Marshall County Group Homes, Inc.

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