

Patient Self Administration of Medicine Policy

Effective: July 2011

Review: March 2012

1. Executive Summary

Self-administration of medicines, wherever it is appropriate, is supported by the Nursing and Midwifery Council (NMC) in the document 'Standards for Medicines Management' (2007).

It is evident from research, that through the process of a self-administration of medicines scheme (SAMS) patients become more familiar and confident with the correct use of their medication. Patients are given the opportunity to learn about medication through practice and encouragement. Ultimately, this can improve patient concordance after discharge from hospital.

Additionally, some patients will experience better quality of care from a SAMS; examples include correct dose timing in Parkinson's disease and immediate relief of acute conditions such as asthma or pain.

2. Purpose

The objectives of this policy are:

- To provide patient centred care
- To empower patients
- To encourage independence
- To improve patient knowledge of medication
- To improve patient satisfaction with inpatient care
- To prepare patients and carers for discharge
- To identify and address individual patient needs relating to the administration of medicines.

3. Definitions

Self-administration is the process in which a patient and/or carer takes responsibility for managing their own medication following a period of assessment and education.

4. Duties with the Organisation

The policy must be read in conjunction with the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) Medicines Policy, and applies to all healthcare staff involved in the prescribing, dispensing and administration of medicines to patients.

5. Policy Effect

- 5.1 The policy applies to all patients and carers involved in the administration of medicines, however there is no obligation for patients to undertake self-administration. A written agreement from the patient (or carer, when the carer will be administering medicines) must be sought prior to the use of level 2 or 3 self-administration (appendix I).

- 5.2 On admission to NUTH clinical areas, patients must be assessed by a competent member of staff (doctor, nurse or pharmacist) and are assigned to one of three levels (appendix C).

Level 1

On completion of the assessment, some patients will not be deemed competent to self-administer (or will not wish to self-administer) whilst in hospital. In these instances nursing staff will retain complete responsibility for the custody and administration of medicines.

Level 2

The patient is assessed as competent to self-administer their medicines under the direct supervision of nursing (or pharmacy) staff. Safe custody of the medicines remains the responsibility of nursing staff.

Level 3

The patient is assessed as competent to take responsibility for administering their own medications whilst in hospital. They will not be directly supervised but tablet counts may be performed if considered desirable. The patient may also take custody of their medicines if assessed as safe to do so.

- 5.3 The patient must be assessed on a daily basis (and when there is a change in their condition/medication regimen) for their ability to continue on the programme.
- 5.4 If it appears that a patient lacks the abilities or understanding necessary to achieve level 3 prior to discharge, a plan of care must be devised with the patient, carer and/or primary care health professionals to ensure that the patient can manage their medication at home. Information about medicines should still be given to the patient at discharge.
- 5.5 Schedule 2 Controlled Drugs (or medicines controlled using Schedule 2 Controlled Drug procedures e.g. Oramorph® or ketamine) must be excluded from the programme. Further guidance on additional medicines or clinical situations which should be excluded from SAMS is provided in appendix G.

6. Responsibilities of Staff Groups under the Policy

6.1 Medical staff and non-medical prescribers

- i. To make a record in the patient's medical notes when they start self-administering medicines at level 2 or 3.
- ii. If a patient/carers is self-administering medicines on level 2 or 3:
 - Tell the patient/carers when changes are made to their medicines.
 - Change the patient-held record of medicines (Appendix J) and record the date and your name/signature in the designated column.
 - Tell the patient's nurse when changes have been made to the medicines.
 -

6.2 Nursing staff

- iii. Assess patients (or carers) for suitability for self-administration of medicines at admission and continually throughout their hospital stay (using appendices C and D). Appendix E gives guidance on the assessment.
- iv. Provide information on self-administration to patients who are suitable for participation in the scheme (Appendix J). At levels 2 and 3 only, complete 'Your list of medicines for self-administration' for the patient (also Appendix J). A second healthcare practitioner must check the information in Appendix J before giving it to the patient. Both practitioners must sign and print their names and the date of completion on appendix J.
- v. Ensure the patient/carer agreement form has been completed before commencing level 2 or 3 of the scheme (Appendix I). Appendix H gives guidance on seeking agreement.
- vi. Support patients and carers participating in the three levels of self-administration as described in appendix B.
- vii. At levels 2 and 3 only, record self-administration on the patient's paper or electronic drug chart.
- viii. Ensure medicines are ordered from pharmacy in a timely fashion when informed of changes to the regime of a patient who is self-administering and when supplies run low.
- ix. Monitor and assess the suitability of patients to continue in the self-administration scheme, particularly peri-operatively or at times of acute illness.
- x. Perform daily tablet counts for patients at level 3 if this is identified as necessary by the multidisciplinary team caring for the patient. A sample tablet count record form is provided in appendix F.
- xi. Complete an incident report (DATIX) for any untoward incident (including mistakes made by patients at level 3) that occurs during self-administration.
- xii. If a patient/carer has been responsible for safe custody of their medicines at level 3, ensure that their medicine cabinet key is taken back at the point of discharge.

6.3 Pharmacy staff

- xiii. Supply medicines, labelled correctly, for patients in the self-administration of medicines programme (i.e. when this is indicated on the drug chart or a Med Request).
- xiv. Support nursing staff in using the policy and with individual patient assessment or education on request.
- xv. Assess patients own drugs for suitability for use (and/or train nursing staff to do so).

- xvi. Complete and/or check the information on 'Your list of medicines for self-administration' before it is given to the patient (Appendix J).
- xvii. Provide prompt cards (medicine reminder charts) for individual patients on request. A prompt card contains information about when and how to take medicines and so differs from 'Your list of medicines for self-administration' in Appendix J. A prompt card is not a substitute for, but may be used alongside, the information in Appendix J.
- xviii. Provide guidance to medical and/or nursing staff when a patient makes an error and when discrepancies are identified in tablet counts.

7. Process for Review and Compliance Monitoring

Monitoring the policy for compliance and effectiveness is the responsibility of the assistant director of pharmacy. Key specific aspects that will be monitored annually are:

- Clinical incident reporting analysis for problems reported in process of outcome.
- Ward inspection/audit for completeness of documentation.
- Staff survey to assess knowledge, implementation and experience of the policy.

8. Implementation

The principles of the reviewed policy will be implemented by the clinical pharmacy team and ward sisters. Reading the policy is considered adequate training for competent staff however further support for staff will be provided on request by clinical pharmacists.

9. Standards/Key Performance Indicators

The Newcastle upon Tyne Hospitals NHS Foundation Trust Medicines Code and NMC Standards for Medicines Management (2007) form the basis for this policy.

10. References/Associated Documentation

NMC (2008) The Code

NMC (2007) Standards for Medicines Management (reformatted 2010)

NHSLA (2010) Risk Management Standards for Acute Trusts, Primary Care Trusts and Independent sector Providers of NHS Care.

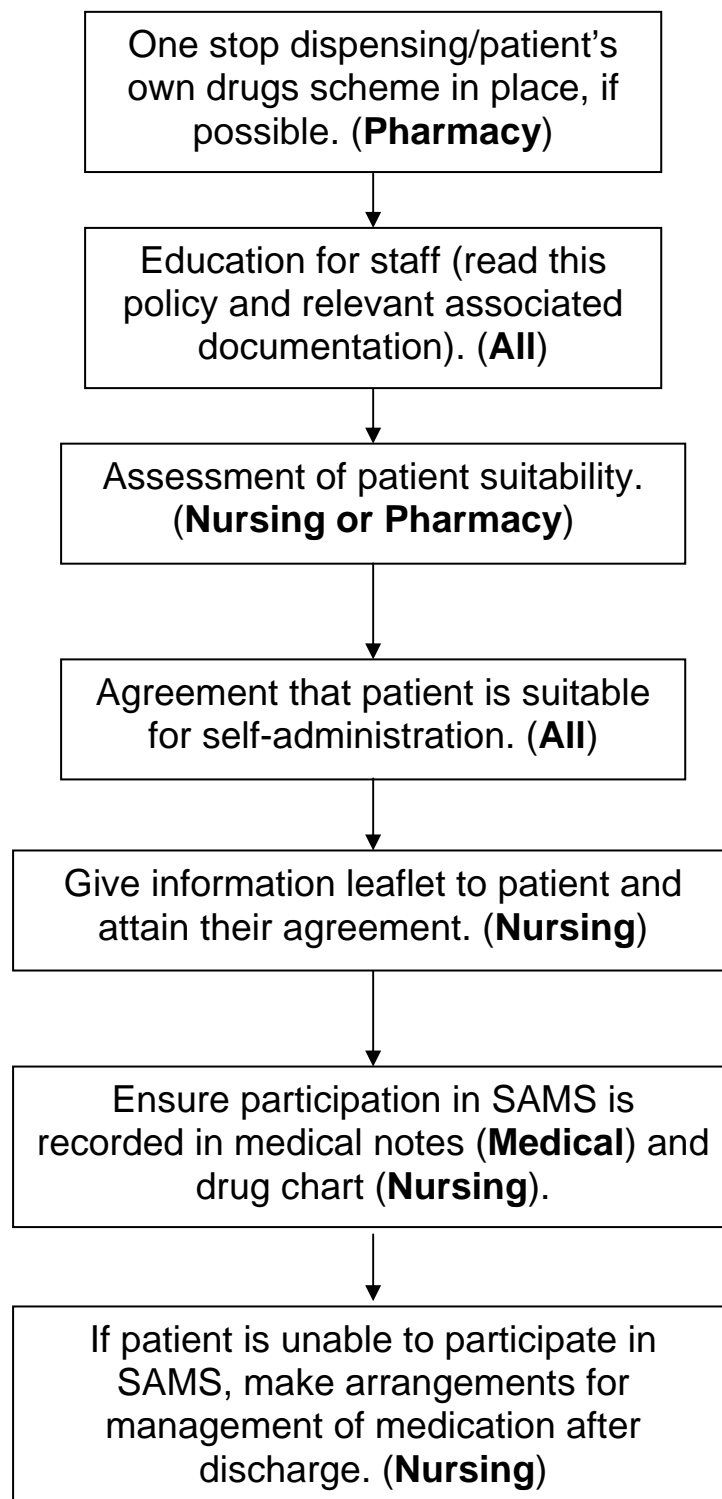
The ordering, storage and administration of all medicinal substances in The Newcastle upon Tyne Hospitals NHS Foundation Trust (2010)

Author: Lead clinical pharmacist for Care of the Elderly, Medicine directorate, in collaboration with the Heads of Nursing and their nominated representatives.

Appendix A

Process for Self-Administration of Medicines (SAMS)

Staff group(s) responsible named in bold at each step.



Appendix B

Levels of Competence

Note While each patient is assessed initially using appendix C, a patient's capacity to self-administer has to be re-assessed at each planned administration time. Further guidance is available in appendix E and in Annexe 4 of the NMC Standards for Medicine Administration (2007).

Level 1 Nurse Administration

At each administration the nurse educates the patient and helps them with each dose that has been prescribed. The nurse retains responsibility for the administration of the medicines.

- The medication may be stored at the patient's bedside, in the dedicated medicine cabinet, or in a locked medicines trolley/cupboard away from the bedside.
- The nurse retains custody of the key.
- At the appropriate time the nurse administers the medicine to the patient following a full explanation of the following information for each medicine administered:
 - The name of the medicine.
 - The purpose of the medicine
 - The dosage of the medicine.
 - Any common side effects.
 - The time that the medicine should be taken
 - Any specific action that is required to take the medicine e.g. with food.
- The nurse must sign the medicine chart following administration.

Once the patient has been assessed as being able to understand their medication regimen they may progress to level 2 or 3. Patients may move straight from level 1 to level 3 if they are assessed as competent to do so (appendix C).

Level 2 Supervised self-administration

- The medication may be stored at the patient's bedside, in the dedicated medicine cabinet, or in a locked medicines trolley/cupboard away from the bedside. All medicines for self-administration must be correctly labelled for the individual patient.
- The nurse retains custody of the key.
- A patient-held record of the medicines being self-administered is completed by the nurse or pharmacist (appendix J).
- The patient prompts the nurse to open the medicine locker (or bring their medicines) at the appropriate times.
- The patient administers their own medicines under the direct supervision of the nurse. If the patient makes an error the nurse must intervene before the dose is taken and educate the patient with the aim of preventing errors at future medicine administration times.
- The nurse must sign the medicine chart following administration.

Level 3 Self –Administration (or Carer Administration)

At this level the patient will be assessed as safe to take responsibility for and administer their own medications whilst in hospital.

Patients will only achieve this level following an assessment (Appendix C)

- Medication is stored at the bedside in the patient's medicine locker. All medicines for self-administration must be correctly labelled for the individual patient. A patient may self-administer some or all of their medicines; the nurse should consider removing from the bedside cabinet any medicines that are prescribed for nurse administration rather than self-administration.
- The patient may be given custody of the key if the nurse considers it safe to do so. The key must be one which opens only their individual medicine locker and not a sub-master key. The patient should be informed of the importance of keeping the key securely about their person. Ward staff could provide a means of safekeeping for the key e.g. a safety lanyard for single-patient use (this is approved by the Infection Control and Health and Safety departments). If a key is lost the nurse in charge should be informed as soon as the loss is reported.
- The medicine locker key should be returned to the nurse for safe-keeping if the patient leaves the ward for any reason.
- If the medicine locker key is lost, the drugs must be removed from the cabinet using the master key. The senior nurse for the clinical area must be informed.
- The patient administers their own medicines at the appropriate times. This can include 'as required' and 'once only' medicines but not controlled drugs or any other medicine identified as high risk within each individual directorate or multidisciplinary team.
- On wards that do not use eRecord, the nurse records on all parts of the medicine chart that the patient is at level 3 of the self-administration programme. In eRecord, once a nurse records that a patient has self-administered a dose, a yellow 'self-administration' bar appears on the drug chart immediately below each medicine that is being self-administered.
- The nurse does not sign the medicine chart, as they are not administering the medication, but records a '5' on the paper drug chart (selects self-administered in the electronic drug chart) to indicate that the drug is being self-administered.
- The nurse must still check the drug chart at usual drug round times to ensure that no changes have been made and for 'once only' or 'as required' medicines that are not being held in the patient's bedside medicine cabinet. Dose changes and new prescriptions should be ordered from pharmacy in the usual way. Medicines that have been stopped must be removed from the bedside cabinet.
- The nurse must also continue to observe the patient for any signs of adverse reactions, and monitor the effectiveness of medicines.
- The nurse undertakes a daily check with the patient, about their continued suitability to self-administer. The time should be such that allows for discussion with the patient regarding their medication, and discussion with the usual prescriber if necessary. This check should be documented in the nursing care plan.
- Nurses are responsible for acting on changes in a patient's condition (for example after surgery or in acute illness). This may require resuming nurse administration of medicines. In these instances a record must be made to that effect in the nursing care plan and on the medicine chart (in eRecord a signature

for nurse administration on the drug chart will remove the yellow self-administration bar).

- If self-administration is no longer appropriate, the medicine-locker key should be removed from the patient and the reasons for this should be documented in the medical and nursing notes.
- Professional judgement may indicate the need for a tablet count at specified intervals. The count should be recorded within the nursing care plan. A sample record form for this is included in appendix F.
- Any discrepancies should be documented in the nursing care plan and the nurse should explore the reasons for the discrepancy with the patient.
- Discrepancies should also be discussed with the ward pharmacist (or directorate pharmacist in the absence of a ward pharmacist).
- If, following discussion with the patient, it is felt that they have suffered any potential harm (either from under dosage or over dosage), the nurse should inform the doctor and senior nurse, and complete an incident report (DATIX).
- If the patient does not appear to be taking the medicines as prescribed and taught this should be discussed with the patient and if necessary the patient should not self-administer.
- Medical staff **must** inform the nurse and patient of any changes to the medication regimen. A written record of this discussion must be made in the patient-held information on self-administration that is kept in the patient's bedside file (Appendix J). This is the responsibility of the doctor making the medication change.
- Changes in the medication regimen should be fully discussed with the patient and additional support and education should be given as necessary.

Appendix C

(Patient sticker)

PATIENT ASSESSMENT FORM

Patient Name:Unit Number.....

		Yes	No	Comments
1.	Does the patient have responsibility for administering their own medicines at home?			If no, not for SAMS, consider carer education.
2.	Does the patient want to self-administer, and has written agreement been obtained?			If no, not for SAMS. Continue with Level1.
3.	Does the patient have any (temporary or permanent) impairment of physical, emotional or cognitive state that may affect their ability to self-administer?			Discuss with patient and multidisciplinary team (MDT) re: suitability for SAMS.
4.	Is insulin included in the list of medicines this patient will self-administer?			If yes, Appendix D must be completed before SAMS.
5.	Does the patient have a history of drug abuse or alcoholism?			Discuss with MDT re: suitability for SAMS.
6.	Is the patient confused (particularly if any deficiency in short term memory) or is their judgement impaired?			If yes, not for SAMS level 3 until this resolves. Level 2 might be appropriate in some circumstances.
7.	Is their medicine regimen stable? (Frequent medicine or dose changes will make SAMS difficult)			If no, consider remaining at level 1 until more stable.
8.	Does the patient understand the following about their prescribed medication: <ul style="list-style-type: none"> ▪ the purpose of the medicine? ▪ the dosage and special instructions? ▪ the common possible side effects? ▪ what to do if a dose is missed? 			If no, Level 1 until educated by nursing/pharmacy staff. Patient information leaflets are available at http://emc.medicines.org.uk A prompt card can be produced by pharmacy staff if needed.
9.	Does the patient have any difficulty in reading the label on their medication packet?			Only move to level 2 or 3 once this has been addressed (with large print labels or vision aid).
10.	Has the patient been given an information leaflet about self-administration of medicines?			If no, give leaflet before progressing from level 1.
11.	Does the patient understand the principles of safe storage of medicines, including their responsibility for safekeeping of the locker key(s)?			If no, do not give the patient custody of medicines.

Based on the patient's knowledge of their drug treatment plus the other assessments as above, please circle the level of supervision that you recommend for this patient.

Level 1

Level 2

Level 3

I know of no reason why the patient should not participate in SAMS at the level indicated

Patient assessed by: (signature).....PRINT.....

DesignationDate.....

File in nursing documentation once complete.

Appendix D

CARE PLAN FOR INPATIENTS WITH DIABETES INCLUDING AN ASSESSMENT OF SELF CARE

Name _____ Hospital Number _____

<p>SELF CARE Assess the patients wishes regarding managing their own diabetes during this admission.</p> <p>Have your brought your own equipment into hospital?</p> <p>Are there any physical/manual dexterity/eyesight difficulties or mental health issues that may impact on ability to self care</p>	<p>Do you wish to manage your own diabetes whilst in hospital?</p> <p>YES NO</p> <p>YES NO</p> <p>YES NO</p>
<p>FOOT CARE</p> <p>Please perform a visual examination of both feet, Remember the heels.</p>	<p>Is there</p> <ul style="list-style-type: none"> • An Ulcer • Inflammation • Swelling • Infection • Acute pain in the absence of trauma <p>One or more of these signs and a referral should be made to podiatry via the TV website.</p> <p>Referred date: _____</p>
<p>Usual Insulin Regime</p> <p>Ask the patients' normal meal time patterns Ensure patient aware of mealtimes on ward. Usual Timing of meals:</p> <ul style="list-style-type: none"> • Breakfast • Lunch • Evening Meal • Snacks <p>What would you have as a snack?</p>	

If the patient wishes to self care the following assessment must be performed

If the patient performs their own insulin injection
Assess injection technique.

- Loads pen fill cartridge
- Mixes insulin
- Attaches Needle
- Dial Dose
- Giving injection
- Site rotation
- Sharps disposal
- Insulin Storage

Record the following

- Insulin injection device
- Needle length
- Frequency of needle change
- Injection site

Self Care assessment tool for blood glucose monitoring

What is your normal blood glucose range?

What is your normal blood glucose testing regime?

On admission to the ward observe the patient perform their own BM.

Name of meter:

- Wash hands
- Calibrate meter
- Preparing finger pricker
- Inserting strip
- Obtaining good blood sample
- Applying blood
- Reading Results
- Recording Result
- Disposal of equipment

Ensure the patient is able to maintain an up to date Diabetes Chart.

Discharge Planning

Have you got a fully functioning blood glucose meter at home?

(N/A for Type 2 on diet/metformin)

YES

NO*

Have you an adequate supply of test strips and lancets (at least one week)?

YES

NO*

Ensure patient has an adequate supply of pen needles and is **fully aware of discharge dose of insulin.**

*Contact DSN for advice.

Ensure patient has an adequate supply of insulin

syringes and has their **discharge dose of insulin clearly documented for the attention of the district nurse**

Has the patient a pending appointment with their regular diabetes care provider?
Ensure discharge summary is sent to their regular diabetes care provider

Date _____ Sign _____

Appendix E

Guidance on Assessment of Patients

Selection of patients suitable for self-administration of medicines should be a multi-disciplinary process. Medical staff, nursing staff or pharmacists may assess patients for self-administration in order to decide when to commence the self-administration programme. Consider simplifying the medicine regime or using compliance aids (e.g. Haleraid, large print labels, non child-resistant closures, medipack) if this would be helpful for the patient.

Carers are able to administer medication under the scheme, if required, following assessment.

The following guidance is offered to assist in selecting those patients who are able to self-medicate:

- Patients should be willing to self-administer their own medication on the ward.
- Patients should be reasonably medically stable.
- Patients should be responsible for their own medication at home or plan to be.
- If a carer is to be responsible for medication at home they may administer medication under the self-administration scheme, and should undergo the same assessment as a patient.
- To self-administer safely at level 2 or 3 patients should as a minimum be able to:
 - Recognise their medication (by name or appearance)
 - Know when to take it
 - Understand the correct dose
 - Have some appreciation of its purpose.
- Patients who have a limited capacity to understand the process of self-administration and retain the information, e.g. those with a degree of confusion, need not be excluded from self-medication. These patients should be assessed using the abbreviated mental test (Appendix I). If they score 6 or less, self-administration may not be appropriate at that time, particularly if short term memory is impaired. The decision for the patient to self-medicate should be made by members of the multidisciplinary team in consultation with the patient and carers/family. Episodes of acute confusion or delirium must be resolved before entering the self-administration scheme.
- A multidisciplinary team decision should be taken regarding whether a patient who is a known substance abuser should be allowed to self-administer some or all of their medication. It may be appropriate to spend more time at levels 1 and 2 before progressing to level 3.
- Patients who have communication difficulties, sensory impairment or who do not use English as their first language should not be excluded from the programme. Every effort should be made to ensure that they understand their medicines through the use of accessible methods of communication or an interpreter.

Appendix G

Guidance on Medicines Management

Exclusion of medicines from self-administration

Controlled drugs (including Oramorph oral solution 10mg/5ml and ketamine) must be excluded from self-administration. Advice on excluding other medicines from self-administration for individual patients follows below.

- Medicines prescribed on a 'when required' basis – consider how urgently it might be needed and whether it has been requested recently by the patient.
- Drugs with varying doses (e.g. warfarin, digoxin) - consider how stable the regimen is presently and whether the patient is likely to know what dose is due that day. There may be supplementary prescription charts in use, and these must be checked. If the dose is not stable, these medicines should not be self-administered.
- Refrigerated items - the pharmacist / pharmacy technician can check which are suitable for storage in the bedside medicine locker. The expiry of the product may need to be reduced when it is removed from the fridge.

Patients unsuitable for participation in SAMS

- There may be times when the patient will be temporarily unable to participate in SAMS e.g.; nil by mouth, peri-operatively, sedation. Following an explanation to the patient, they should be returned to level 1 (nurse administration) and re-assessed at an appropriate opportunity. The aim should be to return the patient to level 2 or 3 as soon as they are able.
- If a patient is assessed as not suitable to participate in SAMS on admission due to a clinical condition which is deemed to be temporary, the nurse should periodically re-assess their suitability during the in-patient stay.
- The following strategies can facilitate self-administration
 - modify labels or packaging
 - simplify the medicine regime by eliminating unnecessary prescriptions, changing medicines or using modified release preparations.
 - educate the patient to improve their knowledge about their medicines
 - use supervised administration sessions to improve their understanding of medicine doses and frequency
 - input from pharmacist or specialist nurse to improve techniques or attitudes
 - input from pharmacist to identify intentional and unintentional barriers to concordance with medicines.

If a patient makes a mistake at level 3

- If the patient is at risk of harm from the error, the nurse who discovers it must inform the patient's doctor immediately.
- Establish the cause of the error by questioning the patient and looking at the prescription, the patient-held record of medicines and the labelled medicine.

- Take steps to reduce the chance of the error happening again (for example: patient education, changing the directions on the medicine label or (if it is identified that the patient lacks the ability or understanding for level 3) step down to level 2 of the self-administration programme).
- Complete a DATIX report about the error.

Discharge planning

A competent member of staff (pharmacist, pharmacy technician or nurse trained by pharmacy in the assessment of patients own drugs) must assess if the patient's current self-administration supplies are suitable for discharge, or whether further supplies should be issued by Pharmacy.

A three way check (of discharge medication list against inpatient medicine chart and the labelled medicines) should be carried out immediately before discharge to ensure that the medicines and the discharge list are correct and complete.

Appendix H

Guidance on Patient Agreement

Patient Agreement

Written agreement of the patient or carer (when the carer will be administering medicines) must always be sought prior to starting a self-administration of medicines programme.

At level 2 and 3, the patient (or carer) should be aware and agree that they are taking responsibility for administering their medicines whilst in hospital.

At level 3, the patient (or carer) should be aware and agree that they are also taking responsibility for safe custody of the medicines (and that they must return the key to the nurse for safe-keeping if they leave the ward for any reason).

Adult agreement (over 18 years of age)

Only patients who have capacity are able to state their agreement. This means that they should be able to:

- Understand what is being said to them.
- Believe what is being said to them.
- Retain what is being said to them.

Patients who have a limited capacity to understand the process of self-administration and retain the information, e.g. those with a degree of confusion, may still be considered for involvement in a self-administration of medicines programme if it is in their best interest to do so. A confused person should not progress to level 3 unless their capacity improves. It is good practice to discuss self-administration with the patient's family and others close to the patient before instigating the self-administration programme in these cases.

The completed assessment and consent forms should be retained in the patient's bedside folder.

Carer agreement

In the case of a carer being involved in a self-administration of medicines scheme, agreement should be gained from:

- The **patient** agreeing to participate in the programme
- The **patient** agreeing to the carer being the person to administer the drugs
- The **carer** agreeing to administer the drugs as part of a self-administration programme.

There may be times when a patient cannot state their agreement to participate or for their carer to administer drugs to them under a SAMS. The carer may still participate in the scheme if the multidisciplinary team believes it to be in the patient's best interests. The carer must be assessed as competent and agree to participate in accordance with the policy.

Agreement of children

Patients aged less than 18 years are excluded from this policy.

Withdrawing agreement

The patient or carer should be made aware that they are able to withdraw agreement at anytime.

The patient or carer should be aware that they are able to ask the nursing staff to give medication at any time.

The patient or carer should be aware that upon reassessment the nurse may at any time take over the administration of medicines of the patient or move them between the levels of the self-administration programme.

Appendix I

Patient agreement for self-administration of medicines

Patient		
Unit No.	DOB.	
Consultant	Ward	Hosp.

Use patient sticker if available

The self-administration scheme has been explained to me and I have had the chance to ask questions.	Yes / No
I have read the information leaflet provided.	Yes / No
I understand the need for keeping medicines safely locked away and the need to keep the locker key on my person at all times when I am on the ward. If I leave the ward for any reason I will give the key to my nurse for safe-keeping. (Delete if not appropriate)	Yes / No
I understand that the nurses may have to take over the administration of medicines if I am not able to do it safely for any reason.	Yes / No
I understand that I can stop self-administering my medicines if I wish. If that happens I will tell a nurse, doctor or pharmacist.	Yes / No

I agree to take part in the self-administration programme

Patient's signature Date

Carer's signature (if applicable) Date

Healthcare practitioner witnessing signature(s)

Signature Date

Name (BLOCK capitals) Job title

Appendix J

Information for patients and/or carers on self administration of medicines

Self-administration is a scheme that allows you to take your own medicines (or give medicines to the person you usually care for) whilst in hospital. It is also a chance to find out more about your medicines and how to take them.

Before taking part you can discuss with your nurse, pharmacist or doctor what self-administration involves and what benefits there may be for you (or the person you care for).

Self-administration is not compulsory and you do not have to take part if you do not wish to.

If you agree to take part, a nurse or pharmacist will assess your suitability, and ask you to sign an agreement form.

A personal supply of medicines labelled with directions will be given to you. If your medicines from home are suitable they may also be used. Your doctor will tell you and your nurse if they make changes to your medicines. Pharmacy will change the tablets or label to match the new instructions from your doctor.

The medicines will usually be kept in the secure medicine locker beside your bed. If you are looking after the key to your medicine locker, you must keep the key in a safe place.

For various reasons there are some medicines that cannot be self-administered whilst in hospital. For example, it is the law that morphine has to be kept in the ward medicine cupboard and checked by qualified nurses.

If you are unsure about how many tablets to take or when to take them, (or if you have any other questions about the medicines) please ask your doctor, nurse or pharmacist.

Remember medicines can be dangerous if not used properly.

If any visitor or patient tries to take your medicines (or the key to your bedside cabinet) **please tell a nurse immediately.**

Medicine name	Why you are taking it	How much and how often	Any common side effects and what to do about them	Special instructions	How long to take it for	Date, name and signature of doctor making change(s) to this chart

Completed by(name & signature) Checked by(name & signature) on (date)

Appendix K

ABBREVIATED MENTAL TEST

Please ask the patient the following 10 questions		Correct	Incorrect
1	Tell the patient an address and ask them to remember it until later in the test.		
2	What age are you?		
3	The time to the nearest hour		
4	The present year		
5	The name of this hospital/place		
6	Recognise two people (Doctor/nurse/visitor)		
7	Their date of birth		
8	A historical date e.g.; the Second World War		
9	Name the present monarch		
10	Count backwards from 20		
	Ask the patient to repeat address from number 1		
	Total		

Score one point for each correct answer, there are no half marks.

Score of 6 or less suggests impaired cognition. Please discuss suitability of patient for self-administration with the multidisciplinary team.

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Self Administration of Medicines Policy	Policy Author:	Julia Blagburn, Lead Clinical Pharmacist, Older Peoples' Medicine
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)		
	• Race *	No	Assessment for inclusion not influenced by this characteristic
	• Ethnic origins (including gypsies and travellers)	No	Assessment for inclusion not influenced by this characteristic
	• Nationality	No	Assessment for inclusion not influenced by this characteristic
	• Gender *	No	Assessment for inclusion not influenced by this characteristic
	• Culture	No	Assessment for inclusion not influenced by this characteristic
	• Religion or belief *	No	Assessment for inclusion not influenced by this characteristic
	• Sexual orientation including lesbian, gay and bisexual people *	No	Assessment for inclusion not influenced by this characteristic
	• Age *	No	Assessment for inclusion not influenced by this characteristic
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *	No	Assessment for inclusion not influenced by this characteristic
	• Gender reassignment *	No	Assessment for inclusion not influenced by this characteristic
	• Marriage and civil partnership *	No	Assessment for inclusion not influenced by this characteristic
2.	Is there any evidence that some groups are affected differently?		Patient's not deemed competent will not be included in the scheme
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	n/a	
4(a).	Is the impact of the policy/guidance likely to be negative? (If "yes", please answer sections 4(b) to 4(d)).	n/a	
4(b).	If so can the impact be avoided?	n/a	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	n/a	
4(d).	Can we reduce the impact by taking different action?	n/a	

Comments:	Action Plan due (or Not Applicable):
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Name and Designation of Person responsible for completion of this form: Steven Brice, Assistant Director of Pharmacy

Date: 12/7/11

Names & Designations of those involved in the impact assessment screening process:
 (If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)