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| **MEDICATION OR TREATMENT ERROR OR REFUSAL REPORT** |
| Name of person served: Date of error or refusal:        Date of discovery, if different:        |
| **Instructions*** This report will be completed if a dose of medication is not administered or treatment is not performed as prescribed, whether by error by staff or the person served or by refusal by the person.
* Staff will notify the assigned nurse or nurse consultant, if applicable or the Designated Coordinator and/or Designated Manager or designee upon the discovery of the error or refusal.

The following medication or treatment was involved in this error or refusal:Medication or treatment name(s) and order: **Staff will check the applicable boxes to indicate the nature of the medication-related event**

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| [ ]  Medication given at wrong time | [ ]  Medication was given on wrong date | [ ]  Medication refused |
| [ ]  Medication given to wrong person  | [ ]  Medication given by wrong route | [ ]  NA-not a medication-related event |
| [ ]  Incorrect medication dose given | [ ]  Medication was not given  | [ ]  Other: |

Staff will check the applicable boxes to indicate the nature of the treatment-related event

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| [ ]  Treatment not performed correctly as prescribed | [ ]  Treatment refused |
| [ ]  Treatment was not completed  | [ ]  NA-not a treatment-related event |
| [ ]  Treatment was completed on wrong date | [ ]  Other: |

Was the error that occurred as a result of staff error or the person served? [ ]  Staff: [ ]  Person served: **Follow up orders per Nurse or Doctor or ER Nurse:**   **The following notifications were made regarding the error or refusal:**Assigned nurse or nurse consultant: Date:       Designated Coordinator and/or Designated Manager or designee: Date:       Prescriber: Date:       Legal representative: Date:       Case manager: Date:       Other designee: Date:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff completing the report Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nurse Reviewing the report Date |