Florida GER - Medication Error Report

Type of Program:* ☐ Group Home ☐ Family Home ☐ Supported Living ☐ Other
Medication Error Date:*_____
Involved Staff Member:_____
Medication Certified?: ☐ Yes ☐No
Type of Medication Error Involved:*

- ☐ Medication Given to the Wrong Person
- ☐ Wrong Medication Given
- ☐ Wrong Dose of Medication Given
- ☐ Medication Not Given
- ☐ Newly Prescribed Order Not Initiated within 24 hours
- ☐ Medication Not Given at the Right Time
- ☐ Medication Refill Not Ordered Timely (no doses missed)
- ☐ Family Error
- ☐ Shift to Shift Count on Controlled Medication Not Accurate
- ☐ Client Refused Medication
- ☐ Medication Administration Record Not Accurately Documented
- ☐ Other: _____

This Section to be Completed by Supervisory Personnel
Name:_____
Title:_____Contact Phone Number:_____
Follow-up/Corrective Action Taken or Plans:_____
_____
_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
Note:- Required fields are marked with an asterisk (*)