Livewell Southwest

Self-Administration of Medicines Policy

Version No.3.2

Review: June 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW Intranet holds the most recent and approved version of this guidance. Staff must ensure they are using the most recent guidance.

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Self-Administration of Medicines Policy

1. Introduction

1.1 Self-administration refers to the situation whereby in-patients are responsible for administering prescribed medication under staff supervision. The concept involves an initial patient-assessment followed by a comprehensive education and counselling programme. A multi-disciplinary approach is essential, to ensure that all appropriate patients are considered. Careful monitoring of included patients is needed.

1.2 Self-administration of medicines is a fundamental component of rehabilitation and recovery and preparation for discharge. This scheme promotes self-care and in doing so may reduce medicines related re-admissions to hospital. The Care Quality Commission (CQC) requires that services are responsive to people's needs. For self-administration the key questions are:

Do patients have timely access to medicines?

- Includes supporting and reminding them to self-administer their medicines independently where they are able and wish to do so by minimising the risk of incorrect administration; and the arrangements for recording when it is not possible for a person to be able to self-administer their medicines

What actions are taken to ensure patients have timely access to ongoing medicines after discharge?

- Use of self-administration to check understanding and concordance with medication prior to discharge; and preparing patients for independence in medicines administration after discharge

2. Aims

2.1 The main aims of a self-administration programme are:

- to establish a standardised approach for determining the ability of patients to take their own medication safely and correctly
- to increase patients' knowledge and understanding of their medication
- to promote and maintain patient independence and autonomy
- to identify medicines-related problems prior to discharge
- to promote adherence with medication post-discharge

3. Risks

3.1 The potential risks of allowing patients to self-administer their drugs in hospital are:

- Overdose (intentional or accidental)
- Under dose (including omitted doses)
- Theft of drugs from a patient who is self-administering
- Unauthorised access to the patient's medicines by confused patients

3.2 If accidental overdose occurs due to non-adherence it is better for this to happen in hospital where immediate action can be taken and medical aid is on hand. Similarly, it is advantageous to detect under dosing while the patient is still in hospital and can be educated further or given compliance aids.

3.3 The risks associated with self-administration are minimised by:

- Effective multidisciplinary team working and communication
- Comprehensive patient counselling
- Strict adherence to agreed written procedures, as defined in this policy
- Access to appropriate staff training with clearly defined roles and responsibilities. All nurses involved must be registered with a current NMC registration, and have been deemed competent by the ward/unit nurse manager.
- The use of locked facilities for storage of medication to which only the patient and nurse hold a key.
- The separation of confused patients from those self-administering. (Where practicable).
- Only providing patients with a limited supply of medicines
- Close supervision of patients self-administering
- Regular compliance checks. (see section Monitoring progress and checking compliance page 11 and Appendix V)

3.4 The risks of **not** allowing patients to self-administer their medicines include deskilling of patient's ability to manage their own medication during extended hospital stays; poor concordance with medication on discharge; poor outcomes with the potential for hospital re-admission.

4. Criteria for Patient Selection – all patients

4.1 The following patients may not be suitable for inclusion in the self-administration programme:

- Patients who will not be responsible for administering their own medication after discharge (e.g. discharge to nursing home).
- Patients whose medication regime is not stable. Individual unstable items may be administered in accordance with normal practice by registered nursing staff (Safe &Secure Handling of Medicines policy section 10) and should not prevent a patient from self-administering stable medications

- Patients who have no wish to participate in the self-administration programme (however some patients may change their minds following education and explanation of the purpose and benefits involved).

- Patients detained under the Mental Health Act who are not consenting to treatment

4.2 The following patients will not normally be considered for inclusion in a self-medication program, but may be considered following full assessment by the MDT if, after discharge they will be responsible for managing their own medication. Inclusion in the program provides an opportunity to monitor safety and concordance with medication and to plan discharge arrangements accordingly:

- Patients who are confused
- Patients who are deemed by the MDT to lack the capacity to safely administer their own medicines
- Any patient who continues to misuse alcohol or drugs
- Conduct a current risk assessment for those with a history of overdose

5. Medicines to be excluded from Self-Administration – all patients

5.1 The following medication should be *excluded* from self-administration:

- Controlled drugs in schedules 2 and 3 (see "Controlled Drug Standard Operating Procedures v 1 sections 1.1 and 1.16) (although the patient should be encouraged to request their medication when a dose is due).

- Injections (unless the patient is / will be self-administering their medications at home e.g. insulin)

- Once only doses

- Variable regimens may not be appropriate (may cause confusion - assess individually)

  e.g. Loading doses of warfarin
  Reducing courses of oral corticosteroids
  Sliding scale insulin
  Clozapine titration

- Medication which requires refrigeration (although the patient should be encouraged to request their medication when a dose is due).

N.B.: Insulin may be stored out of the refrigerator but the expiry is reduced to one month from the date of removal from the refrigerator.

6. Patient Information and Consent – all patients

6.1 Patients, and where appropriate, their family and/or their carers should be fully informed of the purposes of self-administration and how the scheme works. The nursing staff or the pharmacist may give this information. All patients must be given the 'Information about Self-Administration of Drugs' leaflet (Appendix I). It must be made clear to the patient that they do not have to participate if they are not happy to do so and that they may withdraw from the scheme at any time.

6.2 Once the patient has read all the information and understands what the scheme involves, they must sign the consent form (Appendix II) if they wish to participate in the scheme. A nurse or pharmacist must witness the consent and the form then scanned to SystmOne.

6.3 A doctor caring for the patient must then also sign the prescription form and consent form to indicate their agreement that the patient may participate in the scheme.

6.4 The completed consent form must be filed in patient's clinical record.

7. Patient Selection and Assessment - All Patients

7.1 Patients should be selected by the nursing staff and/or by Multi-Disciplinary Team (MDT). The consultant, registrar, speciality doctor or senior house officer responsible for the patient must agree to the patient's participation.

7.2 Assessment of a patient's suitability to self-administer should be conducted by a trained nurse (in discussion with MDT if appropriate) by completing a 'Patient Self-Administration Assessment form' (Appendix III). The patient should be shown sample bottles / cartons, bottle-tops and labels to assess their ability to open containers and read directions. Patients with special requirements regarding packaging and labelling should be referred to the Pharmacy (and Occupational Therapist if necessary). Any patient deemed unsuitable on initial assessment may be reassessed in the future or may be included after discussion by MDT if the benefits are considered to outweigh the risks.

7.3 Insulin should be considered for self-administration where feasible and safe, even if the patient is unsuitable for self-administration of all their medication. The assessment (see appendix III) should take account of:

- Whether the patient has capacity to understand their medication needs
- Whether the patient is able to remember the times of their doses
- Whether the patient is able to select the correct insulin preparation (particularly if they are using more than one insulin type).
- Whether the patient is able to withdraw the insulin from the vial and / or use the injection device correctly.

- The storage facilities on the ward allow the insulin and syringes / needles / pens, sharps box etc. to be kept safely in the possession of the patient.
- That there are no risks to other patients on the ward by allowing the patient to self-administer their insulin

7.4 The completed assessment form must be scanned to SystmOne.

8. Initiation of Self-Administration – all patients

8.1 Before medicines are prescribed for self-administration the drug regime should be reviewed by the doctor, nurse and (where possible) pharmacist to include only necessary medication and to select dosing regimens that are as simple as possible.

8.2 Patient Information leaflets for each medicine should be provided to the patient to read if available. These can be accessed from www.patient.co.uk

8.3 The patient should be verbally counselled about each of their medications, see section 10.

8.4 Before a patient is allowed to start self-administering their medicines the nurse must complete and sign the 'Initiation of Self-Administration Checklist' (Appendix IV), which should be scanned to SystmOne.

8.5 Self-administration must only be initiated on normal working days. 8.6 For Community and Rehabilitation wards a doctor should complete the self-medication section on the front of the drug chart – indicating the level of self-administration

8.6 For mental health wards and units the front of the prescription chart should be clearly marked "self-administering level ……." and signed and dated by the doctor.

9. Ordering, Supply and Storage of Medication – all patients

9.1 All medications for the patient should be prescribed on the patient's prescription chart.

9.2 The patient must have a correctly labelled supply of medication for all drugs which they will be self-administering. These should be obtained through the normal procedures as detailed in the Safe and Secure Handling of Medicines policy / Medicines Management Policy. **The instructions on the label must be the same as the prescription chart.**

9.3 Medicines dispensed from Derriford Hospital Pharmacy or LSW Dispensaries may be used, and if the ward is working to Medicines Management Procedures then Patient's Own Drugs (POD's) may be used provided they are of acceptable quality.

9.4 For wards where a full medicines management scheme runs the pharmacy technician is responsible for ordering the medication

9.4.1 The pharmacy technician must be made aware that the patient will be self-administering; they can be informed by writing in the ward communication book or sending an email.

9.5 Nursing staff are responsible for ordering medication on wards where a medicines management scheme does not run.

9.6 Any special requirements such as Medidose®, Venalink® blister-pack, large-print labels or non-child- resistant closures should be stated when ordering the medication.

9.7 If a compliance aid (e.g. Medi-dose® or Venalink® blister pack) is required, this should be brought to the attention of the Authorised Pharmacy Staff and a compliance-aid request form completed and scanned to SystemOne.9.8Usually four week's supply of medication will be dispensed but this may be reduced if appropriate to suit the needs of the individual patient. For example, a reduced supply would be appropriate if there are concerns regarding the patient's ability to cope with self-administration. The number of day's supply required must be clearly stated when ordering.

9.8 New supplies must be ordered in advance to ensure the patient does not run out. This is the responsibility of nursing staff, or pharmacy staff for those wards working to medicines management procedures. Usually new supplies should be ordered when current supplies fall below 14 days.

9.9 When medicines for self-administration arrive on the ward from pharmacy they must be checked to ensure that the contents and label are exactly as prescribed and placed in a locked cupboard until the regime has been discussed with the patient.

9.10 Medication should be stored in individual patient locked facilities for medicines storage ("bedside lockers") on wards where these are available. When the patient has reached level 3 of the scheme the patient should keep the key on their person if this is assessed as appropriate.

9.11 Medicines security must be explained to the patient.

9.12 Each patient must be assessed to ensure that they can gain access to the medication in their locker.

9.13 A master key will be held by the nurse-in-charge of the ward.

9.14 If the patient leaves the ward for any reason their key must be given to the nurse-in-charge for safekeeping.

- A record of the key numbers issued to individual patients must be kept by the nurse-in-charge.

All keys will be returned to the nurse in charge at the point of discharge.

9.15 If a key is lost the medicines must be removed from the locker and stored securely.

- If the key is not found the lock must be changed.
- An incident form must be completed.

9.16 If the medication of a patient who is self-administering changes in any way, the supply in the locker must be amended accordingly. If a medication is stopped it must be immediately removed from the locker (by the nurse). If a new medication is started a supply should be obtained, if a dose changes the box must be relabelled – the ward pharmacy technician will co-ordinate this.

9.17 Medical staff must bring any changes to the drug regime to the attention of nursing staff at the time the change is made.

9.18 If a drug is discontinued, a nurse, doctor or pharmacist must remove it from the patient's medicine cabinet immediately.

9.19 The nurse must check the drug regime daily to ensure that no changes have been made which necessitate an amendment to the drug supply held by the patient. If a dose is changed, this should be brought to the attention of authorised pharmacy staff for re-labelling (if appropriate) or re-order on a one-stop order form accompanied by a copy of the prescription chart.

10 Patient Counselling – all patients

10.1 A nurse or authorised pharmacy staff should carry out initial patient counselling. Following the initial counselling, the pharmacist should be contacted for further patient counselling if a problem is encountered. The patient should be further counselled if the drug therapy is changed, and also to discuss the drug regime with the patient at discharge.

10.2 Counselling should include the name and purpose of the medicine, a description of the medicine, how to take the medicine and any common side effects. See 'Initiation of Self-administration Checklist (Appendix IV) and section 11 below.

10.3 A Medicines Reminder Card (Appendix VII) should be completed for each patient by the authorised pharmacy staff or nurse with the aim of ensuring that the patient understands the drug regime

a) Medicine reminder cards completed by a nurse should be checked by a second nurse or an authorised pharmacy staff both of whom should sign the card. (A second copy of the medicines reminder form should be filed in the patient's notes.)

b) Administration of medicines may be linked to daily events such as mealtimes and should be tailored to the needs of the individual patient.

c) The Medicines Reminder Card should be updated by the nurse or authorised pharmacy staff when drug therapy is changed and when further counselling is carried out.

d) The patient should take the Medicines Reminder Card home on discharge from hospital, and should be counselled so that if there is any change to the prescribed medication the old card is removed and a new one produced (either by the community pharmacist, prescriber, themselves or their carer as applicable)

e) It should be explained to the patient/patient's carer that the reminder card refers ONLY to discharge medication and will need to be amended if the GP or other doctor, changes the prescription

10.4 At all times the patient must be given the opportunity to ask questions.

10.5 If the medication of a patient who is self-administering changes in any way, the patient must be informed of the changes and counselled to ensure that the changes have been understood

10.6 See appendix VIII for patient counselling checklist

11 Procedure for Community & Rehabilitation patients

11.1 Levels of Self-Administration

11.1.1 Throughout this scheme the patient has increasing levels of responsibility for taking their own medication, whilst in a supervised and supportive environment.

Level 0: Patient not suitable for self-administration at the present time.

Level 1: The patient administers the medicines with full supervision and support from the registered nurse.

Level 2: The patient requests medication from the nurse at the appropriate time. The nurse supervises administration.

Level 3: When deemed competent, the patient administers his/ her own medicines without supervision and is given responsibility for the key to their own medicine cupboard/ drawer.

11.1.2 The level of self-administration must be entered on the self-administration assessment form, which must be up-dated as the patient increases responsibility for their medication. (See Appendix III)

11.2 Monitoring Progress and Checking Adherence

11.2.1 Any change in the patient's condition may necessitate return to levels zero, one or two as appropriate.

11.2.2 The patient's ability to adhere to both the medicine regime and the storage requirements should be constantly evaluated. If there is doubt about a patient's comprehension and adherence they should return to level 1 or 2 and the problems discussed/resolved at MDT.

11.2.3 For at least the first few days of self-administration the patient must be closely observed by the nurse to ensure no problems are encountered. As the patient progresses, supervision may be gradually reduced but the nurse must always ensure that medication is being administered as prescribed, by means of informal discussions with the patient.

11.2.4 When the nurse is satisfied that each dose has been administered as prescribed, he or she should mark the appropriate section of the prescription chart in the usual way with the letters "S/A". This must continue throughout the hospital admission.

11.2.5 A 'Patient Self-Administration Progress Report and Adherence Check' should be completed by the nurse daily for at least the first 3 days of self-administration (Appendix III). If there is any doubt regarding the patient's ability to cope, this must be continued for longer. Thereafter, a progress report should be completed twice weekly.

11.2.6 In the same manner, compliance should be checked by means of tablet counts. These should be performed by the nurse as follows:

Daily check for the 1st 3 days

then

- Twice weekly for two weeks (as part of progress report)

then

- Fortnightly until discharge.
- A record of all adherence checks by means of tablet count should also be made using the 'Patient Self-Administration Adherence Check' form (Appendix V).

11.2.7 The 'Patient Self-Administration Progress Report and Adherence Check' form should be scanned to SystmOne upon completion.

11.2.8 The nursing staff will have informal discussions with the patient to monitor progress.

12 Procedure for Mental Health Recovery patients

12.1 Throughout this scheme the patient has increasing levels of responsibility for taking their own medication, whilst in a supervised and supportive environment.

Level 0: Patient not suitable for self-administration at the **present time.**

Level 1: The patient administers the medicines with full supervision and support from the registered nurse.

Level 2: The patient requests medication from the nurse at the appropriate time. The nurse supervises administration.

a. Continue to store the medication in the unit's locked drug cupboard/trolley

b. The patient should ask for their regular medication at the appropriate administration times without prompting

c. Prompt the patient if they forget to ask. Complete the relevant section of a "Self-Administration of Medicines Scheme Level 2 – See Appendix VI" form for each administration time, detailing whether the patient remembered to ask for medication without prompting or whether a prompt was necessary

d. Continue to record each medicine administration on the patient's drug chart

e. Continue to administer and record "when required" medication as normal

f. When the patient can consistently ask for medication without prompting, move on to Level 3

Level 3 – Patient takes responsibility for one day of medication at a time

a. The patient must have a locked, secure cupboard/drawer in which to keep medication. Nursing staff must have a master key and must ensure the patient is storing the medication securely
b. The doctor completes a "Leave Sheet" requesting seven days of medication to be dispensed. This may be supplied in normal boxes or a Medidose Pack depending on the individual patient's needs. (The doctor, nurse or pharmacist completes a "Compliance Aid Request Form" if a Medidose is required.)_
c. Send the Prescription chart with leave section completed and Compliance Aid Request Form (if appropriate) to the Mount Gould hospital pharmacy (or Glenbourne pharmacy if the patient is on clozapine)
d. Continue with Level 2 until the medication is received on the unit
e. Once the dispensed medication is received a registered nurse can give the patient one day of supply and endorse the administration section of the drug chart with "one day supply given" against the appropriate date

f. Continue to administer and record “when required” medication as normal
g. The doctor or nurse continues to request the medication on a “Leave Sheet” requesting the medication to be dispensed
h. It may be necessary to undertake “spot checks” to monitor concordance. Complete a “Self-Administration of Medicines Scheme Adherence Check Sheet – Appendix V” every time a check is made
i. Continue giving one day at a time until the MDT feel that the patient is competent with this
j. When the patient is competent with one day at a time, move on to Level 3.1

Level 3.1 - Patient takes responsibility for two or more days (but less than 7) of medication at a time.

a. Gradually increase the number of days’ supply given to the patient at a time
b. Continue to endorse the administration section of the drug chart with the number of days’ supply given against the appropriate date
c. Continue to administer and record “when required” medication as normal
d. The doctor or nurse continues to request the medication on a “Leave Sheet”
e. Undertake unscheduled “spot checks” on a weekly basis (more frequently if necessary) to monitor concordance. Complete a “Self-Administration of Medicines Scheme Adherence Check Sheet” every time a check is made
f. Nursing staff must continue to monitor that the patient is storing the medication securely
g. Continue to increase the number of days’ supply given until the patient is competent at handling one week of medication at a time – see level 3.2

Level 3.2 – Patient continues to self-medicate with one week of medication at a time

a. The MDT should also decide how to manage “when required” medication that is being used on a frequent basis
b. Where possible the medication should be dispensed in normal tablet bottles and boxes (one week at a time). This type of dispensing will be much easier to maintain in the community.
c. If a compliance aid is needed, request that the medication is dispensed in a Blister Pack (there is no need to complete a further “Compliance Aid Request Form” for this but make sure the request is clearly marked on the prescription)
d. The doctor or nurse continues to request the medication on a “Leave Sheet”

e. Continue to endorse the administration section of the drug chart with the number of days' supply given against the appropriate date
f. Continue to monitor that the patient is taking the medication correctly by undertaking 'spot checks' as appropriate. Complete a "Self-Administration of Medicines Scheme Adherence Check Sheet" every time a check is made. Refer any problems to the doctor or MDT.

12.2 If, at any time, the nurses or patient feel that the scheme is not working or not safe, revert back to any of the previous levels and discuss with the MDT

13 Missing Drugs – All patients

13.1 If drugs go missing the doctor and pharmacist should be informed.

13.2 Self-administration should be discontinued for the patient concerned and recommenced only if considered appropriate after patient evaluation and further counselling.

13.3 An incident form must be completed.

14 Drug Administration Errors – All patients

14.1 An incident form must be completed.

14.2 The doctor should be informed immediately.
14.3 The doctor should assess the severity of the error, and advise on appropriate action.

14.4 The pharmacist should be informed who may also advise on what action to take.

14.5 Self-administration should be discontinued for the patient concerned (or moved to a lower level) and recommenced only if considered appropriate after patient evaluation and further counselling.

14.6 Known missed doses should be recorded on the prescription chart. Inform the doctor and pharmacist as above.
14.7 Note that some medications require re-titration if missed, or specific monitoring. Advice should be sought from the doctor and / or pharmacist as per 14.3 and 14.4.

15 Discontinuation of Self-administration – All patients

15.1 The patient may withdraw from the scheme at any time. Drugs will then be administered in accordance with the Livewell Southwest Policy for the Safe and Secure Handling of Medicines.

16 Discharge – All patients

16.1 The patient's medication should be checked to ensure that there is an adequate supply for discharge and that no changes in prescribed medication have been made.

16.2 The named nurse or authorised pharmacy staff will interview the patient prior to discharge to provide further counselling and check understanding (see pages 9 - 10).

16.3 The patient should take the Medicines Reminder Card (Appendix VII) home, as this is a record of the medication they were prescribed in hospital and it also acts as a memory aid.

16.4 All documentation related to self-administration of medication should be filed in the patient's clinical record.

16.5 The key to the patient's lockable facility for medication storage should be returned to the nurse-in-charge.

16.6 Where the patient had special needs e.g. compliance aid or large labels the nursing staff or authorised pharmacy staff will contact the patient's GP and Community Pharmacist to inform them of the patient's participation in the self-administration scheme, advise them of any special requirements and request their continued support.

Appendix I

Information about Self Medication

Patient Information Booklet

Information

About

Self-Medication

Self-medication with your own medicines is a scheme used in hospitals across the country to help improve your knowledge about your medicines. Taking your own medicines, as you would at home, whilst on the ward or unit gives you the opportunity to learn more about them, making it easier to understand and cope with your medicines on returning home.

Before you take part in this scheme you will be able to discuss with your nurse or a pharmacist exactly what self-medication means and what the benefits will be to you.

Self-medication is NOT compulsory, and you must not feel that you have to take part, even if asked. If you are asked and agree to take part, then before starting a nurse or pharmacist will:

1. Explain the self-medication scheme

2. Explain which medicines you will be taking and what they are for

3. Explain the dosage

4. Give you a reminder card explaining the correct times and dosages

- If you require extra medication during your stay it will be dispensed by the Hospital Pharmacy

- A minimum of 14 days supply will be dispensed for you when you go home

A nurse will check your tablets regularly. This is to make sure you have enough and are not having any problems.

WHEN USING A MEDICINE LOCKER

- Please make sure your medicines are kept locked in your personal drug locker. The key must be kept with you at all times. If you leave the ward/unit for any reason please return the key to your nurse before you leave.
- If you cannot find your key tell your nurse straight away.
- If anyone else tries to take your medicines please call a nurse at once.
- If you forget what medicines you have taken or you have any problems please talk to your nurse.

Please RETURN YOUR KEY to your nurse when you go home or leave the ward/unit for any reason

Appendix II

Consent Forms

1. **By Medical Staff**
2. **By Patient**

Use Patient ID label
Name:

NHS No:

Date of birth:

Self-Medication Consent Form

Ward: ……

Date: ……..

Consent by Doctor

I agree to start the self-medication process for _____ with the view to self-medicate his/her medications during this admission, according to the LSW Self- Administration Policy

The patient has been assessed by a registered nurse as suitable.

Doctor's Signature (Consultant, Registrar, Speciality doctor or SHO):

_____

Name (Block Capitals):

_____ Date: _____

Consent by Patient

The self-medication scheme has been explained to me and I agree to participate. I have read and understood the information leaflet and am aware that I am free to withdraw from the scheme at any time.

Patient's Signature: _____

Witnessed by (Nurse/Pharmacist)

Signature:
_____Date_____

Name:
_____Designation_____

When completed this form must be filed in the patient's clinical record

Appendix III

Self-Administration Assessment Form

Use Patient ID label
Name:

NHS No:

Date of birth:

Self-Administration Assessment Form

Ward: ……

Date: ……...

	Question		Yes - Consider Self-medication No - Action to be taken	Comments and issue raised and action to be taken/ Multidisciplinary Tea involvement
1	Will the patient be responsible for taking their own medication in the community on discharge?	Yes		
		No	Need not be excluded: Consider the carers needs, if appropriate, or any other reasons for self-administering e.g. symptom control	
2	Is the medicine regime relatively stable?	Yes		
		No	Should not self-administer unstable medications. Discuss with doctor and or pharmacist. It is possible to self-administer STABLE medications only as identified by the doctor or pharmacist	
3	Has patient been given the information about self-medication booklet and had it explained?	Yes		
		No	Give patient the information booklet and explain the concept of self-medication	
4	Does the patient understand what is involved and their responsibilities?	Yes		
		No	Explain again using the patient information booklet	
5	Is the patient willing and motivated to self-administer?	Yes		
		No	Aim to improve motivation	
6	Does the patient understand the dosage instructions and how to take the medicine?	Yes	Discuss with patient using a medicines information card and other aids if necessary	
		No		
7	Are there any other reasons why the patient is unable to self-administer?	Yes	Please state reasons and action to be taken. Refer to multidisciplinary team	
		No		
8	Does the patient understand the need for the medicines reminder card to be kept up to date if their medication is changed?	Yes	Discuss with patient using a medicines reminder card and/or liaise with community pharmacy and/or carer	
		No		
9	Is the patient depressed, suicidal or have cognitive impairment?	Yes	Refer to multidisciplinary team	
		No		
10	Is the patient confused, or disorientated to time and place?	Yes	Refer to multidisciplinary team	
		No		

Use Patient ID label
Name:
NHS No:
Date of birth:

	Question		Yes - Consider Self-medication No - Action to be taken	Comments and issues raised and action to be taken/ Multidisciplinary Team involvement
11	Does the patient have a history of drug abuse or alcoholism?	Yes No	Refer to multidisciplinary team	
12	Would the patient self-administering their medicines present any foreseeable risk to other/risk from other patient on the ward?	Yes No	Steps need to be taken to resolve the risks ar reassess. Refer to multidisciplinary team	
13	Can the patient read and understand the instructions on the label well enough to be safe?	Yes No	Contact pharmacy for advice on large print labels or consider discussing with pharmacy for advice on various options	
14	Can the patient open child-resista caps if applicable?	Yes No	Request screw caps for bottles	
15	Can the patient open bottles or boxes?	Yes No	Discuss with pharmacy or OT for advice on available options	
16	Can the patient remove tablets from the blister pack if applicable?	Yes No	Discuss with pharmacy or OT for advice on available options	
17	Can the patient pour out liquid doses or dissolve tablets in water if applicable?	Yes N/A	Review medication Discuss with pharmacy, OT or doctor for advice on alternative formulations or options	
18	Can the patient open the cupboard/drawer?	Yes No	Consider discussions with OT for advice on available aids	
19	Can the patient safely look after th key	Yes No	Consider risks to others and discuss with MD	
20	If prescribed eye drops is the patient able/willing to self-administer these?	Yes No	Discuss problem with patient. In the absence of carer able to administer, aim to improve technique, or consider referral to OT or REI for advice on specialist aids	
21	Can the patient access their medicines at appropriate times and frequency?	Yes No	e.g. Parkinson's/asthma Discuss alternatives with MDT or pharmacist	

Assessed by_____ (Registered Nurse) Print Name_____

Date_____

Ward: ……..

Date: ……...

Use Patient ID label
Name:
NHS No:
Date of birth:

Level of Self-Administration on first assessment: (see main policy page 10 for definition of levels of self-medication)

	Tick	Sign and date		Tick	Sign and date
Level 0			**Level 2**		
Level 1			**Level 3**		

On-going Assessment Record

Date/Time	Current Level	Comments	New Level	Signature

Appendix IV

INITIATION OF SELF-ADMINISTRATION

CHECK LIST FOR NURSING STAFF

Self-Administration – Initiation Checklist

To be completed by nursing staff

Ward: ……..

Use Patient ID label
Name:
NHS No:
Date of birth:

The following must be carried out before a patient is allow
stage MUST be signed and dated by the nurse as it is completed.

1)	The patient has been assessed according to the protocol and the assessment/consent form signed by the patient, nurse and/or pharmacist and the doctor.	Signature: Date:
2)	An explanation has been given to the patient of:	
	a) Medicine security – a key to the locker has been supplied.	Signature: Date:
	b) Procedure for administration of any medicine needing refrigeration.	Signature: Date:
	c) Nurse monitoring of the scheme.	Signature: Date:
3)	The following have been explained to the patient by a pharmacist, nurse or doctor:	
	a) The purpose of the medicines prescribed.	Signature: Date:
	b) The dose and time of administration.	Signature: Date:
	c) Any relevant warning or special instructions.	Signature: Date:
	d) Possible side effects.	Signature: Date:
4)	The patient has been given an information leaflet about self-medication.	Signature: Date:
5)	The patient has been given a medicines reminder card completed by the nurse or pharmacist.	Signature: Date:
6)	The prescription chart has been endorsed SELF-MEDICATION.	Signature: Date:
7)	An adequate supply of the correct medication, appropriately packaged and labelled, has been dispensed for the patient.	Signature: Date:

When all above steps have been completed and documented the patient named may commence self-administration of medication.

Appendix V

ADHERENCE WITH SELF-ADMINISTRATION

CHECK LIST FOR NURSING STAFF

Use Patient ID label
Name:

NHS No:

Date of birth:

Self-Administration – Adherence Check List

Date	Time	Correct tablet count YES/NO	Nursing Intervention(s) necessary to ensure correct medication taken - if none state 'NONE'	Name of medication involved in error or intervention	Comments	Signature

When completed this form must be filed in the patient's clinical record

Please continue on another form if necessary

Appendix VI

Self-Administration of Medicines Scheme for Mental Health Units

Stage One: Request for medication at appropriate times

Name..... Ward.....

DoB..... NHS Number.....

Use this form to assess the patient's awareness of their regular medication regime

Record when the patient asks for their medication from the drug cupboard/trolley, and when a prompt was required from staff

Continue to record administration on the patient's drug chart

Week Commencing.....

Regular Medication:

Daily administration times (enter normal administration times)

Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

Enter P for "Prompt Required"

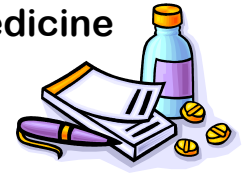
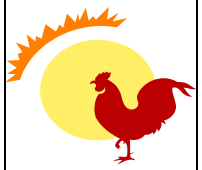
File this form in the patient's nursing notes when completed

APPENDIX VII

MEDICINES REMINDER FORM

Medicines Reminder Card

Name.....

Name of medicine 	What I call it (or shape, colour etc.)	What I take this medicine for	Number or amount to take at:				Notes (e.g. with food, with water, take only when needed, when to stop taking etc.)
			Morning 	Mid-day	Early evening	Bedtime 	

Written by_____ Date_____ Checked by_____ Date_____
Please continue on another form if necessary.

You may wish to take your completed reminder card to your next routine GP or nurse appointment, or discuss with your pharmacist.
Please ensure your reminder card is kept up-to-date and is amended if your prescription changes

Appendix VIII Checklist for Patient Counselling

1 Before counselling a patient check that you know the correct purpose for which each medicine has been prescribed for that patient.

2 Ask the patient if they know what medication they take, when, and what for.

3 Check that the patient can read the labels on their medicines and that they can open the containers.

4 Explain the following to the patient for each medicine:

a) Name and description of medicine.

b) The purpose of the medicine.

c) How many/much to take, the frequency, and the most appropriate times.

d) Any special instructions for administration e.g. before food, after food, with a glass of water.

e) Any common side effects. Any side effects mentioned should be those that the patient can recognise e.g. blackened stools, headaches, nausea etc. Use language appropriate to the individual patient.
NB The patient should also be told that it is not possible to mention every possible side effect for every drug. If they experience any problems, which they think could be related to one of their medicines, they should discuss this with their primary nurse, the pharmacist or doctor.

f) Interactions with alcohol or with other medication

g) Explain what to do if a dose is missed - make sure the patient knows that they should not double the next dose to make up for missing a dose.

h) Any other relevant information e.g. need for blood tests

i) How long to take the drug for e.g. a set course, or not to stop without the advice of their doctor.

Additionally for discharge counselling:

5. Where to store their medication e.g. in a cool place, out of reach of children, not in the bathroom. Indicate any medication that may need to be kept in the fridge.
6. Explain how to obtain further supplies and the need to obtain these before their medication runs out.
7. Tell the patient not to take any other medication which they may have at home (unless agreed with the pharmacist or doctor).
8. Inform the patient or carer of how to dispose of any unwanted medication i.e. take to a local pharmacy.
9. Explain to the patient the need to either show their Medication Reminder Card or explain to the pharmacist what medication they are on if they buy any medicines at all. It should be explained to the patient/patient's carer that the reminder card refers ONLY to discharge medication and will need to be amended if the GP or other doctor, changes the prescription

10. Not to take medication offered by a friend or a relative without advice from a doctor or pharmacist, and not to share their medication with anybody else.

11. Inform the patient of a contact phone number (on Medication Reminder Card) to ring if they have any questions after they get home.

All patients

12. Give the patient an opportunity to ask questions.

13. Check the patient's comprehension by asking them to:

    a) State the correct purpose of each drug.
    b) State the correct dosage instructions.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Dr Adam Morris, Medical Director

Date: 03/06/16