

Self-Administration Assessment

My name is: _____

This assessment is to be completed by a person who knows me well and, when possible, with a second observer present. Assess my knowledge and skills in all the environment where I take my medication(s).

Persons conducting this assessment will need to have ALL necessary information regarding my current medications including medicine name(s), dose(s), route(s), time(s), reason for medication(s), and basic side effects. Complete this form (page 1 & 2) in its entirety regardless of answers. (See instruction page for more information).

Name, Signature & Title of Person Performing Assessment.

Date

Name, Signature & Title of Second Observer

Date

- 1. I can recognize my medication by color, size, shape and/or by reading the label. I will not take my medicine if it looks different.**

YES Continue on to # 2.

NO Unable to Self-Administer With or Without Assistance. Continue to #2.

- 2. I can tell you what my medicine is for (pain, nerves, breathing).**

YES Continue on to # 3.

NO Unable to Self-Administer With or Without Assistance. Continue to #3.

- 3. I know and recognize how much medicine I'm to take (1/2 pill, the cup filled to this line etc.). I will not take my medicine if it is the wrong amount.**

YES Continue on to # 4.

NO Unable to Self-Administer With or Without Assistance. Continue to #4.

- 4. I will recognize and know whom to tell if I don't feel good (pain, nausea, dizziness) as it may be a side effect.**

YES Continue on to # 5.

NO Unable to Self-Administer With or Without Assistance. Continue to #5.

- 5. I know whom to tell when I have 3-4 days of medicine left so I never run out.**

YES Continue on to # 6.

NO Unable to Self-Administer With or Without Assistance. Continue to #6.

- 6. I know whom to call if my medicine is wrong and will tell him/her right away.**

YES Continue on to # 7.

NO Unable to Self-Administer With or Without Assistance. Continue to #7.

*****If questions 1 through 6 are all = "YES", I am able to Self-Administer.
Continue to next question for possible assistance needed with Self-Administration.***

- 7. I take my medicine at the right time every day by using the clock or my routine (before bed, after lunch, etc.).**

YES Continue on to # 8.

NO If Self-Administering, the service plan will include time reminder assistance. Continue on to # 8.

- 8. I can get medication to and from storage, out of the container and to my mouth without spills**

YES If "YES" to all eight questions, Self-Administer Without Assistance.

NO If Self-Administering, service plan will include physical assist regarding storage or packaging or consuming/applying.

Record the assessment outcomes on this page - indicate all applicable outcomes. Then state the outcome(s) and the plan for safe administration of my medications and treatments in my service plan.

My Name: _____

Original Assessment Date: _____

After the page 1 questions are all completed, choose one of the three following assessment outcomes.
My service plan will then specify how my medication administration will be done.

1. I can self-administer medication(s) without assistance. (Questions 1 through 8 all = "YES").
2. I can self-administer medication(s) with assistance. (Questions 1 through 6 = "YES"; 7 and/or 8 = "NO"). Select as many of the following that apply:
 - I need reminders to take my medication on time and/or confirm I'm following the directions on the container. (Specify this assistance as needed in ISP).
 - Assist me by taking the medication in its container from the area where it is stored, handing the container with the medication in it to me, and, if I am physically unable, open the container for me.
 - Upon my request or with my consent, and *with my direction*, remove my oral or topical medication from the container and help me take or apply the medication. If I am physically unable to place a dose of oral medication in my mouth or topical on my skin, assist me physically to do this.
3. I am not able to self-administer medication with or without assistance. A properly licensed or certified and authorized person must administer my medication. (*Also check below IF APPLICABLE*).
 - I am able to do some steps of my medication administration and a properly licensed or certified and authorized person completes the other steps of my medication administration. Details are listed in my plan.

Other Considerations: Indicate any of the following that are applicable:

- I am able to self-administer some of my medications / dosages (i.e., inhaler, nebulizer, sublingual, etc.); those are listed in my plan. A properly licensed or certified and authorized person needs to administer the other medication(s). Describe medication(s) and/or task(s) I do myself: _____

- I have demonstrated unsafe behaviors and am unable to safely self-administer medication with or without assistance: (if yes) This is addressed in my plan as a rights restriction (required). Brief Summary: _____

- I have a G/J Tube or modified texture diet; medications are given via tube, or the prescriber and team have confirmed the safe administration of any medications given orally (or modified the administration to assure safety).
Note: G/J tube Medication Administration requires nurse to do G/J Self-Admin. Assessment and nurse delegation for properly certified personnel to administer.

Annual Review; the confirmation of no changes or the dated edits were noted by:

First Review		
	<i>Signature & Title</i>	<i>Date</i>
Second Review		
	<i>Signature & Title</i>	<i>Date</i>

<p>NOTE: The Assessment must be re-evaluated as needed and at least annually (& redone every 3 years)</p>	<p>Reasons to re-evaluate this assessment include but are not limited to:</p> <ul style="list-style-type: none"> Individual moves to a new home Medication packaging changes New medications (if individual is self-administering other medications) or significant changes in number or dosages of medications Change in the individual's health status Individual exhibits changes in behaviors Any change that could potentially effect safe self-administration
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