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

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	

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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