Better Together Mesa

MEDICATION ERROR REPORT

THIS DOCUMENT IS SUBJECT TO CONFIDENTIALITY REQUIREMENTS AND SHOULD BE HANDLED ACCORDINGLY

Please Print All Information Clearly and Use One Form For Each Occurrence

Report Date (mm/dd/yy):

Agency/Provider: Group Home Family Home Supported Living Other

Address: City: State: AZ Zip:

Date of Med. Error (mm/dd/yy):_____ Time:_____ Location of Occurrence:

Individual Completing This Report: Title: Signature: _____

Name of Staff Member Involved: Title:

Consumer: Participant ID#: DOB (mm/dd/yy):

Name of Medication: Dose: Times Given:

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Type of Medication Error Involved:

____ Medication Given to the Wrong Person
____ Wrong Dose of Medication Given
____ Newly Prescribed Order Not Initiated within 24 hours
____ Medication Refill Not Ordered Timely (no doses missed)
____ Shift to Shift Count on Controlled Medication Not Accurate
____ Medication Administration Record Not Accurately Documented
____ Other

____Wrong Medication Given
____Medication Not Given
____Medication Not Given at the Right Time
____Family Error
____Client Refused Medication

Description of Incident and Required Medical Nursing Care:

Immediate Action/ Intervention:

Notification:

Physician or ARNP Name(Must be notified):_____ PHONE:_____

Family/Guardian Support Coordinator Name: (Must be notified)

Abuse Registry Developmental Disabilities Office Other-List:

This Section to be Completed by Supervisory Personnel

Follow-up/Corrective Action Plan taken:

Name: Title: Signature: _____Contact Phone Number:

RESOLUTION STATMENT: