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Assessment for Resident Self-Administration of Medications

1. Does the resident have the cognitive and functional abilities to self-administer medications? ❑ Yes ❑ No, if their answer is No, explain: ___________________________ then skip *Assessment Criteria*, complete sign and date below. BIMS Score from the most recent MDS 3.0 is 13-15-cognitively intact: ❑ Yes ❑ No

2. Resident has requested to self-administer medications? ❑ Yes ❑ No if Yes, proceed with Assessment

3. Administration of the following medications to be assessed:____
____
_

*Note: If resident requests only Self-Administration of Respiratory Inhalants, proceed to Page 2

Instructions: Proceed by checking the appropriate response in the categories below. The resident must be able to perform each step indicated prior to beginning self-administration of medications.

ASSESSMENT CRITERIA	N/A	Un-Able	Needs Assist	Able
Resident demonstrates ability to open and lock medications in room				
Resident demonstrates proper hand hygiene				
Resident demonstrates ability to read the MAR				
Resident demonstrates ability to open medication containers				
Resident can verbalize identification of each medication				
Resident verbalizes reason/condition for each medication				
Resident verbalizes proper dose of each medication				
Resident verbalizes proper route of each medication				
Resident verbalizes proper time(s) for medication administration				
Resident verbalizes special instructions for administration (i.e. with meals, amount of fluids, etc.)				
Resident verbalizes potential side effects for each medication				
Resident verbalizes indications when to notify the nurse				
Resident verbalizes indication(s), dose, timing and special considerations for prn medications				
Resident demonstrates ability to measure appropriate dose of medication from the container				
Resident demonstrates medication administration of each medication				
Resident demonstrates ability to swallow medications without difficulty				
Resident demonstrates correct procedure for eye drops or eye ointment administration if ordered and included in self-administration				
Resident demonstrates correct procedure for application of topical ointments or creams if ordered and included in self-administration				
Resident demonstrates appropriate practice with transdermal patch removal and application as ordered				
Resident demonstrates correct procedure with ear drop administration if ordered and included in self-administration				
Resident demonstrates correct procedure with SQ injection if ordered and included in self-administration				
Resident demonstrates documentation of administration				
Resident verbalizes notification to nurse for medications not administered as ordered (omitted, late, early, wrong dose, etc.)				
Resident verbalizes notification expectations for medication refusals				

Resident Name: ____ **MR#** __________ **Room#**_________

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Resident demonstrates locking medications after administration				

For Self-Administration of Respiratory Inhalants, attach the "Self-Administration of Respiratory Inhalants" Form

❑ Yes ❑ No

Does the resident have a diagnosis that may interfere with ability to self-administer?

❑ Dementia ❑ OBS ❑ Depression ❑ Schizophrenia ❑ Bipolar disorder ❑Parkinson's ❑ Legally blind

❑ Recent changes in the resident's medical and decision-making status

Other: ____

Results:

❑ The resident is assessed to be able to safely self-administer medications by the Interdisciplinary Team

❑ The resident is assessed unable to safely self-administer medications, for the following reasons:

____
____
____

❑ The resident and representative have been notified of the decision made by the IDT

❑ MD order obtained if resident deemed capable to Self-Administer Medications

❑ Physician notified of inability to self-administer medications

❑ Order received to discontinue order to self-administer medications (for change of status)

❑ If resident assessed as not safe to self-administer medications, options for participation in administration include:

____
____
____

❑ Care Plan updated to reflect Medication Administration status

Comments: ____
____
____

Assessment completed by: _____________________________________ ___________________

Signature Date

Resident Name: ____________________________________ **MR#** __________ **Room#**_________

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Self-Administration of Medication Resident Worksheet

Date:_____________

Medication	Dose	Route	Time(s)	Diagnosis	Side effects

Resident Name: ____ **MR#** __________ **Room#**_________

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**Keep in locked area with medications for resident reference

Resident Name: ____ **MR#** __________ **Room#**_________

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