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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**   |  |  |  | | --- | --- | --- | | 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   |  |  | | --- | --- | | 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 |