CARE 24/7 HEALTHCARE

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MM13

Medication Risk Management Plan - Service User

This Form provides a record of how a service user's medication is to be managed.

A: DETAILS OF SERVICE USER / G.P. / PHARMACY	
Name of Service User:	**Date of Birth:**
Address & Contact Number of Service User:	**G.P. Name:**
	G.P. Telephone Number:
	Pharmacy Name & Telephone Number:
Person completing this Form:	**Contact Number:**
Date of Assessment:	**Date for Review:**

B: ASSESSMENT OF MEDICATION PLAN		
Is the Service User aware of any allergies to medication?	YES ☐ / NO ☐	If YES, state which medicines:
Does the Service User self-administer prescribed medication?	YES ☐ / NO ☐	
Are family members / others providing support with medication?	YES ☐ / NO ☐	

Does the Service User need Level 1 or Level 2 assistance with any of the following medicines?

TYPE OF MEDICINE	SELF-ADMINISTRATION				LEVEL 1 ASSISTANCE				LEVEL 2 ASSISTANCE			
	M morning	L lunch	T teatime	E evening	M	L	T	E	M	L	T	E
Oral – tablets, capsules												
Oral – liquids, syrups												
Topical – ointments												
Topical – patches												
Eye drops / Ear drops												
Inhalers												
Nasal drops / sprays												

Does the Service User need any Level 3 Specialist Administration Techniques? **Level 3 Specialist Administration Techniques must only be carried out by an appropriate Health Care Professional**	☐ YES / ☐ NO

TYPE OF MEDICINE	SELF-ADMINISTRATION				ADMINISTRATION BY HEALTH CARE PROFESSIONAL				ADMINISTRATION BY DOMICILIARY CARE WORKER			
	M	**L**	**T**	**E**								
Injections												
Pessaries												
Suppositories / Enemas												
Oxygen Therapy												
via P.E.G.												

Comments / Action Required:

C: OBTAINING SUPPLIES OF MEDICATION

How does the Service User order medicines from the G.P.?				How will medicines be obtained from the pharmacy or dispensing surgery?			
Ordered by the Service User	Ordered by Family / Friend	Pharmacy	Care Worker	Collected by S/User	Collected by Family / Friend	Delivered	Collected by Care Worker

D: MEDICATION ADMINISTRATION SYSTEMS

How is the Service User's oral medication provided?

MDS / dossette box filled by the pharmacy?	☐ YES / ☐ NO	
MDS / dossette box filled by family member or others (specify):	☐ YES / ☐ NO	
In original containers, clearly labelled:	☐ YES / ☐ NO	
Is a MAR Chart needed to record administration, and is this available?	☐ YES / ☐ NO	
Is there any other additional equipment required for administration?	☐ YES / ☐ NO	
Is this available in the Service User's home?	☐ YES / ☐ NO	

Comments / Action Required:

E: STORAGE & ACCESSIBILITY OF MEDICATION AT THE SERVICE USER'S HOME	
Usual storage location of medicines in the Service User's home:	
Date-expired medicines present in the Service User's home:	☐ YES / ☐ NO
Excess medicines present in the Service User's home:	☐ YES / ☐ NO
If YES, can family / other / Care Worker return medication to the G.P. or dispensing pharmacy?	☐ YES / ☐ NO
Does any medication require special storage; e.g.in the refrigerator?	☐ YES / ☐ NO
Can the Service User access their medication?	☐ YES / ☐ NO
Is there an assessed risk of tampering with medication and / or an overdose risk?	☐ YES / ☐ NO
Can the Service User open medication containers with ease?	☐ YES / ☐ NO
Does additional secure storage need to be considered for the medication?	☐ YES / ☐ NO
If YES, summarise action needed to minimise risk; e.g. need for a lockable box – discuss need with G.P.:	
Does the Service User need medicines left out to be taken later when carers are not present?	☐ YES / ☐ NO
Any assessed risks (children / pets / forgetting to take the medicine, etc)?	☐ YES / ☐ NO
If YES, summarise action needed to minimise risk:	

F: SUMMARY COMMENTS & SIGN-OFF

Signature: _____ *Name (PRINT):* _____ *Date:* _____