Medication Error Report

Client Name(s):___________________________ Agency: ______________________________

Date(s) of error: ____

*****NAME(S) OF STAFF REQUIRED PRIOR TO SUBMISSION OF THIS REPORT*****
Staff at Fault (Last name, First name): ____

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List medications/treatments involved in the error: _______________________________________

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TYPE OF MEDICATION ERROR: (circle the appropriate number)

1. CMT administered medication to incorrect individual
2. CMT administered incorrect dosage of medication
3. CMT administered medication at the incorrect time with no RN approval
4. CMT failed to administer medication
5. CMT administered incorrect medication to individual
6. CMT administered expired medication to individual
7. CMT failed to document the administration of medication
8. CMT failed to refill medications in a timely fashion resulting in missed medication
9. CMT pre-initialed MAR/blister packs resulting in missed medication
10. CMT pre-poured medications; left unattended
11. CMT failed to send medications on LOA resulting in missed medications
12. CMT failed to post new orders or implement new orders resulting in missed medications
13. CMT circled initials but failed to document on back of MAR
14. CMT failed to document reason/result of PRN medication on back of MAR
15. CMT/staff failed to perform Vital Signs
16. CMT/staff failed to document Vital Signs
17. CMT/staff failed to notify RN of findings outside of parameters
18. CMT administered medication using an expired PMOF
19. CMT failed to perform 3 way check
20. Other ____

Notes (**ONLY IF NEEDED):**

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Name of Person Writing this Report: ___________________________________

Signature of Person Writing this Report:___________________________________

Date this Report is written:______________

Updated 10/10/17