**Medication Self -Administration Plan and Monitoring Form**

|  |  |
| --- | --- |
| **Care Home** |  |
| **Name of Service User** |  |
| Prescription details:Name of prescribing Doctor / Nurse |  |
| Name of dispensing Pharmacy |  |
| Is the medication a controlled dosage monitoring system?If no: details of prescribed drug information for monitoring purposes.  | **Yes** | **No** |
| **Description** | **Start Date** | **End Date** | **Frequency** | **Dose** | **Strength** | **Route** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| RISK ASSESSMENTHas the service user made clear their wish to self-administer? | **Yes** | **No** |
| Is the service user agreeable to have their self-administering checked by staff? | **Yes** | **No** |
| If no, is the service user clear they will be responsible for any errors they make in administration?  | **Yes** | **No** |
| How often is checking to be done? |  |
| Are there any doubts to the service user’s mental capacity to administer their own medication in accordance to their wishes? | **Yes** | **No** |
| If so, what are they and how is the persons capacity to be assessed? |  |
| Are there any risk to the service user’s health and safety from self-administration?  | **Yes** | **No** |
| If yes, what are they? |  |
| What is the level of risk?  | High  | Medium | Low |
| How are the risks to be managed? |  |
| Does/ could the service user take over the counter medicines as well as prescribed medicines?  | Yes | No  |
| If yes, have they been checked for compatibility? | Yes | No |
| Is the service user aware of potential incompatibilities? | Yes | No |
| If no, have the issues ben discussed with the service user?  | Yes | No |
| Summary of self-administration plan. |
| Summary of reason for self-administration |
| Assessed Risk Factors | Details of how risks will be monitored and managed |
| Monitoring record: |  |
| Date checks made: | Action taken | Signature of staff member |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Date of next review of self-administration plan |  |
| Comments |  |