## Appendix 2 – Assessment and Consent Form

**Self-Administration Of Medicines In Hospital: Assessment and Consent Form**

Patient Name:

CHI number:

Date of Birth:

Addressograph:

Ward: Hospital:

Assessment

Flowchart

Does the patient self-administer his/her own medicines at home or will they be taking medicines by themselves when they are discharged home?

Is the medicine you are asking the patient to self-administer their usual regime (or will they be going home on the regime being used in hospital)?

Is the patient confused?

Does he/she understand any special instructions?

Are the medicines correctly labelled and can he/she read the labels, open the containers and access and open the POD locker?

Has self-administration of medicines information leaflet been given and explained, and does the patient agree to participate understanding that they may withdraw at any time?

No

Yes

No

Yes

Yes

No

Yes

Yes

No

No

Yes

Do not start patient on self-administration of medicines

No

Move to assessment of levels of supervision

**Decision Outcome**

Suitable/Not suitable for self-administration medicines

Name

:

Signature

:

Date

:

Based on the above assessment flowchart, capability and risk, this patient has been assessed as suitable for self-administration, to commence at the following level of supervision:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Levels of Supervision** | | **Tick** | **Date** | **Initials** |
| Level 1 | The nurse/midwife administers the medicines, giving full explanation |  |  |  |
| Level 2 | The patient administers the medicines, with nurse/midwife supervision |  |  |  |
| Level 3 | The patient administers the medicines without nurse/midwife supervision. At this point, the patient is given the key to their medicine cabinet, thus taking responsibility for storage as well as administration |  |  |  |

|  |
| --- |
| **Action plan:**  (e.g. further support required, plan for progressing through levels if appropriate) |

**Consent – must be signed for levels 2 and 3**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient** (delete as applicable) | | | | | | |
| I have read and understood the leaflet “Information about Self Administration of Medicines in Hospital” and the scheme has been explained to me.  I understand that I must seek help or advice from the nurse or midwife when I have any problems or questions about self-administration of medicines.  I understand I must inform the nurse/midwife or complete the Patient Record of Self-Administration of Medicines when I have taken medicines so that they can record this in my records.  I understand that I may withdraw from the scheme at any time by informing the staff caring for me.  I consent to participate in the self-administration of my medicines on the ward. | | | | | | |
| **Name (PRINT)** |  | | **If not patient relationship to patient** | |  | |
| **Signed** |  | | **Date** | |  | |
| **Assessed by and Consent Witness (Healthcare Professional)** | | | | | | |
| I confirm that I have assessed the patient for suitability for self-administration of medicines in hospital, they have had an opportunity to read the leaflet “Information about Self Administration of Medicines in Hospital and asked any questions. | | | | | | |
| **Name (PRINT)** | |  | | | | |
| **Signed** | |  | | **Date** | |  |