**Nananom Assisted Living**

# INCIDENT REPORT: MEDICATION

Client's Name: _____ Client's Phone No.: _____

Date of Incident: _____Time of Incident: _____AM_____ PM

Address of Incident: _____

Name of Employee Involved in Incident: _____

Name(s) of Other(s) Involved in Incident: 1)_____

2)_____ 3) _____

Type of Medication Error/Incident (Tick relevant points):

____ Wrong Client _____ Wrong Medication _____ Wrong Dosage _____ Wrong Route
____ Expired Medication _____ Client Refused Medication _____ Wrong Storage _____ Wrong Time
____ Medication Not Located _____ Dropped/Spilled Medication _____ Pharmacy Supplied Wrong Medication
_____Directed Not to Administer Medication by _____

____ Order /Other Necessary Documentation Not Available (Name) _____

____Other (Describe) _____

Additional Details: _____

_____

Describe any reactions noted due to the Incident/error:_____

_____

When did you notice the incident/error had occurred?_____

Person(s) Notified and/or Actions Taken (Tick relevant points.):

_____ CPR ____911 ____ Poison Control Center ____ Supervisor ____ Doctor ____Other (Name):_____

Comments: _____

Actions Taken (Contacts made by employee to Supervisor, Physician, nurse, etc.):_____

_____

_____

What should be done to avoid another medication incident or error?: _____

_____

_____

Outcome: (Tick relevant point.)

____ Issue resolved - No improvements implemented
____ Improvement implemented (Explain): _____

_____

Name of Person Completing Report: _____

Phone No. of Person Completing Report: _____

Signature: _____ Date:_____ _____