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

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| **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** |
|  |  | |  | |  | | |  | | | |  | | |  |
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| RISK ASSESSMENT  Has 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 | | | | | | |
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| Date of next review of self-administration plan | | | | | |  | | | | | | | | | |
| Comments | | | | | |  | | | | | | | | | |