MEDICATION OCCURRENCE REPORT

Name of Individual: _____ **Region:** _____ **DOB:** _____

Date(s) of Occurrence: _____ **Time of Occurrence:** _____ ☐ AM ☐ PM

Certification Address: _____ **Name of Provider Agency:** _____

Type of Service: He-M 1001 ☐ 507 ☐ 518 ☐ 521 ☐ 524 ☐ 525 ☐ Other _____

MEDICATION ERROR
- ☐ Wrong Med
- ☐ Wrong Time
- ☐ Wrong Dose
- ☐ Wrong Person
- ☐ Wrong Route
- ☐ Omission

DOCUMENTATION ERROR
- ☐ Med log error
- ☐ Controlled Drug Count not done
- ☐ Controlled Drug Count incorrect
- ☐ Other _____

OTHER CONCERNS
- ☐ Missing med
- ☐ Unauthorized person administered med
- ☐ Other _____

REFUSAL-
Use regular incident report form & notify

Name of Medication(s) Involved	Dose:	Frequency:	Route:	Purpose of Medication:

Describe what happened (including any impact to individual):

Name, Date & Time Nurse Trainer was notified: _____ **By Whom:** _____

Instructions received from Nurse Trainer: _____

Action(s) Recommended by Medical Professional & Taken by Authorized Provider (person authorized to administer meds)

Who was notified (Include name, date/time and method of contact) (Guardian notification, if applicable):

Name	Relationship to individual	Date	Time	Method of contact
	Service Coordinator		☐am ☐pm	
	Program Supervisor		☐am ☐pm	
	Guardian(s)		☐am ☐pm	
	Prescribing Practitioner		☐am ☐pm	

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Report written by: _____ **Date:** _____

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Name of Individual: _____ **Date(s) of Occurrence:** _____

TO BE COMPLETED BY THE PERSON RESPONSIBLE FOR THE OCCURRENCE:

Person responsible for Medication Occurrence: _____

Describe How and Why the Occurrence Happened:

_____

_____

_____

_____

Suggestions to prevent future occurrence:

_____

_____

_____

Signature of Person Responsible: _____ **Date Completed:** _____

NURSE TRAINER REVIEW: to be completed by Nurse Trainer

Type of Occurrence: _____

Cause of Occurrence: _____

_____

_____

_____

Immediate Actions taken in regard to this situation/ Authorized Provider (e.g. corrective action):

_____

_____

_____

_____

Systemic Recommendations to prevent future occurrence(s):

_____

_____

_____

_____

Signature of Nurse Trainer: _____ **Date Completed:** _____

MANAGEMENT REVIEW: to be completed by Program Director/ Designee

Review of Authorized Provider and Nurse Trainer Response & Include any Additional Follow-up:

_____

_____

_____

_____

Signature of Program Director/Designee: _____ **Date Completed:**

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