agency for persons with disabilities
State of Florida

Agency for Persons with Disabilities
MEDICATION ERROR REPORT

APD Use Only: Log #:_____
If APD discovery was NNC issued? Yes ☐ No ☐

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**

APD Form 65G-7.006 A , effective April 2019, Rule 65G-7.006, F.A.C.

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
☐Focused -training by Provider on 65G-7
☐Technical assistance by MCM
☐Provider policy written/trained
☐Staff no longer allowed to give medications
☐Staff Terminated
☐Pharmacy issue
☐Verbal warning to staff by provider
☐Written warning to staff by provider
☐Counseling to staff by provider
☐Insurance issue
☐Physician issue
☐Other (Explain in WHO WHAT WHEN HOW section)

WHO WHAT WHEN HOW of Corrective Action taken or Plans to prevent future occurrence

Name of Supervisory Personnel:	Title:
Signature:	Contact Phone Number:

APD Use Only: Log #_____

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*
- ☐ Focused -training by Provider on 65G-7 *
- ☐ Technical assistance by MCM
- ☐ Provider policy written/trained
- ☐ Staff no longer able to give medications
- ☐ Will accept provider's follow-up/corrective action
- ☐ Pharmacy issue
- ☐ Verbal warning to staff by provider
- ☐ Written warning to staff by provider
- ☐ Counseling to staff by provider
- ☐ Insurance issue
- ☐ Physician issue
- ☐ Other (Explain in notes section)

***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:

APD Form 65G-7.006 A , effective April 2019, Rule 65G-7.006,

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