Self-Medication Flow Chart on Fettle Ward

**PRE ADMISSION ASSESSMENT**
Before admission assess patient’s concordance with medication and potential to meet Level 1 of self-medication on Fettle Ward

**Level 1 – ADMISSION and ASSESSMENT**
**Target** - Patient is given the opportunity to be concordant with medication and presents consistently at the right time for medication.
Nurse remains responsible for administering and recording administration on drug card
Self-Administration Assessment is completed and Pharmacy Team provide patient’s own medication information folder.

Patient concordant with Level 1 for 2 weeks and rarely misses a dose move on to Level 2

Patient non-concordant with Level 1 continue to support with Level 1 and review at MDT meeting

**Level 2 – DURING ADMISSION**
**Target** - Patient self-medicates from individual drawers using labelled medication in clinic room under direct supervision of nurse.
Nurse continues to record administration on patient’s drug card at each administration time.
**Target met** - Patient comes to clinic room at the right time without prompting, reads and understands labels, can pop out tablets, use inhalers or can use the system they have chosen for self-medication under direct supervision of a nurse.

Patient concordant with Level 2 for 2 weeks and rarely misses a dose move on to Stage 3

Patient non-concordant with Level 2 continue to support with Level 2 and review at MDT meeting

**Level 3**
see pg 2

Author: Pharmacy Team 2014
**Level 3 – PROGRESSING TO LEAVE AND DISCHARGE**

**Target** – Patient self-medicates from locked safe in own room and is progressing to leave and discharge.

After completing Stage 2 successfully for a minimum of two weeks, rarely missing a dose, self-medication to be discussed at MDT review.

CPA review to record risk assessment for medication and leave prescription written for 4 x 7 day supply.

Level of support from nursing and pharmacy team – low on ward but high in the community

**Target met** - Patient manages medication for a minimum of four weeks, with one week’s supply stored in locked safe in patient’s room. Patient may also be taking leave so going off ward with medication, supply no more than one week at a time.

Nursing team to record medication count on drug card, initially daily for at least one week, then moving to every other day for at least a week, and then weekly.

If patient has missed doses go back to previous counting regime and start this process again.

After 4 weeks of weekly self-medication without any missed doses and after a further MDT review patient will require a prescription to be prescribed by the medical team for further leave or discharge prescription to supply up to 14 days or 28 days after further risk assessment and depending on placement.

Patients will usually be using original packs of medication labelled and supplied by RCHT Pharmacy as on the ward, which contain information leaflets and have batch numbers and expiry dates.

Nursing team and Pharmacy Team to establish links with GP surgery and local community pharmacy to introduce the patient and explain to patient how repeat medication can be ordered and delivery can be arranged.

For patients who require a blister pack or want to use a Dossett box consider using a FP10 prescription to order medication from a community pharmacy and consider how the patient will get the Dossett box filled in the community.

Please note not all medication is suitable to be stored in a blister pack or Dossette box please contact the pharmacy team for further advice.

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Patient cannot fail to self-medicate as at each stage if the patient is not able to maintain self-medication as this level then the system will be stepped back to the previous stage and reviewed with patient