MEDICATION ASSESSMENT & SUPPORT PLAN

Name of Individual	
D.O.B	
Address of Individual	
Date of Assessment and Support Plan	
Name of Creative Support Assessor	
Any other relevant persons involved **(to include any LPA – Health and Well Being)**	
Date for Review : (annually or following any changes to medication regime/ hospital discharges)	
The outcome of any **Mental Capacity Assessments and Best Interests Decisions** in respect of medication should be clearly highlighted here.	

Guidance Notes: The medication assessment and support plan can be completed by any member of staff who has been appropriately trained. The assessment should be completed with individuals who have been identified as requiring any level of medication support. This need may have been identified through a statutory assessment, by a health worker or prescribing medical practitioner, by the individual receiving support or a member of their circle of support (including staff members)

Medication support, is any support that an individual requires to manage their medication, this may include members of their family, other providers and health care professionals being actively involved.

Creative Support will only take responsibility for managing a person's medication if the overall assessment highlights this is required. Where possible individuals should be encouraged and supported to actively participate in their medication regime.

The following assessment must be completed in line with the following Creative support's policies:

Mental Capacity Act
Medication Support in Community Settings
Local medication policies (if applicable)

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Medication Assessment – Prescribing				
Current GP: **Tel No:**	**Current Pharmacist:** **Tel No:**			
	YES	**NO**	**DON'T KNOW**	**COMMENTS**
Does the individual currently have medication prescribed? If yes, please note below the medication and current prescriber.				

Name of medication (state if liquid, tablet, patch, eye drops, cream etc.)	**Dosage**	**Prescriber (i.e. GP, Consultant, Dentist)**

Any areas of 'don't know' must have actions highlighted	**YES**	**NO**	**DON'T KNOW**	**COMMENTS / AGREED ACTIONS / SUPPORT PLAN**
Does the individual have any nutritional supplements or thickeners that are prescribed? If yes, please ensure they are noted above. **Please note agreed support and if a SALT plan is in place / referral required for SALT**				

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Does the individual need / want to make any changes to their GP or Pharmacist? If so please note changes in comments.				
Please note discussion on the individuals understanding of why they are taking medication				
Medication Assessment-management of medication (ordering, delivery and storing)				
Any areas of 'don't know' must have actions highlighted	**YES**	**NO**	**DON'T KNOW**	**COMMENTS / AGREED ACTIONS / SUPPORT PLAN**
Does the individual currently order their own medication? If no, please note who currently completes this task and what action should be taken should medication not be ordered/arrived.				
Does the individual feel capable of ordering their own medication? If not, please note why.				
Does the individual have a preference in terms of who they would like to order their medication? **Please note agreed support /action**				

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Does the individual currently store their own medication in their own home? If yes, please note where.				
Any areas of 'don't know' must have actions highlighted	**YES**	**NO**	**DON'T KNOW**	**COMMENTS / AGREED ACTIONS / SUPPORT PLAN**
Is the medication currently felt to be stored in a safe place? If no, please note discussions about alternative storage. **Please note agreed support /action**				
Are there any requirements for lockable storage in the individual's home, if yes, please note where and who will supply this.				
Are there any concerns about other people visiting the home in terms of safe storage of medication? If yes, please comment.				
Are there any requirements for medications to be stored in the fridge. If so, clearly note which these are.				
Does the individual currently collect their medication from the pharmacist?				

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If yes, does the individual wish to continue to do so?				
Any areas of 'don't know' must have actions highlighted	**YES**	**NO**	**DON'T KNOW**	**COMMENTS / AGREED ACTIONS / SUPPORT PLAN**
Does the individual have any preferences about medication collection / delivery? **Please record agreed support / action.**				
Does the individual manage their own medication returns? If no, who will be completing this action **Please record agreed support/ action- to include any controlled drugs or disposal of needles/ syringes.**				
Management of medication – Administration				
Any areas of 'don't know' must have actions highlighted	**YES**	**NO**	**DON'T KNOW**	**COMMENTS/AGREED ACTIONS/ SUPPORT PLAN**
Does someone already administer medication to the individual? **Please provide information on who and detail information in the next section of agreed support.**				

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Does the individual currently administer some or all of their own medication? **Please give information. if assistance is required detail agreed support in the next section**				

Which of the following tasks can the individual do without support and where / what needed?

Task	Self	Family	Staff	Other	N/A	**Detailed plan (include any prompts or support required, administration by others, preference on times, if applicable (before or after breakfast) what individuals would like to take with medication (water, juice, food) what environment individuals would like to be in (bathroom, bedroom etc.) and any other environmental factors, wishes or preferences that can be accommodated.**
Reading instructions						
Opening bottles						
Being aware of side effects						
Administering tablets						
Administering eye drops						
Administering inhalers						

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Application of patches						
Administering liquid medication **(Ensure correct syringe is used)**						
Task	Self	Family	Staff	Other	N/A	**Detailed plan (include any prompts or support required, administration by others, preference on times, if applicable (before or after breakfast) what individuals would like to take with medication (water, juice, food) what environment individuals would like to be in (bathroom, bedroom etc.) and any other environmental factors, wishes or preferences that can be accommodated.**
Administering of specialist medication **(please include time sensitive medication, warfarin, PEG nebulizers, oxygen etc)**						
Administering PRN medication (**please highlight where PRN protocols are required/ completed)**						
Administration of over the counter medication **(please refer to policy)**						
Covert medication administration- **(please refer to policy)**						
Taking blood sugar readings						
Administering medication via EpiPen						

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Monitoring medication compliance **Please highlight what staff should do if medication is refused or tenants are not at home**						

Medication –Communication and Compliance				
Any areas of 'don't know' must have actions highlighted	**YES**	**NO**	**DON'T KNOW**	**COMMENTS/AGREED ACTIONS/SUPPORT PLAN**
Does the individual have a court appointed LPA for health and well-being? If yes**, please note** who in the comments and request a copy of this court appointment				
Are there multiple agencies working with the individual in respect of medication (e.g. day services)? **Please note**				
If yes to the above, does the individual give permission for Creative Support to communicate with other relevant agencies in respect of medication? **Please note**				
Does the individual want staff to discuss their medication with family members or other members of their circle of support? **Please note details**				
Does the individual require their medication to be monitored? If yes by whom and how? **PLEASE INCLUDE:**				

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• **CTO actions where required** • **Warfarin clinic details/ plan** • **Time sensitive medication** • **Other specialist medication that requires monitoring.**				
Does the individual feel confident in raising concerns about their medication?				
Does the individual require support to request a review of medication or to make GP appointments? **Please record agreed support/ action**				
Please note any discussions in relation to communication, monitoring or reporting concerns about the individuals medication				

Name of person present	Relationship to individual	Signature	Date

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