|  |  |  |  |
| --- | --- | --- | --- |
| Child’s name |  | Child’s date of birth |  |
| Children’s Home |  | Name of Assessor |  |
| Date completed |  | Role of Assessor |  |
| Date to be reviewed |  | Date of last medication review |  |

**Please use this form to assess the child’s ability to self-administer their medication.**

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| --- | --- | --- | --- | --- |
| Could the child administer their own medication (with or without support) | | | Yes \*2 / No \*1 | |
| **\*1** If no, is this the view of other key adults involved in the child’s care (parent/carers, GP, social worker, LAC Nurse)? | | | Yes / No / Partly | |
| Please provide details of anyone who does not agree with this view **(NB. If there is disagreement, the child will not be permitted to self-administer their medication**) | | |  | |
| **\*2** If yes, what level of support would the child require: | | | | |
| Help to know which medication to take | | | Yes / No | |
| Help to know how much to take | | | Yes / No | |
| Help to know how to take the medication | | | Yes / No | |
| Help to know when to take it | | | Yes / No | |
| Help to physically take the medication | | | Yes / No | |
| Other (please state): | | | Yes / No | |
|  | | | | |
| Does the child understand the consequences of **not** taking their medication or of not following advice of their GP? | | | Yes / No | |
| Can the child make choices and communicate them clearly and reliably, using resources/aids as required? | | | Yes / No | |
| Can the child identify each medication by sight, with support of visual aids as necessary? | | | Yes / No | |
| Does the child need any additional training on administration of medication? | | | Yes / No | |
| Date provided |  | Date training due | |  |
| Has the child’s competency to self-administer been observed by a trained practitioner? | | | Yes / No | |
| Date of competency assessment |  | Name of person observing competence | |  |

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| **Are their history or lifestyle factors that would affect the child’s ability to self-administer medication?** (ie. history of overdose; difficulty swallowing). |
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| **Would the self-administration of medication by the child present any risks to other children in the home?** If yes, give details. |
| Notes: Self-medicating children must be reminded of the risks to others if medicines are left lying around. |
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| **Recording the administration of medication** |
| Notes: A MAR chart must be used until it has been established that the child is self-administering in a confident and competent way. This may mean initially the child signing the MAR with each self-administration and staff checking and countersigning that the medicine has been taken as prescribed. Following on-going review, this may be reduced to a weekly or monthly check by staff until it agreed that a MAR chart is no longer required |
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| **How and where will medicines be stored?** |
| Notes: This should be in a lockable cupboard or drawer in the medication cupboard or child’s room. The child should be able to get any medication that needs special storage e.g. fridge items at the right time. There are medicines that may be better kept by the child using the service (e.g. asthma relievers). Storing these away from them may delay treatment. This must be included in the individual risk assessment. |
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| **Responsibilities of the residential staff** |
| Notes: describe what level of supervision will be in place and for how long; and what will happen if there any concerns arise that the child is not self-administering or storing their medication correctly |
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| --- | --- | --- | --- | --- | --- |
| **Current medications and how to take them** | | | | |  |
| Name | Dosage | Time to be taken | Route to be taken | Other important information | Can the child self-administer this medication? |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |
|  |  |  |  |  | Yes / No |

We hereby consent that the above named child will be supported to self-administer their medication following the guidelines described above. We understand that this arrangement will be reviewed every 6 months, or after any medication incident or error and may be withdrawn depending on any change in the identified risks.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Child |  | Signature |  | Date |  |
| Name of Parent/s |  | Signature |  | Date |  |
| Name of Assessor |  | Signature |  | Date |  |
| Name of Registered Manager |  | Signature |  | Date |  |
| Name of LAC Nurse |  | Signature |  | Date |  |
| Name of Social Worker |  | Signature |  | Date |  |