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:

|  |
| --- |
|       |