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| Learning to Self-Administer Medication Teaching/Support Plan  Page 1 of 3 |

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| **Individual**: |  | **Date**: |  |

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| Criteria (Taken from the ‘Self-Administration of Medication Skills Determination/Assessment’ Tool used): |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Individual meets criteria for the learning to self-administer process:** | **YES** |  |  | **NO** |  | | |  | | | | | | |

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| Goal (include timeline for goal achievement): |
| **Specify what this will mean for this individual:** |
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| Medication Administration Skills (Taken from the ‘Self-Administration of Medication Skills Determination/Assessment’ Tool): |
| **Specify Medication Administration Skill(s) to be addressed**: |
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| Learning Objective(s): |
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| Teaching Plan/Documentation: |
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| |  | | --- | | Learning to Self-Administer Medication Teaching/Support Plan |   Page 2 of 3 |

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| **Individual**: | |  | |
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| Supports Needed for the Individual Learning to Self-Administer Medication.  Check all applicable boxes: | | | | |
| Obtaining their medication (e.g., from the pharmacy). | | | | |
| Storing their medication so that it is inaccessible to others. | | | | |
| Understanding the reason the medication is being taken. | | | | |
| Knowing when and how to take the medication. | | | | |
| Understanding common side effects. | | | | |
| Removing pills from pharmacy labeled medication container (Individual removes medication from the pharmacy labeled medication container). | | | | |
| Placing medication into ‘pill-organizer’ (Individual places medication from pharmacy medication container into pill-organizer). | | | | |
| Tracking Tool used when the Medication is taken (e.g., Individual places check mark on chart or calendar). | | | | |
| Knowing when and how to dispose of medication. | | | | |
| |  |  | | --- | --- | | Other: |  | |  | | | | | |
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| Designate Supports Needed (which require the assistance of Certified Staff).  Check all applicable boxes: | | | | |
| Prompts needed and when: | | |  | |
| A Certified staff is required in-person and when: | | |  | |
| Assistance with Aids, (e.g., Smartphone, Tablet, Timer, Watch, etc.) are needed and when: | | |  | |
| Other: |  | | | |
|  |  | | | |
|  |  | | | |
| Designate how the Individual, who is Learning to Self-Administer their Medication, is Monitored by Certified Staff.  Check all applicable boxes: | | | | |
| Certified staff assists when medication is received from the pharmacy. | | | | |
| Certified staff observes each time medication is taken. | | | | |
| Certified staff observes each time medication is packed in the ‘pill-organizer’ by individual. | | | | |
| Certified staff conducts periodic pill counts. | | | | |
| Certified staff reviews the individual’s medication Tracking Tool method (e.g., calendar, etc.). | | | | |
| Certified staff checks the pill-organizer for contents, if any, when returned (and documents, as applicable). | | | | |
| Other: |  | | | |
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|  | | |
| Date: | |  |
| Signature: | |  |
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| |  |  | | --- | --- | | |  | | --- | | Self-Administration of Medication Teaching/Support Plan Form |   Page 3 of 3 |  |  |  | | --- | --- | | **Individual**: |  | |
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| Self-Administration Goal was Met |
| |  | | --- | | When the Individual meets the Goal Criteria for Self-Administration, check the box below, add comments, date, and signature (as applicable): | | Individual meets all criteria as listed in ‘MAP Policy No. 20-1’ for self-administration of their medication and is deemed ‘self-administering’ of their medication**.** | |  | |
| |  |  | | --- | --- | | Comments: |  | |  |  | |
| |  |  | | --- | --- | | Date: |  | | Signature: |  | |
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| Follow-up: |
| |  |  | | --- | --- | | After the Individual is deemed ‘Self-Administering,’ describe what system(s) will be used if the Individual becomes ‘Unable to Self-Administer’ for a Period of Time: | | | Certified staff will administer medication from pharmacy labeled medication containers. | | | Other: |  | |  |  | |
| |  |  | | --- | --- | | Comments: |  | |  |  | |

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| Individual’s Signature |  | Date |
|  |  |  |
| Site Supervisor’s Signature |  | Date |
|  |  |  |
| Service Coordinator/Case Manager (or designee) Signature |  | Date |