agency for persons with disabilities
State of Florida

Agency for Persons with Disabilities

# 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: ___ Zip: _____

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

Individual Completing This Report: _____ Title: _____ Signature: _____

Name of Staff Member Involved: _____ Title: _____ Medication Certified? Yes ☐ No ☐

Consumer: _____ SSN: _____ Date of Birth (mm/dd/yy): _____

Name of Medication: _____ Dose: _____ Times Given: _____

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Name of Medication: _____ Dose: _____ Times Given: _____

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
- ☐ Wrong Medication Given
- ☐ Medication Not Given
- ☐ Medication Not Given at the Right Time
- ☐ Family Error
- ☐ Client Refused Medication
- ☐ Other _____

Description of Incident and Required Medical Nursing Care:

_____

_____

_____

Immediate Action/Intervention:

_____

_____

Notification:

- ☐ Physician or ARNP Name: _____ (Must be notified)
- ☐ 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 taken or Plans:

_____

_____

Name: _____ Title: _____ Signature: _____

Contact Phone Number: _____

_____

***This Section to be Completed by Department***

Date Report was received by DD Office (mm/dd/yy): _____

Follow-up Recommended by DD Office:

_____

_____