

**APPENDIX 2  
INFORMATION AND ASSESSMENT/CONSENT FORM FOR PATIENTS PARTICIPATING IN  
THE HOSPITAL SELF-ADMINISTRATION SCHEME AS PART OF A REHABILITATION  
PROGRAMME (SELF-ADMINISTRATION SCHEME B)**

Dear Patient,

A self-administration programme is offered on this ward to allow patients to be responsible for taking their own medicines.

Self-administration is not compulsory and you need not feel that you have to take part.

Your own medicines from home will be used where suitable. Any other medicines you require will be given to you from the hospital pharmacy.

Your medicines will be locked in your medicine locker and you will be responsible for keeping the key in a safe place and out of sight.

All your medicines should have your name, the name of the medicine and instructions on how often to take them on the label. Use your medicines according to these instructions.

If you have any questions regarding your medicines, please ask one of the nursing staff or the ward pharmacist.

Please remember to give the key to your nurse before you go home

**Please do not hesitate to ask a member of staff if you are unsure about any of the information provided on this sheet.**

Thank you.

**ASSESSMENT FORM FOR PATIENTS ENTERING SELF-ADMINISTRATION SCHEME B AS PART OF A REHABILITATION PROGRAMME**

Addressograph label
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Ward.....
Date.....

*To be completed by ward staff assessing patient's ability to self-medicate- tick boxes as appropriate.*

QUESTION	YES	NO
<b>Does the patient wish to self-admin?</b>		
<b>Is the patient responsible for administering his or her own medicine at home?</b>		
<b>Can the patient access their medication?</b>		
<b>Can the patient read the label?</b>		
<b>Can the patient access the POD locker?</b>		
<b>Does the patient understand the purpose of the medicines?</b>		
<b>Does the patient understand the dosage and any special instructions?</b>		
<b>Is the patient mentally competent?</b> Consider any risk of confusion/emotional upset/drug abuse/any other anticipated problems		
<b>Is the ward environment safe?</b> Are there any other patients in the bay likely to cause problems with the key/drug custody		
<b>Has the patient read and understood the information provided explaining self-administration?</b>		
<b>Has the patient signed the consent form and has it been placed in the notes?</b>		
<b>Has the drug chart been endorsed with "self-admin (Level 1,2 or 3)"?</b>		
<b>Depending on the above responses the named nurse/midwife should assign the patient to self-administration level 1, 2 or 3</b>		

COMMENTS / ISSUES
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FORM COMPLETED BY: NAME.....  
SIGNATURE.....  
GRADE.....  
DATE.....

FILE THIS ASSESSMENT FORM IN PATIENT'S HEALTHCARE RECORDS

See overleaf for consent form

**CONSENT TO SELF-ADMINISTRATION OF MEDICINES AS PART OF A REHABILITATION PROGRAMME**

**(Self-administration scheme B, cont.)**

I..... have read and understood the information sheet regarding self-administration and am willing to take part in the scheme.

I understand that I may withdraw from this scheme at any time by informing my named nurse and that continual assessment on my ability to take part in the scheme will be made by staff responsible for my care.

Signed .....

Witnessed .....  
(sign and print)

Designation .....

**Date**.....

**THIS CONSENT FORM MUST BE FILED IN THE  
PATIENT'S HEALTH CARE RECORD**