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| **MEDICATION ADMINISTRATION RECORD REVIEW**  |
| Name:  Date of review:  | Frequency of review: Months reviewed:  |
| When assigned responsibility for medication administration, the company will ensure that the information maintained in the medication administration record is current and regularly reviewed to identify medication administration errors. This review must be conducted every three months or more frequently as directed by the *Support Plan and/or Support Plan Addendum* or as requested by the person served and/or legal representative.  |
| **Review area** | **Evaluation** |
| Current medication and health related information | The person’s medications and treatments are current. [ ]  Yes [ ]  NoIndicate what is not current and how it will be corrected:      Changes to medication or treatment orders were made to the monthly medication sheet. [ ]  Yes [ ]  No [ ]  NA. If no, indicate how this will be corrected: |
| Medication errors | Upon review of the medication administration record, medication or treatment errors were identified: [ ]  Yes (complete the following section) [ ]  NoError 1Date of error: Date of discovery, if different: Type of error:Name and title of person who made the error:Who was notified about this error and when:Error 2 Date of error: Date of discovery, if different: Type of error:Name and title of person who made the error:Who was notified about this error and when: |
| Person specific information | Are there any concerns regarding the person’s self-administration of medications or treatments? [ ]  Yes [ ]  No [ ]  NA If yes, please specify what will be done to address this: Are medication errors related to the person’s refusal or failure to take or receive medication or treatment as prescribed? [ ]  Yes [ ]  No |
| Based upon this review, the company must develop and implement a plan to correct patterns of medication administration errors. If there is no corrective action needed, check here: [ ]  NA If corrective action is needed, indicate plan:    |

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Signature of person completing this form Date