Policy for the safe administration of Insulin

This is a working document and any changes that become necessary to this policy must be notified in writing to the Medicine Management Group via the Chief Pharmacist, East Cheshire Trust
<table>
<thead>
<tr>
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<th>Policy for the safe administration of Insulin</th>
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<tr>
<td>Executive Summary:</td>
<td>This document provides all staff at East Cheshire NHS Trust involved with the management of patients using insulin therapy with a clear framework of how to administer insulin at ward level and the provision of patient passports. It should be used in conjunction with the Medicines Policy.</td>
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<td>Description of Amendment(s):</td>
<td>The policy is now fully compliant with the Trust Policy on Procedural Documents. Version 5-</td>
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<tr>
<td>This policy will impact on:</td>
<td>All health professionals working within East Cheshire NHS Trust who administer insulin.</td>
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<td>Financial Implications:</td>
<td>None</td>
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<td>Medicines Management</td>
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<td>Issued By:</td>
<td>Chair of Medicines Management Group</td>
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<td>Review Date:</td>
<td>July 2019</td>
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<tr>
<td>Author:</td>
<td>Jabeen Razzaq-Sheikh Lead Pharmacist for Surgical Specialities, Clinical Support &amp; Diagnostics Services.</td>
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<td>Impact Assessment Date:</td>
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**APPROVAL RECORD**

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<tr>
<td>Dr Wai (Diabetes consultant)</td>
<td></td>
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<tr>
<td>Karen Bliss Advanced Specialist Practitioner – Diabetes</td>
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<tr>
<td>Karen Doyle –Clinical Specialist Practitioner - Diabetes</td>
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<td>Other (please specify)</td>
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1. INTRODUCTION

1.1 Background Information

NPSA /2010/RRR013 Safer administration of insulin was issued on 16 June 2010 and was in response to receiving 3881 wrong dose incident reports (August 2003 to August 2009) involving insulin. Insulin is frequently included in the list of top 10 high alert medicines worldwide. Three deaths and 17 other incidents between January 2005 and July 2009 were reported where an intravenous syringe was used to measure and administer insulin. The use of intravenous syringes to measure insulin doses in units is an error prone practice as the graduations are in volume not units of activity.

NPSA/2011/PSA003 The adult patient’s passport to safer use of insulin was issued in March 2011 in response to errors involving the wrong insulin product. Together these accounted for 60 per cent of insulin-related adverse drug events reported in the UK. The National Reporting and Learning System (NRLS) identified 16,600 incidents including six deaths and 12 resulting in severe harm between 1 November 2003 to 1 November 2009.

1.2 Policy Statement

This policy aims to support the implementation of the National Patient Safety Agency (NPSA) guidance on the safer administration of insulin and Patient Safety Alert NPSA/2011/PSA003 and the adult patient’s passport to safer use of insulin.

1.3 Aims

The aim of this policy is to ensure that:

- The right patient receives the right insulin, at the right dose and at the right time.
- The most appropriate insulin syringe is used to prepare and administer insulin.
- The most appropriate technique is used to administer insulin with an insulin syringe.
- The most appropriate technique to inject insulin using the most commonly used pens.
- To be aware of other delivery systems used to administer insulin.
- Adult patients on insulin therapy receive a patient information booklet and an insulin passport.
- Essential information is communicated across all healthcare sectors.

Insulin is a used to control blood glucose levels and is a prescription only medication that must be expressed in number of “units”.

Storage of Insulin

- Unopened vials /Cartridges /prefilled pens should be stored in a fridge (2-8 DegreesC)
- Insulin in use can be stored at room temperature (below 25 Degrees C) for up to 28 days. When the insulin is used for the first time, ensure a label is used to note the date and time of opening.
- Ensure Insulin is discarded if it has been out of the fridge for 28 days or more.
- Do not place insulin in or close to the freezer compartment as it should not be frozen.
- Do not expose vials, cartridges or pre filled pens to sunlight or high temperatures.
- Do not use insulin if it has expired (Always check the pack for the expiry date)
Methods and devices used for administration of insulin

1. Insulin Syringe Size

BD Insulin syringes are available in these sizes

Products shown not actual size

If the insulin dose is...          Use this capacity syringe
30 units or less, measured in half-units 3/10 mL/cc (30 units) with half-unit markings
30 units or less, measured in whole units 3/10 mL/cc (30 units) with whole unit markings
31 to 50 units                        1/2 mL/cc (50 units)
51 to 100 units                       1 mL/cc (100 units)

Choose the smallest syringe that's big enough to hold the largest dose. The smaller the syringe, the easier it is to read the markings and draw up an accurate insulin dose.
If the largest insulin dose is close to the syringe's maximum capacity, it would be best to use the next size up to accommodate any increases in the insulin dose. For example, if the insulin dosage is 29 units and a 3/10 mL syringe is used, it will not be possible to continue to use this size syringe if the insulin dosage is increased to 31 units or above.

**BD 3/10 mL syringes** are available with two different kinds of barrels: one with dosage markings at every unit and one with dosage markings at every half-unit.

- People who take whole unit insulin doses of less than 30 units should use the BD syringe with markings at every unit, because its large, easy-to-read markings make it simple to draw up an accurate dose.

- People who take very small doses (such as children) and who are told to measure their doses in half units (such as 2 ½ units or 5 ½ units) should use the BD syringe with dosage markings at every half unit.
1. **Injecting insulin with a syringe**

It is important to know how to draw up and inject insulin safely. By learning to use the correct injection technique, insulin can be given accurately and with a minimum of discomfort and inconvenience to the patient. These are guidelines on how to inject insulin with a syringe. Please ensure you follow the principles of ANTT (Aseptic Non Touch Technique as per Trust Policy) and good hand hygiene (Infection Prevention and Control Goods Practice Policy). Please note a syringe should be used only once and disposed of safely.

- Always check the label on the insulin vial to confirm the correct insulin as prescribed, the expiry date and for any special instructions. Wear gloves and using a large alcohol wipe (2% chlorhexidine & 70% alcohol) to wipe the insulin vials as per ANTT.

- If the insulin is cloudy, roll the vial gently between your hands several times in order to mix it completely.

- Remove the white cap covering the plunger. Carefully remove the orange needle cap. Pull back the plunger to measure an amount of air equivalent to the amount of insulin required.

- With the vial standing upright, insert the needle through the centre of the rubber cap of the insulin vial and push the plunger down. This expels the air into the vial, making it easier to draw out the insulin.

- Turn the vial upside down. Make sure the point of the needle inside the vial is well beneath the surface of the insulin. Pull back the plunger gently until you have measured slightly more than your correct dose of insulin.

- If any air bubbles are in your syringe, remove them. Flick or tap the syringe at the bubbles with your finger. When the air bubbles go to the top, push the plunger back to the desired dose expelling the bubbles into the vial.
Remove the needle from the vial and perform the injection as prescribed. A sharps bin must be taken with you to the point of patients care (As per Infection Prevention and control Good Practices Policy). The sharp must be disposed of immediately after use.

Injecting insulin with a pen

These are general guidelines common to most insulin pen devices. It is important to read the manufactures instructions. Pens are designed for patient use. The prescriber must be mindful of the potential risk for a needle stick injury. If the patient is unable to use a pen device, the prescriber should explore the option of prescribing insulin that is available in a VIAL (which can be administered by the nurse using an insulin syringe).

- If the prescribed insulin is not available in a vial do not draw up insulin from a pen fill cartridges please refer to appendix – administration of insulin via a pen device
- If the patient is unable to self-administer and the insulin is only available in a pen fill cartridge for pen device administration, the nurse should reduce the risk of needle injury. as follows: Please refer to appendix 1 – administration of insulin via a pen device.

Inserting penfill cartridge into pen device

- Pull the cap off the pen and remove the cartridge holder from the pen body. Put an insulin cartridge into the holder. Reattach the holder to the pen body.

Preparing prefilled pens and cartridge pens for administration of insulin

- If the insulin is cloudy, gently tip the pen 10 times and roll it between the palms of your hands 10 times to mix it.
• Screw on a new needle before each injection. Remove the outer cap of the needle, then the inner cap.

• Before each injection, check the pen is working by priming the pen. Set the dial to 2 units. With the pen pointing upwards slowly press the button. A tiny bead of insulin should appear at the needle tip, if not, repeat this step until you see a tiny bead of insulin at the needle tip.

• Check the dial is a zero and dial up the dose as prescribed

• Please check prescription for:
  ➢ name of insulin
  ➢ dosage in units
  ➢ time of administration
  ➢ subcutaneous administration

Please refer to good injection technique on page 9

• With the pen prepared for the injection, push the needle all the way into the skin and inject the insulin by depressing the plunger. Hold down the button for at least 10 seconds after the dial has returned to zero to assist absorption. Withdraw the needle slowly.

• Remove the needle (Refer to Appendix 1). A sharps bin must be taken with you to the point of patients care (As per Infection Prevention and control Good Practices Policy). The sharp must be disposed of immediately after use.

• Pen devices and cartridges are for single person use only and should never be shared due to the risk of cross contamination.

• Pen needles should be used only once. Using a new needle each time may reduce the risk of needle breakage in the skin, ‘clogging’ of the needle, inaccurate dosing and indirect costs. Reusing needles can cause lipohypertrophy at the injection site.

• Injecting through clothing should be discouraged. As needle lengths are becoming shorter there is increased risk of intradermal injection.
2. **Good Injection Technique**

A good insulin injection technique can contribute to maintaining good glycaemic control.

**a) Injecting Correctly**

Insulin needs to be absorbed steadily to work properly and this is why insulin is injected into subcutaneous tissue. Injecting into subcutaneous tissue ensures that the insulin is released smoothly and this helps to regulate glycaemic control.

If the needle goes deeper, the injection may go into the muscle tissue. Muscle tissue absorbs insulin more rapidly than subcutaneous tissue, and this could contribute to hypoglycaemia. For most people, using a short (e.g. 5mm to 8mm) needle is ideal to make sure the end of the needle is in the subcutaneous layer and doesn't go deeper reaching into the muscle layer.

Remember: when injecting, to leave the needle in the subcutaneous tissue for at least 10 seconds (after you have pressing the plunger) to make sure that all of the insulin is injected properly.

**b) Lift a fold of skin (A gentle pinch)**

- In a suitable injection site area take a fold of skin between the thumb, index and middle finger. Only lift the skin - not the muscle below it.
With the pen (or syringe) correctly prepared for the injection, push the needle fully into the skin at the peak of the fold. Proceed with your injection.

Ensure safe needle disposal to avoid cross infection/needle stick injury (see local infection control guidelines). A sharps bin must be taken to the point of patient care.

c) Rotation.

There are three areas that generally could be used for injecting: thighs, abdomen and buttocks.

Note: Injecting into the arms should be avoided unless advised by the diabetes team (there is an increased risk of hypoglycaemia when injecting into the arms as these injections might become intra-muscular rather than subcutaneous).

The main reason for rotating between and within sites is to make sure injections are not repeatedly given into the same site area each time. The reasons are:

- The speed of insulin absorption varies from site to site. It is important to develop a pattern where injection sites are rotated. Rotating injection sites can help control blood glucose levels.
- If insulin injections are given regularly into the same site, the tissue beneath may harden or become lumpy - a condition known as lipohypertrophy (or lipo’s as they are often called).
**Absorption Rates**

**Key points**

The thigh and buttocks are the preferred injection sites for administration of long acting basal analogues and medium and long acting insulins as absorption is slowest from these sites.

The abdomen is the preferred site for rapid acting analogues and short acting neutral insulin since absorption is fastest there.

Massaging the site before or after injection may speed up absorption and is not generally recommended.

All insulin should be injected subcutaneously except short acting neutral insulin (Actrapid and Humulin S) in a rate controlled device for sliding scale purposes only.

**Premixed Insulin**

- Premixed insulins (human or analogue) injections should be rotated around abdominal injection sites (as illustrated above) or thigh (upper-outter) site areas.

**Basal bolus insulin regime**

- Rapid or short acting insulins should be administered into the abdominal injection site
- Intermediate/Long acting insulin should be injected the thigh (upper-outter) or buttocks.

**Alternative devices to administer Insulin**

Injecting insulin with a syringe or insulin pen device are the most popular methods of insulin delivery. However, other options also exist:-

**Insulin Pump**

*Insulin pumps* provide a continuous flow of rapid insulin, as well as larger bolus doses that are released by the operator pressing a button at mealtimes.

- The patient should only use an insulin pump if trained by a skilled health care professional who has received training and is competent in the use of continuous subcutaneous insulin infusion.
- An insulin pump should be worn at all times.
- If there is any failure in the pump occurs immediate medical advice should be sought to avoid diabetic ketoacidosis does not develop and so an alternative route to insulin administration is prescribed i.e.: basal bolus regime.
Jet Injector

Jet injectors are devices that force a tiny stream of insulin through the skin by pressure. Please seek guidance from a health professional trained with this system.

Caution / special considerations

Bio similar insulins
Biosimilar insulins demonstrating similar properties are not interchangeable or bioequivalent.

Lantus® is the originator brand of insulin glargine and recently Eli Lilly has introduced a biosimilar insulin glargine preparation with the brand name Abasalgar®.

High strength insulins
High strength insulins should only be administered via the manufacturer's pen device.

Degludec (Tresiba) 200 units/ ml
Humalog 200 units/ ml (non formulary)
Toujeo (insulin glargine) 300 units /ml (non formulary)

For safe prescribing and administration insulin products should be prescribed by:-

brand name
concentration
formulation i.e. vial/disposable pen/cartridge

The Adult Patient’s Passport to safer use of Insulin

From August 2012, adult patients administering insulin should be provided with an Insulin Passport and supportive Patient information Booklet to help provide accurate identification of their current insulin products and provide essential information across healthcare sectors. These should be issued by the prescriber.

On admission to hospital/out-patient clinics the information in the patient’s passport must be cross-referenced against the prescription. If a passport is not presented this should be documented on the chart and in the clinical notes so that either:

1. Arrangements can be made for the insulin passport to be brought into hospital
2. A new passport can be issued if the current one has been lost
3. The patients right not to engage in this initiative can be documented

Changes in treatments should be communicated to the GP so they can confirm updates in the passport at the patient’s next review. This may be by annotation to the electronic discharge notification form (EDNF) or by letter.
In Primary Care

1. Clinicians need to cross-check information in the Insulin Passport with their EMIS/PCS system during diabetes consultations and prescribing/dispensing processes.
2. In order to facilitate record keeping/audit it is suggested that the Diabetes Annual Review Template is amended to include:
   a. Insulin passport discussed and provided
   b. Insulin passport discussed but patient declined to accept

*(See Patient Safety Alert, NPSA/2011/PSA003)*

For more information on insulins, pens and pumps please refer to the pages below (Please note this is only a guide and to refer to the latest BNF for all current insulins as some may have discontinued).

(“The Balance guide to testing and treating diabetes 2010 “Available from the Diabetes UK website www.diabetes.org.uk). Please note to refer to the latest BNF for all current insulins as some may have discontinued.

References

- NMC Standards for Medicine Management (2010)
- The Balance guide to testing and treating diabetes 2010 from [www.diabetes.org.uk](http://www.diabetes.org.uk)
- Safe medicines newsletter march 2016

For more information on insulins, pens and pumps please refer to the pages below (Please note this is only a guide and to refer to the latest BNF for all current insulins as some may have discontinued).

Appendix 1 - Administration of insulin via an insulin pen device

The aim of this protocol is to minimise the risk of sharps injury to healthcare workers (HCWs) when using patient’s insulin pen injection devices as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and in line with European Council Directive 2010/32/EU.

Insulin pen injectors are auto-delivery systems designed for self-administration of medication (insulin) via the subcutaneous route. Needles on insulin pens have to be unscrewed before disposal which poses a risk of sharps injury.

Assessment of Insulin Administration

- **Admission To Hospital**
  - Assess patient’s ability to self-administer insulin injections.
  - Patients who were previously able to self-administer insulin with a pen device, but now unable to do so temporarily due to clinical condition.
  - Ward Nursing staff to administer insulin using patients own insulin pen.
  - Use a safety retractable needle. Size of needle is according to patient’s BMI:
    - BD Auto Shield Duo Safety Pen Needle 5mm
    - Novofine Auto cover (8mm)
  - On clinical improvement reassess and decide if suitable for self-administration.

- **Patient discharged to Community**
  - Assess patient capacity and ability to self-administer insulin and remove pen needle. If patient unable to remove needle, a needle removal device should be used to safely remove and dispose of the pen needle.
  - The Novofine Remover is compatible with most pen needles. Its cap fits over the needle on the end of the insulin pen and is twisted off. Depression of the button ejects the needle straight into a sharps bin. It is for individual patient use and available on prescription.
  - Other safer sharps options available for HCWs administering insulin via a pen device following risk assessment include:
    - **Uniguard pen needle safety remover device** (a single use device for use by HCW for disposal of pen needles).
    - If above options are not suitable then consider safety retractable needle.

- **If on Novomix 30 insulin.** (Not available in vial)
  - On discharge prescribe and supply:
    - Novomix 30 insulin either penfill or flexpen
    - Novofine remover
  - For all other types of insulin available in a vial.
    (Currently only exception Novomix 30)
  - Prescribe and supply the following on discharge for district nurse to use:
    - Vial of brand specific insulin
    - Insulin needles and syringes
Novofine Remover
This is suitable for use in community, for HCW to safely remove insulin pen needles. If used it should be patient specific, not transferred between patients. This devise is also suitable for patients to use if they have difficulty removing pen needles. The Novofine remover is available on prescription or can be ordered through supplies
Novofine remover: 3449733

Uniguard pen needle safety remover
These can be used for patients in primary or secondary care by the HCW for safe removal and disposal of pen needles. They are single use devices. These can be ordered via NHS supply Chain: FTR744

Safety retractable pen needles
To ensure HCW safety, safety (retractable) needles should be used where appropriate conditional upon injection zone and BMI

Two brands of retractable needles are available:
BD Auto Shield Duo Safety Pen Needle
5mmNovofine Autocover 8mm

*8mm needles are not suitable for patients with a BMI <22 kg/m2 because the injection is likely to penetrate the muscle.

These retractable needles are fitted with a sliding shield. This shield covers the needle before injection, retracts during injection, and then slides back into place to cover the needle again, locking permanently into a shielding position following insulin delivery. Once the needle has been used, the safety lock indicator turns red to indicate that the shield is now locked. This effectively blocks any accidental needle puncture wounds as well as any re-use of the needle. These can be ordered from supplies on:
Novofine Autocover 8mm: 441686
BD AutoShield 5mm : SBS FTR1083

For Further Guidance on the most appropriate needle remover device or safety retractable needles please contact:
Diabetes Specialist Nursing Service
Tel 01270 415414
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, and strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services. Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

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

State main purpose or aim of the policy, procedure, proposal, strategy or service:
This document provides all staff at East Cheshire NHS Trust involved with the management of patients using insulin therapy with a clear framework of how to administer insulin at ward level and the provision of patient passports. It should be used in conjunction with the Medicines Policy.
Incorporates guidance from
NPSA/2011/ PSA003
NPSA /2010/RRR013

The aim of this protocol is to minimize the risk of sharps injury to healthcare workers (HCWs) when using patient’s insulin pen injection devices as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and in line with European Council Directive 2010/32/EU

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

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

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

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

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

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

• Gypsies & travellers – estimated 18,600 in England in 2011.

**Gender:** In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

**Disability:**
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

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

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

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

**2.2 Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

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**2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?**

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3. Assessment of Impact

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

**RACE:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?  
Yes ☐ No √

**Explain your response:**

If the patient’s first language is not /English, trust staff should follow the interpretation policy. The patient information leaflet can be translated into other languages.

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

**Explain your response:**

Staff will respect patient’s privacy and dignity and for further guidance can view the trust privacy and dignity policy.

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

**Explain your response:**

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

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

**Explain your response:**

Written into the policy are instructions on using half unit syringes for children having smaller doses. Picture communication books can be used to aid explanation. Carers can be involved to support older and younger patients.

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

Explain your response:

Policy applies to all patients equally within the scope of the policy

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

Explain your response:

Policy applies to all patients equally within scope of policy. Staff will check at the time if any drug contains ingredients that are not acceptable to a person’s faith e.g. porcine or bovine products and would discuss this along with the alternatives with the patient and prescriber if requested. Staff will be mindful of the cultural and religious requirements of some to remain covered and needing a female staff to administer to a female patient. Privacy and dignity will be promoted at all times.

CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?  
Yes ☐  No √  
Explain your response:

Carers will be involved as detailed above.

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

No impact on the above in terms of administering insulin
4. Safeguarding Assessment - CHILDREN

| a. Is there a direct or indirect impact upon children? | Yes ☐ No √ |

b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:)

c. If no please describe why there is considered to be no impact / significant impact on children

Policy applies to adult patients only

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

No. Policy applies equally to all patients within the scope of the policy

6. Date completed: July 2016 Review Date: July 2019

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

| Action | Lead | Date to be Achieved |

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: Andy Chambers - Head of Safety, Risk and Resilience (on behalf of Lyn Bailey)

Date: 10/8/16