

**RISK ASSESSEMENT FOR SELF ADMINISTRATION OF MEDICATION – YOUNG PERSON**

**HALTON BOROUGH COUNCIL**

**PEOPLE DIRECTORATE**

**FOSTERING SERVICE**

**RISK ASSESSMENT FOR SELF ADMINISTRATION OF MEDICATION – YOUNG PERSON**

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| **NAME** **CARERS ADDRESS****CONTACT DETAILS** **NAME OF NURSING SPECIALIST /PROFESSIONAL (OTHER)****CONTACT DETAILS** |  |
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**This assessment must take into consideration medical advice; the young persons; the foster carer’s and the social workers views. The review of this assessment should be incorporated within the care planning process.**

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| **1. What is the medication?** |
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| **2.** **Does the young person want to self-administer? Y/N** |
| **3. Has the young person been responsible for their medication at home or in previous placements? Y/N** |
| **If yes give details** |
| **4. Does the young person recognise the medication by name or appearance? Y/N** |
| **5. Does the young person know when to take it? Y/N** |
| **6. Does the young person have some appreciation of its purpose?**  |
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| **7. Does the young person understand the implications of not taking the medication?**  |
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| **8. Is the young person able to understand the information leaflet provided with the medication?** **Have they red this or had this explained to them? Y/N** |
|  |
| **9. Does the young person understand the need for keeping medication stored safely?**  |
|  |
| **10. What support from the carer if any will the young person require?** |
|  |

**Signed**

**Young person**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signed**

**Foster Carer/s**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Confirmation of agreement seen and checked**

**Signed**

**Young person’s social worker**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**