Reference Number: UHB 565 **Version Number:** 2	**Date of Next Review:** *28/04/2029* **Previous Trust/LHB Reference Number:** UHB 565

Self-administration of Medication within Inpatient Mental Health Rehabilitation Wards Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that self-administration within our mental health rehabilitation wards is carried out in line with this guidance.

Policy Commitment

We are committed to supporting our patients to maintain their independence and to manage their illness in line with mental health rehabilitation goals. This includes supporting our patients to self-administer medication, where safe and appropriate.

Supporting Procedures and Written Control Documents

- 'Professional guidance on the Administration of Medicines in Healthcare Settings' Royal Pharmaceutical Society and Royal College of Nursing (2019)
- 'Talking about Medicines – The Management of Medicines in Trusts Providing Mental Health Services' Healthcare Commission (2007)

Other supporting documents are:

- The Medicines Code (CAVUHB)
- NMC code of practice

Scope

This policy applies to qualified nurses (including those with honorary contracts) who are involved in any way with caring for patients in mental health rehabilitation wards in CAV UHB.
The wider rehabilitation multidisciplinary team (MDT), including consultants need to be aware of this policy and their responsibilities. All pharmacy staff providing a clinical or technical service to mental health rehabilitation wards need to be aware of this policy and their responsibilities.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has not been completed.
Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed.
Policy Approved by	MHCB Controlled Document Oversight Group

Group with authority to approve procedures written to explain how this policy will be implemented	MHCB Controlled Document Oversight Group
Accountable Executive or Clinical Board Director	Rachel Dix

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	*31/05/2024*		*New document*
2	28/04/2026	30/04/2026	**Pg 7** – Link updated: https://www.choiceandmedication.org/nhswales **Pg 7** – Amended to specify "any level change of programme". **Pg 8** – Added *"**NB:** For patients who are likely to be granted leave in the next month, it may be more appropriate to request a medic or pharmacist complete a leave TTH. This will then cover nurses to dispense from the ward using labelled medication at short notice. **See Leave/Discharge Prescription section below for further information."*** **Pg 8** – Amended green sheet ordering to EPMA: *"Registered nursing staff should order medication from pharmacy via EPMA"* **Pg 9** – Amended drug chart to EPMA – *"Medicines must be prescribed on the electronic prescribing system (EPMA)."* **Pg 10** – Added *"…**ONLY** if this was previously ordered via a leave prescription (written by a medic or a pharmacist) and NOT if these medications were ordered via EPMA".* **Pg 10** – Amended drug chart to EPMA – *"Staff must use EPMA to check it is the correct drug, formulation, dose, label (directions, patient name) and expiry date."*

			Pg 11 – Added *"Staff should always endeavour to provide reasonable opportunity for patients to engage with Stage 1, but it is accepted that in some circumstances, due to ward routine/acuity, it may not always be possible to wait for patients to approach staff regarding medication."* **Pgs 11 and 12** – Amended drug chart to EPMA – *"The registered nurse must record administration on EPMA"* **Pg 12** – Amended ordering sheet to EPMA – *"Nursing staff should clearly specify the following on the EPMA order:"* **Pg 13** – Amended drug chart to EPMA – *"Registered Nurses are required to record Stage 3 administration on EPMA as 'self-administered'. "* **Pg 24** – Amended appendix 6 (Stage 3 Compliance Monitoring Record). Replaced days of week with dates and times following feedback from staff.

CONTENTS

1. AIMS AND OBJECTIVES

The aim of this policy is to enable patients to safely self-administer medication as part of their mental health rehabilitation whilst an inpatient on a rehabilitation ward. This will enable patients to become self-reliant and competent to administer their own medication.

Rehabilitation psychiatry can be defined as:

> *"A whole system approach to recovery for mental illness that maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support."* (Killaspy et al, 2005)

The policy has been prepared in line with the following documents:

- 'Professional guidance on the Administration of Medicines in Healthcare Settings' Royal Pharmaceutical Society and Royal College of Nursing (2019)
- 'Talking about Medicines – The Management of Medicines in Trusts Providing Mental Health Services' Healthcare Commission (2007)

The second document highlights that people wishing to self-administer should be encouraged to do so or, if deemed inappropriate, should be advised as to the reasons why. To be able to offer self-administration to patients, we need to ensure there is no unacceptable increase in risk to the patient or others. As such, there must be an assessment of competency to self-administer.

Opportunities during the self-medication assessment process are extended to provide education to the patient regarding the importance of medication in their treatment, and for the patient to discuss any concerns they may have about their medication and possible side effects.

2. RESPONSIBILITIES

It is the responsibility of the clinical team to ensure that patients are offered the self-administration scheme, where clinically appropriate, and to ensure that the safe systems in place are adhered to throughout.

Registered nursing staff are responsible for the initial and continued assessment of patients who are self-administering, and have continuing responsibility for recognising and acting upon changes in a patient's condition with regard to safety of the patient and others. They are also responsible for recording patient progress and communicating this to MDT meetings.

The MDT should review the risk assessment at each level of the programme as a minimum, but ideally frequently throughout the patient's stay.

3. IMPLEMENTATION

Assessment

- The patient must be assessed by their named nurse and consultant (or delegate) to establish the following:

Observation	Risk
Mental state	Confusion, risk or self-harm, suicidal thoughts, disorientation, risk to self or others
Intellectual capability	Level of understanding
Sensory perception	Visual or hearing problems, manual dexterity problems
Likelihood of stay in hospital being long enough to progress through the programme at a pace suitable to the patient	Imminent discharge may require an element of "fast tracking" the process which can affect success

- Patients with a history of substance misuse should not be excluded from self-administration of their medication. Please note:
    - These patients may require extra supervision and reinforcement of education. This should be highlighted and documented.
    - These patients may require more time on Levels 1 and 2 to ensure they receive adequate supervision and education.
    - These patients may never administer at Level 3, however these patients should not be excluded from Levels 1 or 2 for this reason alone. (NMC 2006)

- **Risk assessment (Appendix 1)** must be completed initially by a qualified nurse, then discussed at the patient's next multidisciplinary team (MDT)

meeting. See Appendix 7 – 'Guidance for Registered Nurses to help with self-administration of medicines initial assessment'.

  - As a minimum, the assessment should be discussed and agreed with the patient, registered nurse and consultant (or delegated medic).
    - Other healthcare professionals such as pharmacists and occupational therapists may provide feedback during this MDT, but their attendance is not essential for the purposes of discussing the risk assessment, and this should not prevent decision making.
  - After discussing in MDT, this document should be uploaded to Paris as an attached document, and the following should be documented within the ward round Paris case note as a minimum:
    - **Risk level**
    - **Stage of medication agreed (if self-administration is agreed)**
    - Any other important discussions had around the risk assessment

  - The MDT should revisit the risk assessment (Appendix 1) at any level change of the programme at a minimum, but ideally frequently throughout the patient's stay. When risk assessments have changed, the risk assessment form should be amended and uploaded to Paris, and the above same information documented within a ward round Paris case note.

  - Registered nurses should make every effort to provide feedback to each MDT meeting.

- **Consent form (Appendix 2)** must be completed and signed by the patient and a member of the multidisciplinary team as a witness. A copy should be offered to the patient and scanned onto Paris attached documents. The original should be kept with the patient's paper notes.

  - Note that **withdrawal of consent** can take place at any stage, and the consent form (Appendix 2) amended to this effect.

- Patients who have been participating in the self-administration programme on their previous ward/unit within the Health Board, should have their Self Administration of Medicines records checked to confirm their suitability to continue on the programme.

Education

- Approved Patient Medication Leaflets can be obtained from the National Centre for Mental Health: https://www.choiceandmedication.org/nhswales

    - Leaflets are available in a range of formats including Brief, Extra-Large print, Easier on the eye and Very Easy-Read. Translations into a variety of languages are also available.

- NICE decision aids may also be helpful tools to support patients in making informed decisions about their medications: https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids
- Ward staff should contact the ward pharmacist or medic to arrange 1:1 discussions with patients about their medications if needed.

Supply of Medicines

- For all patients who have been assessed as suitable to commence STAGE 2 or STAGE 3 self-administration on the ward, individually labelled medicines should be used (i.e. no stock medications).

- Registered nurses may need to order individually labelled medication from the pharmacy if stock medication has been used up until this point.

    - Registered nursing staff should order medication from pharmacy via EPMA and should specify if Stage 2 or 3 medication is needed
        - If Stage 2 medication is ordered, individually labelled full original packs of medications will normally be supplied (usually 28 days).
        - If Stage 3 medication is ordered, individually labelled full original packs (usually 28 days) will be supplied. However, depending on the patient's individual risk assessment, smaller pack sizes e.g. 7 days, may be requested.
        - Nursing staff should **clearly specify the following on the EPMA order:**
            - The patient's current stage of medication
            - Pack sizes required (if this is left blank then pharmacy will usually supply individually labelled full original packs (usually 28 days) as default).

- **NB:** For patients who are likely to be granted leave in the next month, it may be more appropriate to request a medic or pharmacist complete a leave TTH. This will then cover nurses to dispense from the ward using labelled medication at short notice. ***See Leave/Discharge Prescription section below for further information.***

- Each item should be individually labelled with clear instructions.

- If the patient is awaiting a supply of their individually labelled medicine and there is a stock supply of the medicine on the ward/unit, doses should be administered from this supply by the registered nurse – not the individual patient – until an individual supply can be obtained from the pharmacy.

- Individually labelled medicines required for self-administration purposes should be ordered from the pharmacy on week days only, NOT on weekends. (See section 5.7.2 of Medicines Code for guidance on obtaining medication outside of normal pharmacy hours)

- If required, large print labels can be requested from pharmacy.

- Supply of pre-filled 'dossette boxes' or 'blister packs' must be discussed on an individual basis with the ward pharmacist.

Implementation

- Only Registered Nurses can supervise patients participating in the programme.

- Medicines must be prescribed on the electronic prescribing system (EPMA).

- Patients at Stage 2 or 3 of the programme should be encouraged to record medication times on their personal administration record (Appendix 3).

- Stage 2 – Custody of the keys will remain with the registered nurse.

- Stage 3 – Patients should be supplied with a secure, lockable medicines 'container' which must be able to accommodate all of the medication for storage of their individual medicines. This container will be in the patient's bedroom. If individual lockable storage is not available then the patient cannot progress to Stage 3.

- Most 'as required', once only and variable dose medicines will continue to be administered by Registered Nurses and patients will not be allowed to keep their own supply. Exceptions to this rule include inhalers, which may be suitable for self-administration.

    - An MDT discussion would be needed to discuss whether self-administration of any other PRN medication for physical health (e.g. GTN spray, Hyoscine Hydrobromide – list not comprehensive) would be appropriate/safe.

- Controlled drugs will generally continue to be administered by Registered Nurses whilst on the ward e.g. morphine, oxycodone, methylphenidate,

temazepam, buprenorphine, gabapentin, pregabalin, tramadol (list not comprehensive).
    - There may be exceptions for patients on Stage 3 of the programme and risks will be assessed by MDT on an individual basis.

- Drugs liable to misuse must be assessed in individual cases in MDT discussions. These may include benzodiazepines (other than temazepam), 'Z' drugs, certain injections or Procyclidine (list not comprehensive).

- It may be deemed appropriate for some patients to self-fill their own 'dossette box' or 'blister pack'. In these cases, patients must fill the compliance aid themselves and the Registered Nurse should supervise and complete the transfer of medicines form (Appendix 7) Please note that the medication transferred will not be labelled and checked by pharmacy.

Leave/Discharge Medication

- Leave prescriptions for patients on Stage 1 or 2, and all discharge prescriptions must be sent through pharmacy as normal for dispensing.

    - Pharmacy may use supply of labelled medications from the ward to complete the prescription.

- **Leave prescriptions for patients on Stage 3** may be dispensed from the **ward** using labelled medicines which have previously been dispensed for self-administration, but **ONLY** if this was previously ordered via a leave prescription (written by a medic or a pharmacist) and NOT if these medications were ordered via EPMA.

    - The medicines on the ward are checked either by nursing or pharmacy staff.

    - Staff must use EPMA to check it is the correct drug, formulation, dose, label (directions, patient name) and expiry date. They must document this check in the notes.

    - The quantity prescribed for leave may not match exactly what the patient is given to take out. The amount supplied on leave must be documented on the monitoring record form (appendix 6) and on Paris. The amount the patient returns with must be counted and documented on the monitoring form and on Paris. Any discrepancies must be documented on the monitoring form and Paris, and reported to the MDT.

- If the quantity of medicine remaining in the supply is considered too great a risk to take out of the hospital, a leave prescription must be written, and the medicines obtained from the pharmacy in the usual way.

Patients' Personal Record

- Appendix 3 is for patients to record when they have self-administered medication. This should be encouraged, but is not compulsory. Staff or the patient may decide if it will or will not be used. It is hoped that by using the form, patients will feel more included in the process.

Stages of Self-Administration

- Patients receiving Depot injections on any Stage of the programme will be expected to request their injection from nursing staff at the appropriate time on the day indicated. Any discrepancies should be noted on the relevant monitoring record (Appendix 4).

- **Stage 1: Assessment**

  - Staff will use available medication (this may be a combination of stock and individually labelled medicines) to assess a patient's ability to:
    - Approach staff at the correct time and request their correct medication. The Registered Nurse will then select the appropriate medication and administer the medication in the usual way.
      - The Registered Nurse will draw attention to any discrepancies noted e.g. incorrect medication requested or any not requested.
  - If patients do not approach staff for medications within an agreed timescale (usually 30 minutes either side of the administration time), it will be the qualified nurse's responsibility to prompt the patient to attend the medication room and request their correct medication.
  - Failure to attend at the correct time should be noted on the monitoring record, along with any other concerns (Appendix 4).
  - Staff should always endeavour to provide reasonable opportunity for patients to engage with Stage 1, but it is accepted that in some

circumstances, due to ward routine/acuity, it may not always be possible to wait for patients to approach staff regarding medication.
- The registered nurse must record administration on EPMA and record any refusals etc. in the usual way, then complete the monitoring record and note any concerns (Appendix 4).
- It is recommended that this stage lasts for 14 days. Once the 14-day period is completed, an assessment of the patient's progress must be undertaken by the MDT in ward round to determine their suitability to move on to Stage 2. As a minimum, the consultant (or delegated medic) and qualified nurse will authorise moving to Stage 2 by signing the authorisation at the end of the assessment in Appendix 1. This should be documented in a ward round case note on Paris.

- **Stage 2: Self-Administration with Direct Supervision**

  - Pharmacy will supply individually labelled full original packs (usually 28 days) of medications. This must be stored in the ward/unit medicine cupboard.
  - Stock medications should not be used.
  - The patient is expected to:
    - Approach staff at the correct time and request their medication.
    - Select the appropriate medication, read the instructions to them, select the correct dose and return the container to the registered nurse, who will then observe the selection and administration of the correct medication.
  - Registered nurse in charge will retain custody of the medicine locker key, but the patient is expected to contact the nurse at the correct time to take their medicine.
  - The registered nurse will draw attention to any discrepancies noted, e.g. incorrect medication or any not selected, and will administer these in the usual way.
  - The patient should be encouraged to complete their personal administration record (Appendix 3).
  - The registered nurse must record administration on EPMA and record any refusals etc. in the usual way, then complete the monitoring record and note any concerns (Appendix 5).
  - If self-administration does not happen within an agreed timescale (usually 30 minutes either side of the administration time), it will be the qualified nurse's responsibility to prompt the patient to attend the medication room and observe the selection and administration of the correct medication.
  - Failure to attend at the correct time should be noted on the monitoring record, along with any other concerns (Appendix 5).

- It is recommended that this stage should last for a minimum of 14 days. A further MDT assessment of the patient's progress must be undertaken and the consultant (or delegated medic) and qualified nurse (at a minimum) will authorise moving to Stage 3, if appropriate, by signing the authorisation at the end of the assessment in Appendix 1.
- If secure individual storage facilities are not available, this should not be a barrier to commencing Stage 2 of the programme. All medicines will need to be stored securely in the ward/unit medicine cupboards.

- **Stage 3: Self-Administration without Direct Supervision**

  - Patients should be offered a copy of the Patient Information Sheet for Self-Administration of Medicines – Stage 3 (Appendix 9)
  - Pharmacy will usually supply individually labelled full original packs (usually 28 days). However, depending on the patient's individual risk assessment, smaller pack sizes e.g. 7 days, may be requested.
    - Nursing staff should **clearly specify the following on the EPMA order**:
      - The patient's current stage of medication
      - Pack sizes required (if this is left blank then pharmacy will usually supply individually labelled full original packs (usually 28 days) as default).
  - Registered nurses should monitor the patient's compliance by completing the Stage 3 compliance monitoring record (Appendix 6). Nursing staff are expected to complete the number of doses that they expect to find in the patient's locker and the number of doses that are actually remaining.
  - Compliance checks must be completed at least once in a 48 hour period
  - If a patient has leave exceeding 48 hours, then the compliance check should be carried out immediately before and after the period of leave.
  - This must be stored in the patient's secure medicine locker.
  - Stock medications should not be used.
  - The patient will have custody of their locker key and their medicines stored in the locker.
    - Ward staff will also keep a key.
  - Registered Nurses are required to record Stage 3 administration on EPMA as 'self-administered'.

Errors in Medication Self-Administration

- Self-administration errors may be identified where the expected and actual number of doses do not match on compliance checks (Appendix 6).

- If an administration error has occurred (or a near miss observed), immediate action should be taken to prevent any further harm to the patient. Decisions around continued self-administration should be made with the clinical team.

- Depending on the severity of the discrepancy, nurses may wish to seek advice from a medic, the National Poisons Information Service (https://www.npis.org/index.html), Pharmacy or the Patient At Risk (PaRT) team if necessary.

- Nurses should document any discrepancies on Paris and report to MDT.
    - The patient should be re-assessed by the MDT to determine whether they are able to continue self-administration at the current stage.

- All incidents and errors should also be reported using the CAV incident reporting process (Datix). Additionally, any administration or prescription errors made by staff should be dealt with as usual as per Appendix 3 in the Medicines Code.

4. ACCOUNTABILITY

Cardiff and Vale University Health Board accepts responsibility for the degree of risk involved in allowing normal medicines practices to be waived, but consider that the risk can be minimised by:

- Careful selection of patients in order to identify and possibly exclude those who may endanger themselves or others.
- Particular vigilance on the part of staff involved in the operation of this programme, especially nursing staff within whose professional responsibility regarding medicine administration rests.
- Ensuring procedures are adhered to and all relevant documentation is completed accurately and filed correctly.
- Ensuring patients are provided with accurate information to make an informed decision.

The Registered Nurse is responsible for the initial and continued assessments of patients involved in self-administration.

- They are also responsible for recognising and acting upon changes in a patient's cognitive and/or physical wellbeing that may prejudice their safety in continuing with the scheme.

- Responsibility for subsequent actions or omissions by the patient rests with the patient.

5. REFERENCES

Killaspy H et al. What do mental health rehabilitation services do and what are they for? A national survey in England. Journal of Mental Health. 2005:14(2);157-65.

Royal College of Psychiatrists. Faculty of Rehabilitation and Social Psychiatry. 2005. https://www.rcpsych.ac.uk/members/your-faculties/rehabilitation-and-social-psychiatry

The Healthcare Commission Talking about Medicines – The Management of Medicines in Trusts Providing Mental Health Services (2007)

Royal Pharmaceutical Society and Royal College of Nursing Professional guidance on the administration of medicines in healthcare settings (2019)

6. ACKNOWLEDGMENTS

Thanks to Cwm Taf University Health Board for permission to adapt their guidance ‘Self administration policy for use in Cefn Yr Afon’.

7. APPENDICES

(See overleaf)

APPENDIX 1 – RISK ASSESSMENT

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Self-Administration of Medication – Risk Assessment

Patient Details:

Name:
Address:
DOB:
Hosp no.:
Paris:
NHS no.:

Addressograph

Ward: ……

Current Medication ***(include any medicines not appropriate for self-administration and document why e.g. CDs):***

Knowledge of Prescribed Medication

Does/is the patient:

a. Know the names of the medications they are taking?

Yes ☐ No ☐

b. Familiar with the number of tablets or capsules to take and the frequency?

Yes ☐ No ☐

c. Know what they are taking the medicines for?

Yes ☐ No ☐

d. Able to identify the tablets or capsules correctly?

Yes ☐ No ☐

If any of the above answers are “No”, then a decision has to be made as to whether the patient is able to self-administer medication at this stage, or whether education and a later review is more appropriate.

Administration Ability

a. Can the patient open containers, bottle-tops, blister packs and cartons?

Yes ☐ No ☐

b. Is the patient able to read the labels?

Yes ☐ No ☐

c. If inhalers, eye drops or any other devices are used, can the patient use them correctly?

Yes ☐ No ☐

If any of the above answers are “No”, then a decision has to be made as to whether adjustments can be considered e.g. large font labels, compliance aids.

Risk Assessment

Risk Consideration	Yes	No	Level of risk *(High, Medium, Low)*	Comments
Mental health stable enough to administer own medicines				
Understands indications for medicines				

Understands importance of taking medicines as prescribed				
Knows how and when to take their medicines				
Can read labels and has no obvious visual, hearing or manual dexterity issues				
Likely to conceal prescribed medicines				
History of non-compliance				

Risk Levels:
HIGH – Unlikely to succeed safely with self-administration
MEDIUM – Likely to succeed with high levels of support
LOW – Likely to succeed with support
This patient has been assessed as suitable/unsuitable ***(delete as appropriate)*** **to start the self-administration of medication programme and has agreed to take their medication as prescribed, and to store medicines in safely lockable facilities.**

After MDT review and assessment of this patient's progress, it has been agreed that …… should commence:
(Sign relevant box below)

Stage ONE

Consultant / delegated medic signature …….…….. Date ……

Nurse signature …….…….. Date ……

Comments:

Stage TWO

Consultant / delegated medic signature …….…….. Date ……

Nurse signature …….…….. Date ……

Comments:

Stage THREE

Consultant / delegated medic signature …….…….. Date ……

Nurse signature …….…….. Date ……

Comments:

It is recommended that each stage should last for a <u>minimum</u> of 14 days, however shorter durations may be agreed at discretion of the team.

APPENDIX 2 – CONSENT FORM

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

<u>Self-Administration of Medication – Consent Form</u>

As part of your long-term rehabilitation, the multidisciplinary team has determined that you have reached a stage in your treatment when it would be helpful to you to administer your own medicines.

Name: …….. Ward: ……

Consent to Administer Own Medicines

The self-administration of medications programme has been explained to me and I am willing to take part. I have been made aware that I can withdraw my consent at any time and return to nurse-administered medicines.

Patient's signature: ……..

Date: ……..

Witnessed by: ……..

Withdrawal of Consent

I no longer wish to be involved in the self-administration of medications programme and, therefore, I withdraw my consent and wish to return to nurse-administered medicines.

Patient's signature: ……..

Date: ……..

Witnessed by: ……..

APPENDIX 3 – PERSONAL WEEKLY ADMINISTRATION RECORD

Personal Weekly Administration Record

Name: …… **Ward:** ……

Week commencing: ……

Put a tick or your initials in the correct box each time you have taken your medicines.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Lunchtime							
Teatime							
Night time							

APPENDIX 4 – STAGE 1 MONITORING RECORD

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

Name: …… **Ward:** …… **Week commencing:** ……

Complete the table below for each dose using the key provided (**M** = Morning, **L** = Lunchtime, **T** = Teatime, **N** = Night time)

	Monday				Tuesday				Wednesday				Thursday				Friday				Saturday				Sunday			
	M	L	T	N	M	L	T	N	M	L	T	N	M	L	T	N	M	L	T	N	M	L	T	N	M	L	T	N
Requests medicine(s) at the correct time																												
Knows the correct medication, dose and when to take																												
Takes medicine(s)																												
Initials of registered nurse																												

KEY: **I** = Independently performs tasks, **P** = Needs prompting, **N/A** = Not applicable.

Please record any comments overleaf

APPENDIX 5 – STAGE 2 MONITORING RECORD

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Name: …… **Ward:** …… **Week commencing:** ……

Complete the table below for each dose using the key provided (**M** = Morning, **L** = Lunchtime, **T** = Teatime, **N** = Night time)

	Monday				Tuesday				Wednesday				Thursday				Friday				Saturday				Sunday			
	M	L	T	N	M	L	T	N	M	L	T	N	M	L	T	N	M	L	T	N	M	L	T	N	M	L	T	N
Requests medicine(s) at the correct time																												
Selects correct medicine(s)																												
Selects correct doses																												
Reads instructions on labels correctly																												
Takes medicine(s)																												
Returns medicine(s) to appropriate container																												
Initials of registered nurse																												

KEY: **I** = Independently performs tasks, **P** = Needs prompting, **N/A** = Not applicable.

Please record any comments overleaf

APPENDIX 6 – STAGE 3 COMPLIANCE MONITORING RECORD

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Name: …… **Ward:** …… **Week commencing:** ……

Compliance checks MUST be carried out AT LEAST once in a 48-hour period. Record findings below.

Drug name	Drug dose and frequency	Number of doses received	Number of doses remaining on check	Date …… Time ……	Date …… Time ……	Date …… Time ……	Date …… Time ……	Date …… Time ……	Date …… Time ……	Date …… Time ……
			Actual:							
			Expected:							
			Initials:							
			Actual:							
			Expected:							
			Initials:							
			Actual:							
			Expected:							
			Initials:							
			Actual:							
			Expected:							
			Initials:							
			Actual:							

			Expected:							
			Initials:							

Drug name	Drug dose and frequency	Number of doses received	Number of doses remaining on check	Date …… Time ……..	Date …… Time ……..	Date …… Time ……..	Date …… Time ……..	Date …… Time ……..	Date …… Time ……..	Date …… Time ……..
			Actual:							
			Expected:							
			Initials:							
			Actual:							
			Expected:							
			Initials:							
			Actual:							
			Expected:							
			Initials:							
			Actual:							
			Expected:							
			Initials:							
			Actual:							
			Expected:							
			Initials:							
			Actual:							

			Expected:							
			Initials:							

APPENDIX 7 – TRANSFER OF MEDICINES TO COMPLIANCE AIDS

Name: …… **Ward:** ……

This record must be completed on each occasion a patient is supervised transferring their medicines to a compliance aid.

Complete the table below for each dose using the key provided.

	Date of Transfer											
	……	……	……	……	……	……	……	……	……	……	……	……
Independently requests to transfer medicines												
Selects correct medicine(s)												
Selects correct doses												
Reads instructions on labels correctly												
Inserts medicine(s) into all correct spaces in tray												

Initials of registered nurse												

KEY: **I** = Independently performs tasks correctly, **N** = Performs task incorrectly, **P** = Needs prompting.
Please record comments overleaf

APPENDIX 8 – GUIDANCE FOR REGISTERED NURSES TO HELP WITH THE SELF ADMINISTRATION OF MEDICINES INITIAL 1:1 ASSESSMENT

Preparation

- The 1:1 Assessment must take place in a quiet, safe environment where the conversation cannot be overheard by others. A chaperone should be available if the assigned practitioner in charge identifies that a one-to-one session is inappropriate, or if requested by the patient.

- The following items must be available during the assessment:
  - The patient's current medication screen on EPMA
  - All the patient's medication, including any appropriate PRN (as required) medication
  - Approved patient information leaflets, where applicable/requested (see https://www.choiceandmedication.org/ncmh/printable-leaflets/)
  - A self-administration patient consent form (Appendix 2)

Content of assessment

- Talk through the details of the patient's current medication (see EPMA)
- The assessment should involve discussion of the following:
  - What a self-medication programme involves
  - Why the patient has been considered suitable to undertake the scheme
  - Confirmation of whether the patient would like to self-administer medicines
  - Assessment of the patient's knowledge and discussion to clarify the medicines they are prescribed, including strengths, doses and timing of doses
  - Assessment of the patient's knowledge and discussion to clarify the reasons for taking each medicine
  - Any side effects experienced and level of concern
  - The possible outcomes of stopping taking medication or not taking as prescribed
  - What to do if a dose is missed
  - Information about the length of time they are likely to be prescribed the medication
  - The effects of drinking alcohol whilst taking prescribed medication
  - Ability to read a label or whether large print labels are required
  - Ability to open child-resistant containers ("clic-loc" caps) or foil packs
  - Ability to count out tablets and/or measuring liquids
  - Ability to take medicines with adequate volumes of water (e.g. 100 ml)

- How to dispose of unwanted medicines
- How to order repeat medicines from the GP service (if going out into community care)
- Explanation of each stage of the self-medication scheme and the essential monitoring that will be required by both the patient and staff

Reflection time

- Following the assessment, time must be allowed for the patient to absorb the information and ask questions. If the patient is unable to think of any questions, the following prompts may be helpful:
  - Does my medicine have any other names and what are they?
  - Why am I taking it?
  - How much should I take and how often?
  - Is there a best time to take it?
  - How long will I need to take it?
  - Are there potential side effects, and what should I do if they happen?
  - What should I do if I miss a dose?
  - Does this medication interact with any other medications or with any foods?
  - Does this medication replace anything else I have been taking?
  - Where and how should I store it?
  - How soon should I start to feel better?
  - When should I report back to my healthcare professional?
  - Should I avoid any liquids, foods, other substances or activities while using this medicine?
  - Could I become tolerant, dependent or addicted to this medicine? If so, how can I avoid this?
  - Where can I get more information about this medicine?
  - If the directions state I should take the medication every three or four hours, does that mean throughout the night as well as during the day?
  - Is this medication available in a child-resistant container?
  - What is this medication's expiration date?

Conclusion/Documentation

- If the patient agrees to participate in the programme, a self-administration patient consent form (Appendix 2) should be completed and a this should be documented in a Paris case note.

- Patients should be advised they can withdraw from the scheme at any time. A withdrawal of consent form should then be completed (Appendix 2).

APPENDIX 9 – PATIENT INFORMATION SHEET FOR SELF-ADMINISTRATION OF MEDICINES STAGE 3

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

- **Why am I being asked to think about taking my own medicines in hospital?**
  - As part of your recovery plan being able to take your own medicines, when you need to, means better care for you. Continuing to take your own medicines allows you to maintain your independence while in hospital.

- **What will happen if I do want to take my own medicines?**
  - A member of the nursing /medical team will need to ask you some questions to make sure it is safe for you to take your own medicines on the ward. You will be asked to consent to taking your own medication to make sure you feel ready to do so.

- **What will happen to my own medicines?**
  - Your own medicines will be kept safely in your locked facility. This may be in a locked drawer/locked cabinet in your room. It will usually be possible for you to have a key to this locker.

- **What if I don't have enough of my own medicines, or I start to take something new?**
  - Further supplies of your current medicines, or new medicines, will be ordered from pharmacy. These will be fully labelled with instructions and, as well as taking them on the ward, you will be given them to take home.

- **What if I become unwell?**
  - If your condition changes, your nurse will assess whether you are still able to take your own medicines. If not, they will take over giving you your medicines until you recover.

- **How can I be sure this is safe?**
  - Make sure you always lock your medicines in your room's locked drawer/locked cabinet and keep the key somewhere safe. Never take more than the dose on the label, and never share your medicines with anyone else. If you are not sure how to take your medicines, ask the nurse, doctor or pharmacist on the ward. If anyone else tries to take your medicines, please contact one of the nurses immediately.

- **What happens when I go home?**
    - The doctor will write a prescription for all the medicines you are taking. Your medicines will be checked to to make sure there are enough supplies and that they are correctly labelled. Your medicines will be given back in time for you to go home.

If you have any questions about the medicines you are taking, please ask your nurse, doctor or pharmacist.