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 Use Only: Log #_____