St. Clair County Community Mental Health Authority

Medication Error Report

Individual: _____ Site/Home: _____

Case #: _____ Date of Error: _____ Time of Error: _____

PROGRAM: ☐ Residential ☐ Partial Day ☐ Foster Home ☐ OP ☐ Other: _____

PLEASE CHECK ALL THAT APPLY FOR THIS ERROR and COMPLETE MEDICATION INFORMATION:

01 ☐ Wrong Consumer
02 ☐ Wrong Medication
03 ☐ Wrong Time
04 ☐ Wrong Route
05 ☐ Missed Medication
06 ☐ Wrong Dosage
1 ☐ Lower Dose
2 ☐ Higher Dose
07 ☐ Label
08 ☐ Pharmacy
09 ☐ Interpretation
10 ☐ Type of Medication
1 ☐ Oral
2 ☐ Topical
3 ☐ Injectable
11 ☐ SMMO
12 ☐ Wrong Documentation
13 ☐ Other

Medication, Dose and Frequency of Medication Involved: _____

REPORTING PERSON: *(Use additional forms to complete narrative description, if necessary)*

Person Discovering Error: _____ Date/Time Error Discovered: _____

Person Responsible for Error: _____ Time Supervisor Notified: _____

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ERROR: _____

EFFECTS ON INDIVIDUAL: _____

_____ _____

Reporting Staff Signature Date

_____ _____

Person Responsible for Error Signature Date

Name of Physician Called: _____ Time: _____ Date: _____

Physician Instructions: *(Include immediate action and directions for when the next scheduled medications are due)*

SUPERVISORS REVIEW: *(Supervisor's review includes assurance that form is correctly completed, includes all necessary signatures and routed)*

Describe the remedial action taken to prevent future reoccurrence of this error:

_____ _____

Supervisor's Signature Date

MEDICATION ERROR NURSE FOLLOW UP: _____

Fax- ATTN: Med Error Nurse (810) 985-7620

☐ Recipient Rights _____ Date

Health-Medical Form: #04-0051
Revised Date: 5/1/2023
Policy Ref: #04-001-0045, #04-003-0060, #04-003-0075
EHR: Health Services, Other Health Documents, Note: Medication Error Report