Macomb County Community Mental Health
MEDICATION ERROR FORM

CONSUMER: **Case Number:** **Date of Birth:** **Gender: F M**

CATEGORY OF ERROR/ DISCRIPANCY:

MEDICATION ADMINISTRATION ERROR o Medication omitted o Medication administered at wrong time o Wrong consumer/resident received medication o Wrong medication administered o Wrong dose administered o Wrong route of administration o Wrong form of administration o Medication given without physician order o Medication given without following instructions o Medication given after physician order discontinued o Consumer allergic to medication administered	**CHARTING DISCREPANCY** o Error in transcribing order o Failure to list on MAR o Failure to initial MAR o Signature omitted from MAR o Sign –out error (narcotics) o Sign-out error (non-narcotics) o No current informed consent o Other **DISPENSING** □ **ERROR** □ **DISCREPANCY** o Wrong medication dispensed o Wrong dose/concentration dispensed o Expired drug dispensed o Wrong drug form dispensed o Wrong quantity is formulated o Medication not dispensed	**PRESCRIBING** □ **ERROR** □ **DISCREPANCY** o Consumer/Resident allergic to medication o prescribed o No current Informed Consent o Unclear/Illegible order o Incorrect drug o Incorrect drug dosage o Incorrect drug form o Incorrect drug quantity o Incorrect drug route o Incorrect drug concentration o Incorrect rate of administration o Incorrect instructions for use of drug

Self Medication Level in the care plan: ( ) Yes ( ) No N/A Level: ( ) I ( ) II ( ) III

Has there been any change in the consumer's living situation in the past 7 days?
□ Yes □ No

If yes, describe
____

Was the consumer on leave of absence (LOA) when the medication error occurred? □ Yes □ No

Medication/s Lists: including name and dosage

All medications Prescribed	All medications Received	All medications not received

Please, list any additional medications in a separate sheet.

STAFFING:

Staffing-consumer ratio: (excluding supervision) at time of incident: ( ) 1:1 ( )1:2 ( )1:3 ( )1:4 ( )1:5 or more

Staff involved was: (check all that applies)

- o New hire (less than 6 months)
- o Regularly assigned to a different site or location
- o Working over 8 hours that day
- o Working after regular hours shift
- o Working weekend
- o Working Holiday
- o Working in an understaffed site

Was supervisor/ manager available at site when the incident happened? [ ] Yes [ ] No

Did the consumer need any medical care or observation as a result of the medication error (check one):

- o Yes: Explain:

  ____

- o No

Was the consumer sent for medical care (check one): ( ) Yes ( ) No ( ) N/A

- o Outpatient clinic
- o Urgent Care
- o ER

Was the consumer admitted to a hospital as a result of the medication error (check one):

- o Yes
- o No
- o N/A

Persons notified:	Name/Title	Date/Time	Response
Consumer			
Family/ guardian			
MD (Required)			
RN/ Pharmacist			
Supervisor			

Vital Signs: Blood Pressure: ___________ Pulse Rate: _______ Respirations: _______ Temperature: _______

	Name/Title	Phone	Signature	Date
Person completing form PRINT				
Witness PRINT				