

Medication Error Report

Client Name: _____

Date: _____

Agency: Center for social change

TYPE OF MEDICATION ERROR: (circle the appropriate number)

- 1. Incorrect client
- 2. Incorrect dose
- 3. Incorrect time
- 4. Missed medication
- 5. Failure to document administration of medication
- 6. Incorrect medication
- 7. Other Error

Date of error: _____

Name of Staff(s) involved in error: _____

List medications involved in the error: _____

Describe medication error: _____

THE FOLLOWING INDIVIDUALS WERE NOTIFIED:

Nurse's Name: _____ Date: _____ Time: _____

Supervisor's Name: _____ Date: _____ Time: _____

Individual writing report signature: _____ Date: _____

Supervisors (Director) signature: _____ Date: _____

If you have any questions or concerns please contact the nurse at:

DIMENSIONAL HEALTH CARE ASSOCIATES, INC.

Fax: (410) 654-1049 • Phone: (410) 654-1010 • Website: www.dhcamd.com