EVALUATION FOR SELF-ADMINISTRATION OF MEDICATIONS

INSTRUCTIONS: Before conducting this evaluation, verify that there is a physician order in the resident's record for self-administration of the specific medication under consideration and that the resident has signed the appropriate document(s) stating the desire to self-administer his/her own medication. Proceed by checking the appropriate response below for each of the items listed. The resident must be able to perform each step indicated below prior to beginning self-administration of medications. The interdisciplinary team will be responsible for approving self-medication using this evaluation as a guide.

EVALUATION CRITERIA	FULLY CAPABLE	ABLE WITH ASSIST/PROMPT	UNABLE	NOT APPLICABLE
1. Correctly states name of each medication and what it is used for				
2. Able to read print on prescription label				
3. Correctly states common side-effects of each medication				
4. Correctly states what time medications are to be taken				
5. Correctly states the proper dosage for each medication				
6. Demonstrates proper handwashing prior to and following medication administration				
7. Correctly measures the prescribed amount of medication from the container				
8. Correctly documents self-administration of medications				
9. Demonstrates secure storage for medication kept in room				
10. Correctly states situations warranting administration of PRN medication(s)				
11. Correctly documents the administration of PRN medications				
12. Correctly requests medications stored at nurses' station				
13. Able to open and close medication containers				
14. Correctly administers eye drops or eye ointments				
15. Applies topical ointments, creams or transdermal patches correctly				
16. Demonstrates removal and proper disposal of transdermal patches				
17. Administers ear drops correctly				
18. Administers suppositories correctly				
19. Administers inhalant medications correctly				
20. Administers subcutaneous injections correctly				

This evaluation was completed by____________________ __________
Signature/Title Date

INTERDISCIPLINARY TEAM EVALUATION

Date reviewed__________ BIMS Score (00-15) _____ PHQ-9© Score (00-30) _____

Approval granted to self-administer: ❍ Yes ❍ No, explain why not approved____________________

INTERDISCIPLINARY TEAM SIGNATURES

Signature/Title	Date	Signature/Title	Date

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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