MEDICATION ERROR REPORT

DESCRIPTION OF MEDICATION ERROR

Date of error:_____ Time of error:_____ ❍ AM ❍ PM Date of report:_____

Physician notified? ❍ No ❍ Yes, Name:_____ Date:_____Time:_____ ❍ AM ❍ PM

If No, explain why not:_____

DON/Supervisor/Manager notified? ❍ No ❍ Yes, Name:_____ Date:_____Time:_____ ❍ AM ❍ PM

If No, explain why not:_____

Pharmacy notified? ❍ No ❍ Yes, Name:_____ Date:_____Time:_____ ❍ AM ❍ PM

If No, explain why not:_____

Resident/Representative/Family notified? ❍ No ❍ Yes, Name:_____Date:_____Time:_____ ❍ AM ❍ PM

If No, explain why not:_____

Medication ordered:_____

Description of error - record name of medication, dose, route and time(s) administered:_____

_____

Outcome to resident (provide details including care provided after error):_____

_____

ASSESSMENT AND SUMMARY OF MEDICATION ERROR

Type of Error

❑ Wrong medication
❑ Wrong dose
❑ Wrong dosage form
❑ Wrong time
❑ Wrong route
❑ Wrong resident
❑ No physician order
❑ Dose missed
❑ Failed to follow manufacturer's specs or accepted professional standards
❑ Other:_____

Reason(s) for Error

❑ Transcription error
❑ Misread order
❑ Miscalculated dose
❑ Mismeasured dose
❑ Pharmacy error
❑ Failure to identify resident
❑ Self-medication error
❑ Other:_____

Corrective action taken:_____

_____

Measures taken to prevent the recurrence of similar error(s):_____

_____

	SIGNATURE	TITLE	DATE
Person making error			
Person finding/reporting error			
Director of Nursing/ Health Services			
Attending Physician			
Medical Director			
Pharmacist			
Administrator/Manager			

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed