THIS DOCUMENT IS SUBJECT TO CONFIDENTIALITY REQUIREMENTS AND SHOULD BE HANDLED ACCORDINGLY

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| Client:       Date of Birth (mm/dd/yy): |

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| **Discovery Type: Provider reported  APD discovery  QIO discovery  Other  (describe):** |

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| ***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**

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| **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**

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**If medical care required, please describe care and current status of individual**

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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:

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## 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

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

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## 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:**

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**Date APD-recommended follow-up completed:** **Date provider-recommended follow-up completed:**

Notes:

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