PROCEDURE FOR THE SELF- ADMINISTRATION OF MEDICINES
BY INPATIENTS WITHIN PENNINE CARE NHS FOUNDATION TRUST

Version 5

Supporting policy

Medicines Policy CL15

Approved by the Horizon Scanning and Prescribing Guidance sub group
18 March 2016

Review date: 18 March 2019

G/TGH/ Chief Pharmacist/Procedures/ MM 012 Procedure for the self-admin of med by inpatients of
1. BACKGROUND

The principal of supporting patients in managing their own medications is two-fold:

- As patients move towards more independent living, the ability to correctly and confidently look after medications is a significant factor in preventing relapse.

- Self-administration can lead to improved self-esteem and sense of well being.

The scheme detailed in this procedure provides for the structured and monitored handing of all medication prescribed for the patient. This is achieved through a series of stages.

It is essential to the success of the scheme that a team approach is adopted. Safe progress through the scheme involves the activities of several professions.

All inpatients are under the care of the Trust. The principal objective must be that patients receive the correct prescribed medication.

At the time of writing, the self-administration of medicines by inpatients in accordance with this procedure is being undertaken within the Rehabilitation and High Support Directorate (R&HSD) of the Trust. The self-administration of medicines by other inpatients is not precluded but the resource consequences of such initiatives must be considered on an individual basis.

2. RESPONSIBILITIES

2.1 Nursing Staff

Are responsible for ensuring:

- They have received appropriate training prior to participating in the scheme
- Patients are assessed for suitability for self-administration
- They retain the responsibility for the safe and correct administration of medication and for appropriate care of the patient in relation to their medication.
- They bring to the attention of the multidisciplinary team (MDT) any problems or risks encountered in respect to patients’ medication.
- They obtain informed consent from the patient prior to participating in the scheme.
- That all appropriate paperwork is filled in correctly.
- They inform the pharmacist of changes in medication in a timely manner.

2.2 Prescriber
Is responsible for ensuring:
• The medication regime is simplified prior to patient starting on the scheme.
• Reviewing the appropriateness of the scheme periodically but at least at every Clinical Team Meeting (CTM).

2.3 Pharmacist
Is responsible for ensuring:
• That appropriate information is communicated to the supplying pharmacy.
• Concordance and compliance issues are addressed with the patient and MDT.
• Assistance with simplification of the regime prior to patient starting on the scheme.

The level of pharmacist support may vary across the Trust, efforts should always be made to resolve any problems with pharmacy even in the absence of the unit pharmacist.

3. GENERAL POINTS

Storage of Medication

Medicines for self-administration must be stored in a locked cupboard in a suitable room when not in the patient’s possession. Ideally this will be a suitably designed patient locker/ cupboard in the patient’s bedroom. Currently this may need to be the treatment room. When medication is with the patient it must be kept securely.

Patient Assessment and Monitoring

It is anticipated that the patients in the scheme will be at different competency levels and therefore staff must ensure that the appropriate level of monitoring is carried out and documented accordingly.

Patients who are not able to self-administer should have their drugs supplied and administered as laid down in the Medicines Policy (CL15).

Recording

Each stage details the recording that is required.

Patients subject to compulsory detention under the Mental Health Act 1983 are not automatically precluded from the self-administration scheme. Detained patients may enter the scheme if they are able to give consent to self-administration in the way that informal patients do.

Medication errors

Any medication error incident which occurs whilst a patient is participating in the self-administration scheme must be reported in accordance with:
Suspension/Removal from the scheme

If a patient suffers a relapse in their mental or physical state which impairs their ability to self-administer the nursing staff have authority to temporarily suspend the scheme or change the patient to a lower stage if appropriate. If a patient is consistently unable to self-administer despite multiple attempts, support and education, removal from the scheme would have to be considered. The reasons for suspension or removal from the scheme need to be communicated to the MDT and the reasons should be documented in the patient’s notes.

3. THE SELF-ADMINISTRATION SCHEME

There are five stages in the scheme

For each stage suitable documentation must be made either within the patient’s notes or using the supporting paperwork attached at the back of this procedure which is subsequently filed in the patient’s notes.

Supporting paperwork includes:
Self-Administration of Medication
- Consent Form
- Drug Attitude Inventory form (DAI-30)
- Withdrawal of Consent Form
- Preparation Form
- Attendance Without Prompting (Stage 0)
- Attendance Without Prompting and Dispensing (Stage 1)
- Progress Record (Stage 2, 3 and onwards)

Preparation

A multi-disciplinary team will identify a patient as appropriate for self-administration and record this in the patient’s notes and care plan. Written consent must also be obtained from the patient.

Refer to:
- Pre Self-Administration Risk Assessment Form (Appendix 1)

Any rationalisation of the patient’s current treatment regime can usefully be carried out at this stage to minimise the frequency of dosing and help with compliance and concordance. This might also include changing liquid and orodispersible formulations to tablet formulations.

Assessment of the patient’s ability to read specimen labels and manage child resistant packaging must be carried out by an agreed member of the team and should then be recorded on the Pre Self-Administration Risk Assessment Form.
A pharmacist must be contacted for advice and assistance should the labels and/ or packaging prove inappropriate for the patient. The advice of the pharmacist in respect of more general medicines management may also prove helpful.

The use of Monitored Dosage Systems (MDS) for example, medidose boxes, blister packs, venalinks, nomad boxes, MUST only be considered as a final option. Patients must be encouraged to self-administer from tablet bottles and white boxes/ cartons wherever possible. If this proves difficult for the patient the advice of a pharmacist must be sought. The introduction and use of an MDS must be authorised by the pharmacist before ordering from pharmacy department.

Refer to:
• Guidance for requesting a Monitored Dosage System for in-patients (MM 015) (Appendix 2)

To prepare the patient for self-administration the DAI-30 form (Appendix 3) should be completed and knowledge of their medication should be checked.

**Stage 0 Attendance without Prompting**

As part of Stage 0 the patient should be encouraged to attend the treatment room unprompted at the specific times that their medication is prescribed. Registered Nurses may need to assist, prompt or intervene particularly during the early period. Records of whether the patient attended prompted or unprompted should be made on the form (page 16). Such records will be useful in informing the MDT whether the patient can progress to Stage 1. Before moving onto Stage 1 there should be good evidence of unprompted attendance for self-administration.

Progress is recorded on the inpatient prescription chart as ‘Stage 0 [date]. A registered nurse is expected to sign the administration box to record administration.

**Stage 1 Attendance without prompting and self-administration under supervision**

Stage 1 medication is supplied to the unit with each container labelled with directions on how to take it. Patients will be expected to attend the clinic room for medication at the appropriate time without prompting from staff.

When medication is due, the patient will be given their set of self-administration containers. A Registered Nurse will observe that the correct medication is taken and that for any particular time of day, inappropriate drugs are **not** taken. This stage should generally continue for four weeks for patients who are very new to managing their own medications. The ability of the patient to respond to changes in a drug regime by paying particular attention to the label directions is a key skill and should be recorded if there are any changes to medication during this stage.
Progress is recorded in the inpatient prescription chart as ‘Stage 1 [date]’. Code 7 (drug self-administered) must be used to record administration.

Medicines should be ordered in suitable quantities not exceeding a 28 day supply.

**Stage 2  One day’s supply**

At this stage the patient is supplied with medication in quantities sufficient for 24 hour periods (i.e.: 1 day supply) which they will keep in the locked cupboard in their room; the patient retains one key and the other is held by a Registered Nurse. Each set of containers should be handed to the patient at the start of the day and packs from the previous day recovered and inspected.

A count of any remaining medication must be made and recorded. This stage allows the patient total control over a small quantity of medication. Progress to the next stage can occur as soon as satisfactory compliance has been achieved. If a patient deemed to be struggling after four weeks of trialling this stage consideration should be made to change the patient to a lower stage.

Progress is recorded on the inpatient prescription chart as ‘Stage 2 [date]’. Code 7 (drug self-administered) must be used to record administration.

**Stage 3  Increasing the length of the self-administration period**

The patient is supplied with increasing quantities of medication as skills in this area become more developed. For example, the patient may move through two day, three day, weekly, fortnightly and then onto four-weekly supplies. Progression through this stage can be by negotiated by the pharmacist, Registered Nurse and the patient.

Stage 3 is documented in the patient’s notes, and on the inpatient prescription chart as ‘Stage 3 [date]’. Code 7 (drug self-administered) must be used to record administration.

The patient manages their own supply of medication under supervision of a Registered Nurse.

The supplies of medication are requested from the pharmacy department using the Trust Leave Prescription chart which must be clearly marked as “SELF ADMINISTRATION” or in the case of the Low Secure Unit at Birch Hill Hospital using the Pharmacy Order Form for Self Administered Medication for Ward Use form shown in Appendix 4.

Supplies of medicines are stored in the patient’s own locker, to which the patient holds the key.

A Registered Nurse must check if the medicines have been taken correctly on a regular basis and progress should be documented in the patient’s notes.

**Stage 4  Community Model for Prescribing**
Following satisfactory outcomes with self-medication at the higher level of Stage 3 and formal review of the patient’s progress by the multidisciplinary team, no further formal monitoring is required.

Stage 4 is documented in the patient’s notes, and on the inpatient prescription chart as ‘Stage 4 [date]’. Code 7 (drug self-administered) must be used to record administration.

The patient manages their own supply of medication under supervision of a Registered Nurse.

At this stage the patients are required to request fresh supplies of medication by themselves following the community model of obtaining a repeat prescription. The aim of Stage 4 is to promote patient initiation of further medical supplies.

The patient may be accompanied to the pharmacy department to collect their own medicines on a weekly, fortnightly or monthly basis as assessed by MDT.

Patients may drop to a lower stage of self-administration if advancement proves difficult for any reason and then work back up to the higher stage when appropriate.

Discharge is not dependent on a patient having passed through the full self-medication scheme.

Additional notes regarding prescribing and recording

Stages 1, 2 & 3

The prescriber must indicate that the patient is to go in to the self-administration scheme by writing “FOR SELF ADMINISTRATION” on the front of the prescription chart and adding their signature.

The ‘stage’ of the self administration process should be documented in the care plan and on the inpatient prescription chart as each stage is commenced, along with the date of commencement.

Progress is recorded on the inpatient prescription chart as ‘Stage 2 [date]’ and code 7 (drug self-administered) used to record administration. If no medication is taken, the appropriate code (and initials) should be entered in the corresponding box on the inpatient prescription chart and the matter discussed with the patient. A decision regarding the missed medicines must be taken and full documentation made in the patient’s notes and care plan.

- Supporting paperwork is available for use, where appropriate or if documentation within the patient’s notes is deemed unsuitable, for each stage and is attached to the back of this procedure. For further details please see Page 3.
The pharmacist will assist, advise and support the ordering of medicines for self-administration using the relevant forms.

4. MONITORING

Monitoring of practice in relation to this procedure will be carried out as follows:

Registered Nurses will monitor patients included in the self-administration scheme and document the patients handling of medication accordingly.

Clinical pharmacists will monitor patients included in the self-administration scheme and provide advice and support to medical and nursing staff in relation to concerns or problems.

Incidents which occur as part of the self-administration scheme will be reported as medication error incidents in accordance with the Trust Incident Reporting, Management and Investigation Policy (CO10) and reviewed by the Managing Prescribing Risk sub group of the Drugs and Therapeutics Committee.

Compliance with the procedure will also be monitored through analysis of incidents or complaints where there has been a failure to follow the procedure. Action plans to improve practice will be developed where necessary.

Overall responsibility for the monitoring of medication errors in relation to the self-administration procedure is through the Managing Prescribing Risk sub group of the Drugs and Therapeutics Committee on a quarterly basis. The managing prescribing Risk group reviews all medication error incidents on a quarterly basis and develops action plans where required. The action plan is reviewed and monitored on a quarterly basis.

It is the responsibility of the Drug and Therapeutics Committee to monitor, advise on and amend any aspects of the procedure that may be required. The approval for any amendments will be given by the Drug and Therapeutics Committee or its sub groups.
## Pre Self-Administration Risk Assessment Form

1. Is the patient able to read?  
   - a. Standard print  
   - b. Large print  

2. Can the patient understand simple instructions?  

3. Does the patient suffer any disability which may affect the self-administration of medication e.g. arthritis?  

4. Do all the members of the multi-disciplinary team feel this patient is capable of self-administering medication?  

5. Is the patient motivated to self-administer?  

6. Does the patient suffer from any memory impairment?  

7. Does the patient need a compliance aid?  

8. Does the patient have a history of non-compliance with medication?  

9. Does the patient have a history of misuse of medication?  

10. Does the patient have a history of medication related relapse?  

11. Does the patient understand the programme and its responsibilities?  

12. Are there any reasons why this patient should self-administer? e.g. about to be discharged.  

**Comments:**  

**Signature:**  

**Designation:**

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Guidance for requesting a Monitored Dosage System (MDS) for inpatients
Version 3

This guidance must be followed before an MDS is requested for a discharge or leave prescription from the pharmacy department of the Acute Trusts. The multidisciplinary team, including a pharmacist must work together as part of the discharge planning process and decide if an MDS is appropriate.

Non-compliance with oral medication regimens may occur for many reasons. The provision of a monitored dosage system (MDS) to a patient is not a cure for poor compliance but one of many possible means of improving it. Any assessing of need must be patient-centred and outcome focused and designed to support capability and independence as oppose to dependence, incapacity or the assumption that it will always be required. Use should only be considered when other strategies have failed or are considered inappropriate, and each case should be assessed individually.

Issues for consideration
1. **Reasons for non-compliance:-**
   - Complex regimen
   - Multiple dose times throughout the day
   - Difficulty with packaging
   - Difficulty in remembering to take or if taken
   - Unacceptable side-effects
   - False beliefs about medicines.

2. **Appropriate measures that may be taken:-**
   - Simplify regimen
   - Provide suitable packaging
   - Introduce calendar or other reminder
   - Change medication to increase acceptability
   - Provide information/education about medicines.

3. **MDS may be considered for supply by a Trust Pharmacy if:-**
   - Medication is stable when dispensed into an MDS
   - An appropriate style of MDS has been assessed and selected for the patient’s needs
   - A Community Pharmacy has been found that is willing to replenish it and has accepted the assessment by the pharmacist, of the patient and their needs
   - The General Practitioner (GP) is informed of the outcome of the assessment and compliance support arranged and is willing to prescribe suitable quantities to allow use of an MDS

Sufficient time must be allowed for arrangements to be made for the provision of the MDS by the Community Pharmacy and initial supply by the hospital pharmacy department if required. The hospital pharmacist should carry out an assessment of the patient’s needs and liaison with the Community Pharmacist is important in case the Community Pharmacy has previously supplied the patient and can help with the assessment and provide relevant information. All options must be considered and as much information gathered before a device is suggested or agreed.

If an MDS is to be supplied, the discharge or leave prescription must be annotated with “compliance aid agreed” by the pharmacist and sent to the pharmacy department.
Where an MDS is required, to facilitate self-administration of medicines, by a patient under supervision of Social Services or other unqualified carers, the pharmacy department will supply seven days discharge medication in such a system. The care co-ordinator is responsible for facilitating subsequent supplies and this should be taken into account when such a system is requested.

Requests for MDS for use in care homes or social service premises should be assessed and supplied by the relevant Community Pharmacy.

Approved by the Horizon Scanning & prescribing Guidance sub group 21 February 2014
Review date: 21 February 2017
Appendix 3

DRUG ATTITUDE INVENTORY (DAI-30)

Name  
(please print):

Date of Assessment:

The aim of this questionnaire is to gain some understanding of what people think about medications and what experiences people have of them. Your answers will be used for research purposes only, are strictly confidential and will in no way affect your treatment.

How to fill in this questionnaire:
1. Read each statement and decide whether it is true as applied to you or false as applied to you.
2. If a statement is TRUE or MOSTLY TRUE to you, circle the T at the end of the line.
3. If a statement is FALSE or MOSTLY FALSE to you, circle the F at the end of the line.
4. If you want to change an answer, mark an X over the incorrect answer and circle the correct answer.
5. If a statement is not worded quite the way you would put it, please decide whether the answer is mostly true or mostly false to you.

There are no right or wrong answers. Please give YOUR OWN OPINION, not what you think we want to hear.
- Do not spend too much time on any one question.
- Please answer every question.
- The medications referred to are those for mental health needs only.

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<tbody>
<tr>
<td>1. I don't need to take medication once I feel better</td>
<td>T F</td>
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<tr>
<td>2. For me, the good things about medication outweigh the bad</td>
<td>T F</td>
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<tr>
<td>3. I feel strange, &quot;doped up&quot;, on medication</td>
<td>T F</td>
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<td>4. Even when I am not in hospital I need medication regularly</td>
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<td>5. If I take medication, it's only because of pressure from other people</td>
<td>T F</td>
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<td>6. I am more aware of what I am doing, of what is going on around me, when I am on medication</td>
<td>T F</td>
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<td>7. Taking medications will do me no harm</td>
<td>T F</td>
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<td>8. I take medications of my own free choice</td>
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<td>9. Medications make me feel more relaxed</td>
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<td>10. I am no different on or off medication</td>
<td>T F</td>
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<td>11. The unpleasant effects of medication are always present</td>
<td>T F</td>
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<tr>
<td>12. Medication makes me feel tired and sluggish</td>
<td>T F</td>
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<tr>
<td>13. I take medication only when I feel ill</td>
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<td>14. Medications are slow-acting poisons</td>
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<td>15. I get along better with people when I am on medication</td>
<td>T F</td>
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<td>16. I can't concentrate on anything when I am taking medication</td>
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<td>17. I know better than the doctors when to stop taking medication</td>
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<td>18. I feel more normal on medication</td>
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<td>19. I would rather be ill than taking medication</td>
<td>T F</td>
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<tr>
<td>20. It is unnatural for my mind and body to be controlled by medications</td>
<td>T F</td>
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<td>21. My thoughts are clearer on medication</td>
<td>T F</td>
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</table>
22. I should keep taking medication even if I feel well  
   (T F)  
23. Taking medication will prevent me from having a breakdown  
   (T F)  
24. It is up to the doctor to decide when I should stop taking medication  
   (T F)  
25. Things that I could do easily are much more difficult when I am on medication  
   (T F)  
26. I am happier and feel better when I am taking medications  
   (T F)  
27. I am given medication to control behaviour that other people (not myself) don't like  
   (T F)  
28. I can't relax on medication  
   (T F)  
29. I am in better control of myself when taking medication  
   (T F)  
30. By staying on medications I can prevent myself getting sick  
   (T F)  

**DAI-30 SCORING:**

<table>
<thead>
<tr>
<th>PS</th>
<th>NS</th>
<th>TS</th>
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**Drug Attitude Inventory (DAI-30)**


The scale has 15 items that will be scored as True and 15 scored as False if the person is fully compliant (positive subjective response).

"Positive" answers will be as follows and score as plus one:

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<td>11</td>
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"Negative" answers score as minus one

E.g. a circle round the above letters counts as plus one (e.g. a circle or tick on the F of question one will score plus one, a circle or tick on the T of question one will score minus one).

The final score for each person at each time is the positive score minus the negative score.

A positive total final score means a positive subjective response (compliant). A negative total score means a negative subjective response (non-compliant).
### Pharmacy Order Form for Self-Administered medication for Ward Use

**ALL MEDICATION TO BE DISPENSED IN CARTONS/BOTTLES WITH FULL DIRECTIONS**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Ward</th>
<th>Consultant</th>
<th>Date of Birth</th>
<th>Hospital Number</th>
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**Additional Information**

- Total number of days supply

- Please dispense in the specified number of days supply, e.g. 3 day supplies

**Ordered By**

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<tr>
<th>Medicine</th>
<th>Frequency</th>
<th>Other directions</th>
<th>Date</th>
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**Date Dispensed:**

Dispensed by:

Checked by:

Required by:
Appendix 5
SUPPORTING PAPERWORK for the procedure for the self-administration of medicines by inpatients

- Consent Form
- Withdrawal of Consent Form
- Preparation Form (Stage 0)
- Attendance Without Prompting (Stage 1)
- Progress Record (Stage 2, 3 and onwards)
SELF-ADMINISTRATION OF MEDICATION
CONSENT FORM

Patient's name: .............................................................................................................................

Date: ............................................................................................................................................

Unit: ..............................................................................................................................................

The self-administration programme has been explained to me.

I understand that I can withdraw my consent at any time.

I wish to be involved in the self-administration program and therefore give my consent.

Patient's signature: .............................................................................................................................

Date: ............................................................................................................................................

Witnessed by: .................................................................................................................................
SELF-ADMINISTRATION OF MEDICATION
WITHDRAWAL OF CONSENT FORM

Patient’s name: 

Date:  

Unit:  

The self-administration programme has been explained to me.

I understand that I can withdraw my consent at any time.

I do not wish to be involved in the self-administration program because

I therefore withdraw my consent.

Patient’s signature:  

Date:  

Witnessed by: 

SELF-ADMINISTRATION OF MEDICATION

PREPARATION FORM

Record the medicines prescribed and subsequently identified and requested by the patient, to assess suitability for the self-administration process.

Patient’s name: .............................................  Unit: .................................................................

Date commenced: ...........................................

<table>
<thead>
<tr>
<th>What the doctor prescribed</th>
<th>What they look like</th>
<th>What they are for</th>
<th>When to take them</th>
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# SELF-ADMINISTRATION OF MEDICATION

## STAGE 0 - ATTENDANCE WITHOUT PROMPTING

Record the attendance of the patient to request medication. Any interventions, prompts or problems should be recorded on this sheet. Ensure inpatient prescription is signed by a Registered Nurse; note and report any omissions. Use further record sheets if required.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time due</th>
<th>Time attended</th>
<th>Prompted? (tick)</th>
<th>Interventions/ problems</th>
<th>Nurse initials</th>
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I agree that this patient is competent to progress to Stage 1 of the Self-Administration Programme.

Signed: .................................................. (Ward Doctor/ Consultant)  Date: ........................................
SELF-ADMINISTRATION OF MEDICATION

STAGE 1 - ATTENDANCE WITHOUT PROMPTING and DISPENSING

Record the attendance of the patient to request medication. Any interventions, prompts or problems should be recorded on this sheet. Ensure inpatient prescription is endorsed with Code 7 (drug self-administered) and note and report any omissions.
Use further record sheets if required.

Patient’s name: .................................................................  Unit: ...........................................................................

Date commenced: .........................................................  Sheet ...... Of ......

<table>
<thead>
<tr>
<th>Date</th>
<th>Time due</th>
<th>Time attended</th>
<th>Prompted? (tick)</th>
<th>Interventions/ problems</th>
<th>Nurse initials</th>
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I agree that this patient is competent to progress to Stage 2 of the Self-Administration Programme.

Signed: ................................................................. (Ward Doctor/ Consultant)  Date: ........................................
SELF-ADMINISTRATION OF MEDICATION

STAGE 2 and 3 - PROGRESS RECORD

The medication is stored in a locked cupboard. The patient holds one key, the other remains with the nurse in charge. At administration times, the patient self-administers and should be left uninterrupted. Occasional checks on security and compliance should be unobtrusively made and recorded below as well as any interventions or problems. Ensure the inpatient prescription is endorsed with Code 7 (drug self-administered) and note and report any omissions.

Patient's name: ..................................................  Unit: ..............................................................

Date commenced: .............................................  Sheet ...... Of ......

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Security and compliance check completed (tick)</th>
<th>Interventions/ problems</th>
<th>Nurse initials</th>
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