**Illinois Department of Human Services**  
**Division of Developmental Disabilities**  
**Medication Error Report**  

**Directions:** In accord with Rule 116, CILA providers must document all medication errors. In addition, all medication errors for which there is an adverse outcome to the person receiving services must be reported to the Division of Developmental Disabilities' Bureau of Quality Management. This form must be completed for each such error. Adverse outcome errors must be faxed to (217) 782-9444 within 7 calendar days of discovery. It is not necessary to notify BQM of errors for which there is no adverse outcome. However, errors for which there is no adverse outcome must be documented, reviewed by the RN-Trainer and summarized/analyzed on at least a quarterly basis by the agency. If assistance is needed, phone BQM at (217) 782-9438.

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>Telephone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Receiving Services:</td>
<td>Date of Error:</td>
</tr>
<tr>
<td>CILA Address:</td>
<td>Date of Discovery:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Discovered by:</td>
</tr>
<tr>
<td>Medications Involved:</td>
<td>Does the person receiving services independently administer his/her own medications?</td>
</tr>
<tr>
<td>Notification:</td>
<td></td>
</tr>
<tr>
<td>Supervisor (name):</td>
<td>Date:</td>
</tr>
<tr>
<td>RN-Trainer (name):</td>
<td>Date:</td>
</tr>
<tr>
<td>Pharmacy (name):</td>
<td>Date:</td>
</tr>
<tr>
<td>Physician (name):</td>
<td>Date:</td>
</tr>
<tr>
<td>O.I.G. (name):</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**Description of Events:**

**Medication Error Type:**
- Wrong Consumer
- Wrong Drug
- Wrong Dose
- Wrong Time
- Wrong Route
- Wrong Consistency
- Wrong Technique
- Other (explain):

**Staff/Persons Involved:** (Check all that apply)
- Authorized Staff Name:
- Unauthorized Staff Name:
- RN Name:
- LPN Name:
- MD Name:
- Pharmacist Name:
- Parent/Guardian Name:
- Other Name:

**Corrective Action Taken:**

**Additional Action Needed:**

- Person served did not require medical intervention.
- Person served required medication attention. (Explain: )
- Person served required hospitalization. (Explain: )
- Person served sustained permanent harm. (Explain: )
- Person served died as a result of this error. (Explain: )

Form Completed By: (Name) ____________________________ (Title) ____________________________ (Date) ____________

Reviewed by RN-Trainer Signature: ____________________________ (Date) ____________ (Phone) ____________________________