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

|  |  |
| --- | --- |
| Client: | Date of Birth (mm/dd/yy): |

|  |
| --- |
| **Discovery Type: Provider reported  APD discovery  QIO discovery  Other  (describe):** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Please Print All Information Clearly and Use One Form For Each Occurrence*** Report Date (mm/dd/yy):       Time | | | | | | | |
| Agency/Provider Name:  Group Home  Family Home  Supported Living  Independent Living  Day Program  Other | | | | | | | |
| Address: | | City: | | | | State: FL | Zip: |
| Individual Completing This Report: | | | Title: | | Signature: | | |
| Name of **all** Staff Members Involved **(use additional pages if needed):** | | | | | | | |
| Name: | Title: | | | Medication Validated? Yes No | | | |
| Name: | Title: | | | Medication Validated? Yes No | | | |
| Name: | Title: | | | Medication Validated? Yes No | | | |

**Error Made by RN or LPN? Yes No  IF Yes, Name of Nurse:**

**ALL MEDICATIONS INVOLVED IN ERROR MUST BE LISTED. USE ADDITIONAL PAGES IF NEEDED.**

**Describe all errors involving times in description of incident.**

**DATE OF ERROR:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication: | Dose: | Time Given: | **Total doses involved:** |
| Name of Medication: | Dose: | Time Given: | **Total doses involved:** |
| Name of Medication: | Dose: | Time Given: | **Total doses involved:** |

**ARE ANY OF THE MEDICATIONS LISTED CONTROLLED SUBSTANCES: YES  NO**

**Type of Medication Error Involved: Please select the option that best fits the type of error. If you select “Other”, please explain**

|  |  |
| --- | --- |
| **Wrong Medication Given\***  Administration of medication for any symptom, illness, or reason  For which it was not prescribed **(wrong reason = wrong medication)**  Administration of medication for which there is no current  prescription or MD order  **Wrong Dose of Medication Given\***  Administration of an incorrect dose of medication  Administration of more than one dose of the same medication in a  scheduled time period  **Medication Given to the Wrong Person\* (**Administration of  medication prescribed for someone else)  **Medication Not Given at the Right Time\***  **Wrong Route\***  **Medication Administration Record Not Immediately and**  **Accurately Documented**  **Medication given by staff not validated per 65G-7.004** | **Shift to Shift Count on Controlled Medication Not Accurate**  **Other error (except not given)**  Administration of expired or improperly labeled  Medication  **Medication Not Given\* (select reason not given below)**  Client refused medication Legal Rep. refused for client  Failed to give  Medication not available **(select reason not available below)**  New order not initiated within 24 hours  Refill not ordered timely  Insurance Issue  Pharmacy Issue  Family Error (Explain)  Other not given reason (Explain)  **\***  **Error type starred above must be reported to healthcare practitioner** |

**Did medication error result in MD or ER Visit or Hospitalization? Yes No  IF Yes, include explanation in description below**

Description of Incident and Immediate Action or Intervention (Include any medical care required): **WHO WHAT WHEN WHY HOW**

|  |
| --- |
|  |

**If medical care required, please describe care and current status of individual**

|  |
| --- |
|  |

Notification:

Physician, PA, or APRN Name:       (Must be notified **for errors starred above**)

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

Abuse Registry Developmental Disabilities Office Other-List:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## This Section to be Completed by Supervisory Personnel (APD Provider)

Follow-up/Corrective Action taken or Plans **(to prevent future occurrence)**: **Select from options below**

65G-7 Medication Administration Re-training and validation required Verbal warning to staff by provider

Focused -training by Provider on 65G-7 Written warning to staff by provider

Technical assistance by MCM Counseling to staff by provider

Provider policy written/trained Insurance issue

Staff no longer allowed to give medications Physician issue

Staff Terminated Other (Explain in WHO WHAT WHEN HOW section)

Pharmacy issue

**WHO WHAT WHEN HOW of Corrective Action taken** or Plans to prevent future occurrence

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| Name of Supervisory Personnel: | | Title: |
| Signature: | Contact Phone Number: | |

## This Section to be completed by Department (APD/MCM)

Date Report was received by DD Office (mm/dd/yy):      **Total doses involved in all:**

Follow-up Recommended by DD Office:

**65G-7 Medication Administration** Re-training and validation required\* Verbal warning to staff by provider

Focused -training by Provider on 65G-7 \* Written warning to staff by provider

Technical assistance by MCM Counseling to staff by provider

Provider policy written/trained Insurance issue

Staff no longer able to give medications Physician issue

Will accept provider’s follow-up/corrective action Other (Explain in notes section)

Pharmacy issue

**\*Please complete and submit documentation of training to the Area office MCM by** **.**

**It is the recommendation of the APD MCM that the following person(s) take the above mentioned training:**

|  |
| --- |
|  |

**Date APD-recommended follow-up completed:** **Date provider-recommended follow-up completed:**

Notes:

|  |
| --- |
|  |