MEDICATION SELF-ADMINISTRATION ASSESSMENT

Instructions: Using the Guidelines for Administering the Medication Self-Administration Assessment, check the appropriate response for each question below. Upon completion of questions, add score and determine if resident is able to self-administer medications without supervision, self-administer medications with assistance or if medications must be administered by staff. Report any resident stated side effects to Resident Care Director or designee for consultation with family, pharmacist and/or physician, as appropriate..

STEP 1: SCREENING QUESTIONS Resident Name :

Prior to beginning the assessment, answer the following questions by placing a √ in the appropriate box.

A. Does resident choose to have staff administer medications?

Yes □ No □ Not Applicable □ If yes, ask resident to sign this assessment

B. Does resident's cognitive and/or functional status preclude his/her ability to self-administer medication?

Yes □ No □

If yes, √ the appropriate box(s) below,:

□ Cognitive Impairment as indicated by a Mini-Mental Score of _____. (score ≤ 18 indicates impairment)

□ Functional Impairment Explain:_____

STEP 2: ASSESSMENT

ASSESSMENT CRITERIA	Yes(3)	Yes, if Assisted(2)	No(1)
1. Is resident able to demonstrate how he/she takes medications? Includes showing use of compliance packaging, reading labels and directions and opening containers, as applicable.			
2. Does resident know the medications he/she takes?			
3. Does resident know when to take his/her medications?			
4. Does resident know reason for taking medication?			
5. Is resident able to administer medications properly? eg. Insulin/syringe, Eye Drops or Inhalers			
6. Is resident able to store medications properly?			
7. Is resident aware that his/her medications may have side effects?			
8. Does resident state that he/she is having side effects from his/her current medication? Please check (√) all that apply: □ Dizziness — Changes in: □ Changes in Vision — □ Appetite □ Memory Problems — □ Sleep Patterns □ Confusion — □ Bowel/Bladder Habits (circle if only one) □ Tremor — □ Stomach Comfort □ Unsteadiness/Balance Problems — Other _____ (Report any stated side effects to Resident Care Director or designee)			
STEP 3: SCORE : (Sum of point value of non-shaded √'d boxes)			

STEP 4: ASSESSMENT RESULTS (Circle the range of score that applies)

Score	Description
17 – 21	Shows ability to safely self-administer with no supervision (May answer "no" to questions 4 and/or 7)
14 – 16	Shows ability to safely self-administer with low level of cueing or assistance
8 – 13	Requires moderate degree of cueing or assistance
≤ 7	Requires constant cueing/assistance. Requires staff or agency administration of medications.
Any item √'d in #8	Recommend contact with family, pharmacist and/or physician for consultation

It is recommended that this resident : (√) appropriate box below.

□ Self-administer medications with no supervision

□ Self-administer medications with assistance. Describe level of assistance needed here:

_____

□ Have medications administered by staff or agency.

□ Resident Chooses to have staff assist with/administer medications

This assessment was completed by: Date:

Resident Signature: Date: