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| --- | --- | --- |
|  **Name:** | **DOB:** | **IAS:** |
| **Address:** |

|  |  |  |
| --- | --- | --- |
| **Possible Risk** |  | **Comments / Actions Taken** |
| Does the service user consent to support with their medication |  |  |
| Does the service user know and understand what medicines they should be taking? |  |  |
| Do they know where all medicines are stored in the home? |  |  |
| Is medication stored appropriately in the property. | Yes/ No |  |
| Is the service user able to order and collect prescriptions if needed? | Yes/ No |  |
| Is service user aware of date, day time? | Yes/ No |  |
| Does the service user always want to take their medication? | Yes/ No |  |

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| --- | --- | --- |
| **Possible Risk** |  | **Outcome/ Actions Taken** |
| Does the service user usually remember to take his/her medication at the right time? | Yes/ No |  |
| Can service user read the labels on medicines? | Yes/ No |  |
| Can service user remove tabs/caps from the container him/herself? | Yes/ No |  |
| Is the service user able to swallow their tablets/capsules? | Yes/ No |  |
| Can service user pick up a bottle and pour out a dose of liquid medicine accurately? | Yes/ No / NA |  |
| Does the service user take any PRN medication? | Yes/ NoNA |  |
| Does the service user need support with homely remedies? | Yes/ NoNA |  |
| Does service user require any assistance with health care tasks (detail in comments box) | Yes/ NoNA |  |

Key Points

* The aim should be to promote independence with medicines wherever possible,
* The service user’s representative should be encouraged to help if able.
* If substantial help is required from representatives, their contact details should be available, and arrangements agreed for unexpected situations e.g. illness.

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| **Outcome of Assessment**  | **Details of the assessed level of support required** |
| No support required |  |
| Informal carer can assist |  |
| Support to be provided by support workers |  |
| Category 1:Service user takes overall responsibility for their own medication and consents to the specific support being arranged but needs some assistance due to their physical disability, e.g. reading labels, reminders on safe storage, occasional verbal reminder to take tablets. |  |
| Category 2:The service user requires physical assistance to remove medication from packaging or is unable to take responsibility for their own medication due to impaired cognitive awareness or physical limitations. Support Workers physically choose and give medication tothe Service User. Details to be included in the support plan.  |  |
| Category 3:Administration of medication by specialised techniques. These will require training and sign off from the district nurse or health professional. |  |

Assessor Name: …………………………..

 Assessor Signature: …………………………..

 Date: …………………………..

I confirm that I have given all the necessary information to support the planning of any help with my medicines.

I agree to the support being offered

Signed (Service User) ………………………………Date………………………

Signed (Representative) ………………………………Date:……………………...

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| Category 3 Refer to district nurse/relevant health professional if assistance with any of these specialist tasks may be required.Level 3 tasks require a mandatorydiscussion with the health professional to clarify any additional training and sign off required priorto commencement of task. | Assistance may also be required with the following specialist tasks (Please circle)• Assisting customers with nutrition using PEG feeding• Assisting customers with stoma management• Assisting customers with catheters• Assisting customers who have dysphagia• Application of medicated creams – prescribed medicated creams, ointments, lotions for external use where skin integrity is compromised• Assisting customers with insulin• Assisting customers with specialist medication  |