MEDICATION ERROR REPORT

Resident Name: ________________________________________________ Apt: _____________

Date of Incident: ____/____/______ Medication ___________________ Time of Incident: ______ A.M. P.M.

Describe the incident (please attach any evidence associated with this report):

________________________________________________________________________________________________________
________________________________________________________________________________________________________

Immediate Actions Taken

☐ Resident Monitoring ☐ MD/NP/PA orders followed
☐ Sent to ER ☐ Seen by MD/NP/PA in office
☐ Licensed nurse instructions followed (indicate instructions given):

________________________________________________________________________________________________________
________________________________________________________________________________________________________

Person discovering incident: ________________________________/_________________________________

Print Name                                    Sign Name

Error Review

☐ No Error (Potential)

Type of Incident ("No Error" checked, do not indicate type)

☐ Medication Omission ☐ Wrong Technique
☐ Wrong Dose ☐ Wrong Route
☐ Wrong Dosage Form ☐ Wrong Time
☐ Wrong Resident ☐ Monitoring Error
☐ Clinical ☐ Deteriorated Drug Error
☐ Other: ____________________________________________________________________________

Cause/Causes

☐ Communication ☐ Drug Name Confusion
☐ Labeling ☐ Packaging
☐ Knowledge Deficit ☐ Performance Deficit
☐ Recopying MAR ☐ Transcription Error
☐ Other: ____________________________________________________________________________

Corrective Action/Actions

☐ Policy and procedure reviewed (attach evidence) ☐ Training held (attach evidence of training)
☐ System reviewed & corrected ☐ Discipline action taken (attach evidence)
☐ Issue discussed with pharmacy ☐ Other: ______________________________________________________________________

Summary of Findings (including outcome to resident):

________________________________________________________________________________________________________
________________________________________________________________________________________________________

________________________________________  ______________________________________
Administrator  RN Signature

☐ Notified MD/NP/PA Date: __/__/__ Time: _____ A.M. P.M. Whom: __________________________
☐ Notified Resident/Family Date: __/__/__ Time: _____ A.M. P.M. Whom: ______________________
☐ Notified RSD Date: __/__/__ Time: _____ A.M. P.M. Whom: _______________________________