



M 2.5
Monthly Medication Audit

Name:
 D.O.B.
 Address:

Audit Requirements	Date Completed	Initial
Check integrity of ALL medication is stable (ie not discoloured, out of shape, squashed, melted, broken, evaporated, leaking, packaging is intact)		
Medication is stored within the required temperature range as identified in product information documentation		
Check ALL medications have not exceeded their expiry date (where applicable)		
Check ALL packaging is clearly labelled with the persons name, address, date of birth, name of the prescribing medical practitioner, date of supply and expiry date		
Check packaging is clearly labelled with instructions for use including dose, frequency and any special considerations or requirements		
Check all medications have been ratified in writing on a Doctors authority form. Including a signature, instructions and indications for use, commencement and cessation date for each medication		
Check if valid consent has been sought for all medications		
Check all ongoing PRN medications including blister pack sheets, ointments, syrups and lotions are checked to see that enough medication is available for future use. The coordinator/senior worker is to be notified of any medications that need re-ordering. Staff take immediate action to ensure that medication that is required is supplied.		
Check general information on the reason for use, side effects and contraindications for each medication is available for the staff and service users to access.		
Check all medication is stored according to the requirements of this policy, Including: distinctly labeled separate storage of active and non-active medications, secure locked cupboards or drawers available.		
Childproof container labelled "for disposal" is available and stored securely		
Key register is utilized		
Medication administration record sheets, medical authority's and Medication support plans (where required) are located in a folder where they are clearly visible and accessible to staff for use during medication administration		

Actions required	Person responsible	Completion date

Checklist Completed By: _____ Date Completed: _____

Coordinator/Senior Worker: _____ Date: _____