Incident Report Medication Error

Confidential Information

Once Completed Email to your licensing agent.

Date of Incident: _____ Time of Incident: _____ ○ AM ○ PM

Member's Name (Last, First, M.I.): _____

Member's Date of Birth: _____ Member's AHCCCS ID: _____

Provider Name: _____

Provider Address: _____

_____

Describe Service Provided at time of incident:

_____

_____

_____

Name of Provider Involved (Last, First, M.I.): _____

Phone Number: _____

Provide a description of the event and how it was detected?

_____

_____

_____

_____

Does this incident involve more than one medication? ◉ Yes ○ No

Provide a list of the Medication(s) involved in the incident:

Medication Name	Dosage Prescribed	Dosage Administered (Given)	Frequency Prescribed	Frequency Administered (Given)	Route Prescribed	Route Administered (Given)	Time Due	Time Administered (Given)

How many doses were administered in error? _____

How many doses were missed in error? _____

Does the Member administer their own medications? ◯ Yes ◯ No

Did the Member refuse to take or report not taking their medication? ◯ Yes ◯ No

If Yes, was the Member able to explain why they refused or did not take their medication?

_____

_____

_____

Was the medication incident related to a failure to administer medication by the provider? ◯ Yes ◯ No

If yes, why was the medication not administered? *Check all that apply:*

☐ Medication not available ☐ Medication order expired ☐ Medication does not match order

☐ Medication order unclear ☐ Medication past expiration date

Other, Explain:_____

If no, was the medication administration incident a result of any of the following? *Check all that apply*

☐ Incorrect Medication ☐ Incorrect Member ☐ Incorrect Dose ☐ Incorrect Time

☐ Incorrect Route ☐ Incorrect or no documentation

Other, explain:_____

Did the Member vomit or spit out their medication after it was given? ○ Yes ○ No

If yes, was the prescriber contacted for further instructions? ○ Yes ○ No

Provide name of prescriber contacted:_____

Describe instructions received:

_____

_____

_____

Describe the members condition before the medication incident:

_____

_____

_____

Describe the members condition after the mediation incident:

_____

_____

_____

Was any action taken? ○ Yes ○ No

If no, please explain why action was not taken/not needed?

_____

_____

_____

If yes, were any of the following individuals contacted? *Check all that apply*

☐ Pharmacist ☐ Primary Care Physician ☐ Nurse Practitioner/Physician's Assistant

☐ Poison Control Nurse Line_____

☐ Other_____

Were instructions provided? ○ Yes ○ No

If yes, please provide a detailed description of the instructions received:

_____

_____

_____

Were the instructions followed? ◯ Yes ◯ No

If no, why not?

_____

_____

_____

Was 911 called? ◯ Yes ◯ No

Was the Member transported by ambulance to an Emergency Department? ◯ Yes ◯ No

If Yes, Name of Hospital_____ City_____ State_____

Was the Member discharged from the Emergency Department?

◯ Yes ◯ No Not known at time incident report was completed by staff

Was the Member admitted to the hospital?

◯ Yes ◯ No ◯ Not knows at time incident report was completed by staff

Was the Member taken to Urgent Care? ◯ Yes ◯ No

Possible Cause of Contributing Factors: *(Select all that apply)*

- ☐ Lack of Knowledge
- ☐ Illegible prescription
- ☐ Look alike/sound alike medications
- ☐ Wrong labeling/instruction
- ☐ Use of unapproved abbreviations
- ☐ Miscommunication
- ☐ Failure to adhere to work procedures
- ☐ Missing Documentation
- ☐ Other_____

Intervention Taken: *(Select all that apply)*

- ☐ Medical services provided
- ☐ Member Education/training provided
- ☐ Informed staff made error
- ☐ Corrected dose/frequency
- ☐ Communication process improved
- ☐ Policy/procedure reviewed, revised
- ☐ Staff education/re-education provided
- ☐ Behavioral Health Services Provided
- ☐ Other_____

No action taken, provide a detailed explanation:

_____

_____

_____

Medication Administered by: Name_____ Title_____

Medication error identified by: Name_____ Title_____

Prescriber Name: _____ Contact Information: _____

☐ Prescriber Type ☐ MD/DO ☐ Nurse Practitioner
☐ Physician Assistant ☐ Other_____

Pharmacy Name: _____

Pharmacy Address(including city and state) : _____

_____

Notifications:

Parent/ Guardian Notified: ◯ Yes ◯ No ◯ N/A- No appointed Guardian

If yes, name of person notified:_____

Relationship to Member: ☐ Parent ☐ Guardian ☐ Public Fiduciary
☐ TSS Case Worker

Date of Notification: _____ Time of Notification _____ ◯ AM ◯ PM

If no, explain why:

_____

_____

_____

Support Coordinator Notified: ◯ Yes ◯ No

If yes, name of person notified:_____

Date of Notification: _____ Time of Notification _____ ◯ AM ◯ PM

If no, explain why:

_____

_____

_____

Protective Services Notified: ◯ Yes ◯ No ◯ N/A

If yes, please indicate all agencies notified:

☐ Adult Protective Services (APS) ☐ Department of Child Safety (DCS)

☐ Tribal Protective Services ☐ Other

Date of Notification_____ Time of Notification _____ ◯ AM ◯ PM

Report made via: ☐ On-Line ☐ Telephone ☐ Fax

If made via telephone, name of person receiving the report:_____

Report #_____

If No or N/A, explain why:

_____

_____

_____

Law Enforcement Notified: ◯ Yes ◯ No

If no or N/A, explain why:

_____

_____

_____

If yes, how was Law Enforcement notified: ☐ 911 call ☐ Non-Emergent call

Date of Notification: _____ Time of Notification_____ ◯ AM ◯ PM

Name of Responding Law Enforcement Entity: _____

City_____ State_____ Zip Code _____

Name of the Responding Officer: _____ Badge # _____

Enforcement Report #_____

Other Agency Notified ◯ Yes ◯ No ◯ N/A

If yes, please indicate all agencies notified:

☐ Arizona Center for Disability Law (ACDL) ☐ Probation ☐ DES Case Worker

☐ Other_____

Date of Notification: _____ Time of Notification_____ ◯ AM ◯ PM