Medication Risk Assessment Form

Service User Name:

Address:

Telephone Number:

D.O.B:

G.P. (Name, address and contact number):

District Nurse Details:

Assessed by:
Date of Assessment:

List of current medication being taken by the Service User:

Administration

How is medication currently being administered?

If being administered by a friend/relative/neighbour, please state who and their relationship to the Service User:

If medication is to be administered by a care worker from –

a. **Is medication administered during every visit?**

b. **Who administers medication when a care worker is not present?**

c. **How is the medication currently dispensed?**

Where is medication currently stored within the home?

Is this method of administration current with MOONSTONE CARE UK and the Local Authority medication policies?

Record Keeping

Is there a MARS sheet/Medication Book/HC42 in place?

Does the Service User have regular appointments with their G.P.?

Who orders repeat prescriptions for the Service User?

If the Service User orders them, do they need to be prompted? Who currently prompts them?

Who collects repeat prescriptions from the surgery and takes them to the pharmacy?

Who delivers the medication to the Service User?

Service User Ability to comply or concur with Medication

Does the Service User have any problems with Swallowing?

Does the Service User have any physical condition that could interfere with the administration of medication?

Does the Service User suffer from short term memory loss/Dementia?

Does the Service User understand the medication they must take, when and how (particularly understanding the English language)?

Does the Service User comply with medication requests or show behaviour that would indicate occasional or total refusal?

What is the current risk level of administering medication to this Service User? **Low** **Medium** **High**
What are the main issues or risks identified, regarding administration of medication for this Service User? **Action to be taken, and by whom**

Risk Assessed by----------(signature)

Information regarding
Medication administration given by---------- (Service user/representative Signature)

Date: ----------