication may be required imminently. • The consenting patient and/or carer are willing to administer subcutaneous medication and have been assessed as having the capability (physical and mental capacity or in patient's best interest) to do so by the MDT. • Agreement from multi-professional team that it is appropriate and safe for the patient or carer to administer subcutaneous medication. This **must include as a minimum** General Practitioner (GP) and Registered Nurse (RN) Band 6 or above, Senior Hospital or Hospice Doctor in the case of inpatient and Specialist Palliative Care Team **if involved** in any setting.	• The patient or carer is under the age of 18 years. • The patient or carer is not willing to give the subcutaneous medication. • The patient has capacity and does not want their carer to give them subcutaneous medication. • The carer has been assessed and lacks the capacity (mental or physical capacity) to undertake this procedure. • There are concerns related to substance abuse involving the patient, carer or any other people who have possible access to the home environment.

• The patient and/or carer has successfully completed the necessary training and is confirmed competent by a healthcare professional and feel confident to administer subcutaneous medication.	• There are relevant relationship or safeguarding concerns between the patient and carer.

5.2 Preparation: Suitability, Coordination, MDT Decision making and Consent

Requirement / Action	Rationale **For all actions: To protect the patient from harm (NMC 2018)[12]**
The request for this procedure is initiated by the patient or carer. There is no evidence of coercion or compulsion for the patient or carer to undertake the procedure	This procedure is the exception and should not be considered as standard practice. Motivation to implement this procedure should be led by the needs and wishes of the patient or carer and must not be imposed by healthcare professionals.
Patient and/or carer meet the inclusion criteria, with no exclusion aspects present. See 5.1 "Patient and Carer Selection Criteria"	To ensure safety of patient and carer. Reduce risk of failure of the procedure.
Competent Registered Nurse (RN) is responsible for coordinating the procedure. Competence to be determine by line manager / clinical lead following supervision aligned to this procedure.	Facilitate safe practice and minimise risk of errors and miscommunications
Competent RN to lead discussion and agreement on suitability of patient or carer and to proceed with the procedure with Multi-professional Team. **As minimum** this should include GP and RN, with hospital or hospice Doctor in the case of inpatients. MDT discussion may include a member of the local specialist palliative care team	To ensure safety of patient and carer. Reduce risk of failure of the procedure. To ensure collaboration and cooperation of MDT
All aspects of the procedure and implications to be discussed with patient or carer, ensuring full understanding. Including the possibility that they give medication when patient is very close to death, and they may die soon after. With reassurance that their action supported the patient's comfort and the medication and dose prescribed will not cause or hasten natural death.	To fully inform patient or carer of all aspects of the procedure before proceeding. To support informed consent. To ensure carer is prepared that patient may die naturally soon after a medication is given.
Competent RN to provide opportunity for family carer to discuss any fears or anxieties prior to starting the procedure	To ensure family carers are being listened to and provide any support needed.

5.3 Medication Decision Making

Requirement / Action	Rationale **For all actions: To protect the patient from harm (NMC 2018)[12]**
The prescriber and RN to: • agree the medication(s), dose(s), frequency, and indication that the patient or carer can give. • Explain the importance, indication, relevance, action, and possible side effects of each agreed medication. • The agreed medication(s) should be a specific dose with NO dose range. Agree the maximum number of doses that a patient or carer can give in 24hours before seeking further advice from health care professional.	Reduce decision making burden. Reduce risk of error Support understanding and informed consent. Support evaluation of effectiveness and any adverse reactions.
The patient and carer must understand and be provided with written information and escalation plan as recorded on the "Consent Form for Patient or Carer Administration of Subcutaneous Medication (Palliative Care)" for each agreed medication, including: • drug name, • dose, • indication, • possible side effects, • Interval before next dose is permitted. • Maximum number of doses in 24 hrs. • When to seek further advice and support *NB: the Consent Form will contain a list of the medications that the patient or carer can administer as per policy. However, other anticipatory medications that may ONLY be administered by the RN may also be prescribed on the community palliative care medication/drug administration chart.*	To ensure timely review of effectiveness of symptom management plan. To ensure timely resupply of medication stock
Patient or carer to be competent in keeping accurate record of all injections administered including date, time, medication strength, formulation, dose, and name of person administering the medication. This will usually be recorded the organisation's Community Palliative Care Medication Chart/Drug Administration Chart and on any medication stock sheets.	To ensure accurate documentation Safe medication administration across time and person. To ensure adequate stock levels

5.4 Training and Competency of Patient or Carer

Requirement / Action	Rationale **For all actions: To protect the patient from harm (NMC 2018)[12]**
Training of patient or carer is undertaken by competent registered nurse	To ensure safe implementation of the procedure
Training for patient or carer must cover all aspects of this procedure, including information from the patient and carer information leaflet "A Guide to Patient and Carer Administration of Subcutaneous Medication (Palliative Care)	To ensure safe implementation of the procedure
Registered Nurse is responsible for the insertion and management of the subcutaneous cannula (e.g.: Saf-T intima)	To establish a safe and secure subcutaneous route for the family carer to administer the medication
RN to train the patient or carer how to check for signs of insertion site problem (swelling, inflammation, leakage) and report according to local service.	To ensure education and prompt reporting of any issues and maintain patency
RN to train patient or carer to accurately check medication, date, time, medication, dose, indication and signature	To ensure the patient is given to correct medication, in the prescribed dose using the appropriate diluent and the correct route
RN to demonstrate and train on the correct steps involved in administering subcutaneous medication including: • hand hygiene, • checking the medication, • preparing equipment, • drawing up of medication, • injecting the bolus or use of subcutaneous cannula with flush, • disposal of medications, • disposal of sharps and other waste, • accurate completion of all required documentation, including Drug Chart/ Medication Administration Record and Stock Sheets.	To ensure patient or carer understand and can undertake all the required steps correctly and safely
RN to supervise the patient or carer to administer a bolus of a medication (if indicated during the training) or flushing of subcutaneous cannula with 0.3ml water for injection or use of injection simulation	To confirm patient or carer can correctly and safely administer a subcutaneous injection
The 'Consent Form for Patient or Carer Administration of Subcutaneous Medication	To ensure informed consent and competency

(Palliative Care) must be completed when the RN and patient or carer agree they are confident and competent to undertake the procedure without supervision. This must be retained in the home of the patient with any paper-based community record. A copy (photograph or scan) of this form **MUST BE** digitally attached to the patient's clinical recor and 'HIGH PRIORITY' reminder added to clinical record & /or GP record.	To ensure all Healthcare professionals aware when accessing patients clinical record

5.5 Ongoing Support and Management

Requirement / Action	**Rationale** **For all actions: To protect the patient from harm (NMC 2018)[12]**
RN to ensure the patient or carer has the 24-hour contact details for the Community Nursing Team and local OOH, Palliative Helplines and Hospice services as appropriate. Encourage contact at any time if any concerns or questions.	Timely appropriate support available
The patient or carer will contact the Community Nursing Team following administration of subcutaneous medication as agreed in the escalation plan. RN will review effectiveness of medication(s) with patient and carer as appropriate and plan accordingly.	To ensure prompt medication and symptom management review
MDT, patient, and carer to be involved in reviewing effectiveness of medications. Any changes to medication and doses must be discussed and agreed with patient or carer. Further training and supervision to be provided when medications are changed. All changes to be documented in the Consent Form for Patient or Carer Administration of Subcutaneous Medications (Palliative Care)	To ensure shared decision making, effective communication and implementation of medication changes
Patient and carer to be reminded regularly that there is no expectation or obligation on them to administer the medication and to contact the community nursing team for support anytime.	To reduce risk of distress, error or carer strain
Health care professionals should offer increased support when it is recognised that the patient may be within last days or hours of death, with offer to take over administering all medications from this point if carer would prefer.	To reduce risk of distress, error or carer strain

The frequency of contact by nursing teams must be agreed with the patient or carer and recorded within the patient's clinical record and care plan. A minimum of a weekly review by a competent community nurse or palliative care team (if involved) is recommended	To ensure changes in patient and carers status are identified and responded to promptly

5.6 Documentation

Requirement / Action	Rationale **For all actions: To protect the patient from harm (NMC 2018)[12]**
The patient's clinical record should be updated by the registered nurse to record that the patient or carer is competent to administer subcutaneous medication. This information must be recorded as a '**High Priority reminder'** on patient's clinical record and that used by GP if different.	To ensure communication that the procedure is in place and supported across MDT
An individualised care plan detailing the agreement of patient / carer administration of subcutaneous medication and the key detail regarding medications, doses and frequency must be created within the patient's clinical record.	To ensure communication of the plan across clinical team

5.7 Managing Incidents and Errors

Requirement / Action	Rationale **For all actions: To protect the patient from harm (NMC 2018)[12]**
All medication errors or incidents to be communicated to patient's MDT immediately and reported and investigated in accordance with local Incident Reporting Policy. Incidents should be investigated as soon as possible and where necessary the patient or carer will cease the procedure supported by MDT review, and any further injections will be given by healthcare professionals. **Any concerns should be escalated to the GP and/or lead nurse for the organisations relevant directorate /group (e.g matron, associate nurse director) for further guidance.**	To ensure timely, safe and appropriate response to any incidents To ensure patient, carer and healthcare professional safety To ensure effective and safe governance in place
Patients and carers must be aware of the process to follow in the event of a medication error or incident. To report immediately to their community nursing team or GP.	To ensure patient and carers know how to respond to an incident

Patient and carer to be informed of correct action in case of needle stick injury: make it bleed, wash it, cover it and report it to the GP and registered nurse immediately. To be reported according to local Incident Reporting Policy	To keep patient and carers safe from harm
Incidents, investigation and learning in relation to this procedure to be shared in York and North Yorkshire Palliative and End of Life Group as this is a multi-organisation procedure.	To ensure shared themes and learning across systems

5.2. Consent

Where the patient has the capacity to consent to themselves or their carer administering subcutaneous medication, this will be sought. It is recognised that patients nearing end of life, may not have the capacity to agree to this and therefore a decision must be undertaken in the patient's best interest. This should be documented according to local Mental Capacity and Best Interest Decision Making Policy[13.]

Carers must have mental capacity and physical capability to undertake this delegated task. A 'Consent Form for Patient or Carer Administration of Subcutaneous Medication (Palliative Care)' must be completed for all patients and carers who wish to administer subcutaneous medication as per this policy. The completed form should be left in the patient's home and a copy uploaded to the patient's electronic clinical record.

6. TRAINING

Training and support for registered nurses implementing this procedure should be offered as required following the procedure in full. This procedure is not standard practice and training and support for clinical staff to implement this procedure is likely to happen on rare occasions and therefore require individualised training support. Teams are encouraged to seek training support from Palliative Care Teams as appropriate.

7. DISSEMINATION AND IMPLEMENTATION

The procedure will be implemented using existing meeting structures and communication frameworks, including clinical networks, trust communications, divisional communications.

This policy will be available on the Trust intranet for staff to view.

8. MONITORING, AUDITING AND COMPLIANCE

Staff awareness of the guidance: Communication of the procedure to be cascaded to all clinical staff via organisational communication structures.

Practice will be compared to the standards within this policy. Incidents, feedback and complaints relating to this policy will be reviewed as per local trust incident investigation procedure and shared in risk management and relevant clinical forums to determine future learning and action. Any incidents and learning outcomes should also be highlighted to the Palliative and End of Life Leads for the relevant organisation.

An annual review of any incidents, concerns or good practice will be undertaken by the PEoLC Leads collaboratively and shared at relevant forums including the North Yorkshire and York Palliative and End of Life Group or the Humber and North Yorkshire PEoLC Clinical Network group as this is a multi-organisation procedure. An extraordinary meeting can be convened by the Leads to discuss any incidents more frequently as appropriate

9. REFERENCES / RELATED TRUST DOCUMENTS

9.1. References:

1. Wilcox A, Howard P and Charlesworth S. Intermittent SC Drug Administration by Informal Carers. Palliative Care Formulary 8th edition (2022). Palliativedrugs.com Ltd. Nottingham UK.
2. Subcutaneous Drug Administration by Carers (Adult Palliative Care), Bradford and Airedale Teaching Primary Care Trust (2006)
3. NHS Grampian Policy and Staff Guidance On Patient and Informal Carer Administration Of Subcutaneous Medication By Intermittent Injection – Adult Palliative Care (2016)
4. The Lincolnshire Policy for Informal Carer's Administration of As Required Subcutaneous Injections in Community Palliative Care (2013)
5. South Tees Hospitals NHS Foundation Trust: Self Administration or Relative Administration of Subcutaneous Injections (2016)
6. Anderson BA, Kralik D. Palliative Care at Home: carers and medication management. Palliative Supportive Care Dec 2008;6(4):349-56
7. Healy S, Isreal F, Charles M and Reymond L. Lay cares can confidently prepare and administer subcutaneous injections for palliative care patients at home: A randomised controlled trial. Palliative Medicine May 2018 (EPub ahead of print)
8. O'Hara, L., Evans, C.J., and Bowers, B. Family carers' administration of injectable medications at the end of life: a service evaluation of a novel intervention. British Journal of Community Nursing 2023 28:6, 284-292
9. Dying Matters 8 May 2017: http://www.dyingmatters.org/news/most-people-would-be-willing-give-injections-improve-quality-life-dying-person
10. NICE Guideline 31 Care of dying adults in the last days of life (December 2015): https://www.nice.org.uk/guidance/ng31
11. British Medical Association. (2024) https://www.bma.org.uk/advice-and-support/ethics/doctor-patient-relationship/doctor-patient-relationship
12. NMC Code (2018): https://www.nmc.org.uk/standards/code/

9.2. Related Trust Documents

Policy or Guideline	HDFT	York & Scarborough	Humber
Consent	Policy for Consent to Examination or Treatment	consent-to-examination-or-treatment-policy.pdf	Consent Policy N-052.pdf

Medication Incidents	Medicines Management and Controlled Drugs Procedural Guidance	Microsoft Word - Medication Errors Management Nursing Midwifery V4 Oct 23 (002)	Management of Medication Incidents SOP19-015.pdf)
Patient Safety Incident Response Policy	Patient Safety Incident Response Policy	incident-management-procedures.pdf	Patient Safety Incident Response Policy N-075.pdf
Medicine Management	Medicines Policy	Appendix C – Policy Template	Medicines Optimisation Policy M-006.pdf
Safe and Secure Handling of Medicines Procedure	See above	Appendix C – Policy Template	Safe and Secure Handling of Medicines Procedures Proc431.pdf
Mental Capacity and Best Interest Decision Making Policy	Mental Capacity Act (MCA) - Policy and Procedures	mental-capacity-and-best-interests-policy.pdf	Mental Capacity Act and Best Interest Decision Making Policy M-001.pdf
Record Keeping Guidance	Health Records Procedure	health-records-policy.pdf	Record Keeping Guideline G435.pdf

APPENDIX 1 – EQUALITY AND HEALTH INEQUALITIES IMPACT ASSESSMENT (EHIIA) TOOLKIT

Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document of Process or Service Name: Patient or Carer Administration of Subcutaneous Medication (Palliative Care)

2. EHIIA Reviewer (name, job title, base and contact details): Debi Adams - Professional Lead for Palliative and End of Life Care

3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Procedure

Main Aims of the Document, Process or Service To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching NHS FT policies.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Positive = evidence of positive impact Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	How have you arrived at the equality impact score? • who have you consulted with? • what have they said? • what information or data have you used? • where are the gaps in your analysis? • how will your document/process or service promote equality and diversity good practice?

Equality Target Group	Definitions (Source: Equality and Human Rights Commission, 2024)	Equality Impact Score	Evidence to support Equality Impact Score
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).	Neutral	Protocol can only apply to patients over 18yrs old.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Neutral	Protocol applied equally regardless of disability
Sex	Man/Male, Woman/Female.	Neutral	Protocol applied equally regardless of sex
Marriage/Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.	Neutral	Protocol applied equally regardless of martial status

Pregnancy/Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a person unfavourably because they are breastfeeding.		Protocol would not apply to pregnancy or maternity
Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.	Neutral	Protocol applied equally regardless of race
Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Neutral	Protocol applied equally regardless of religion or belief
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	Neutral	Protocol applied equally regardless of sexual orientation
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Neutral	Protocol applied equally regardless of gender reassignment
Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds	Neutral	Protocol applied equally regardless of poverty
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills	Moderate negative	May need additional support / adaptation of written leaflet and forms
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English	Moderate negative	May need additional support, interpretation and adaptation of verbal and written information on an individual basis
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems	Neutral	Protocol applied equally regardless of digital ability.
Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:		
	• people who experience homelessness	Neutral	Protocol could be applied equally following risk assessment

	• drug and alcohol dependence	High negative	May be excluded from this procedure due to risk assessment with use of injectable controlled drugs and risk of misappropriation.
	• vulnerable migrants	Neutral	Protocol could be applied equally
	• Gypsy, Roma and Traveller communities	Neutral	Protocol could be applied equally
	• sex workers	Neutral	Protocol could be applied equally
	• people in contact with the justice system	Neutral	Protocol could be applied equally
	• victims of modern slavery	Neutral	Protocol could be applied equally
Rurality	People who live in remote or rural locations who may have poor access to services.	Positive	Protocol could be applied equally. Procedure likely to be significant benefit to those in rural locations
Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.	Neutral	Protocol could be applied equally
Carers	Carers and families of patients and service users, including unpaid carers and paid carers	Positive	Protocol could be applied equally. Procedure likely to be significant supportive for carers
Looked after children	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.		Procedure does not apply to under 18s
Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.	Neutral	Protocol could be applied equally.
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.	Neutral	Protocol could be applied equally.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted		Would depend on individual risk assessment

Summary

Please describe the main points/actions arising from your assessment that supports your decision above While some groups are excluded from the procedure due to age or known drug dependence, all other categories would be dependent upon individual risk assessment, according to the inclusion and exclusion criteria as set out in the procedure.	
EIA Review	
Date Completed: 16.01.25	Signature: *D.Adams*
Professional Lead for Palliative and End of Life Care On Behalf of North Yorkshire and York organisations adopting this procedure.	

APPENDIX 2

CONSENT FORM FOR PATIENT OR CARER ADMINISTRATION OF SUBCUTANEOUS MEDICATION (PALLIATIVE CARE) – SEE SEPARATE ATTACHMENT ON POLICYSTAT

Consent Form for SC Administration by pat

APPENDIX 3

INFORMATION LEAFLET FOR PATIENT OR CARER ADMINISTRATION OF SUBCUTANEOUS MEDICATION (PALLIATIVE CARE) - SEE SEPARATE ATTACHMENT ON POLICYSTAT

Information Leaflet for Patient and Carers

APPENDIX 4

CONSULTATION AND ACKNOWLEDGEMENT

This procedure has been adapted from a version originally developed by Harrogate District Foundation trust, St Michael's Hospice Harrogate, Leeds Community Healthcare NHS Trust, St Gemma's Hospice Leeds and Wheatfields Hospice Leeds.

York and North Yorkshire Area Prescribing Committee

Patient and Carer Self Administration of Subcutaneous Palliative Medications York and North Yorkshire Task and Finish Group.

We acknowledge and thank all who have supported the development of the procedure.