Illinois Department of Human Services
Division of Developmental Disabilities
Bureau of Clinical Services

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 Clinical Services (BCS). This form must be completed for each such error. Adverse outcome errors must be **faxed to (217) 782-9535** within 7 calendar days of discovery. It is not necessary to notify BCS 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 BCS at (217) 785-6183.

Agency Name:	**Telephone #:**
Person Receiving Services: _____ **CILA Address:**_____ **City/State/Zip:**_____	**Date of Error:** _____ **Date of Discovery:**_____ **Discovered by:**_____
Medications Involved:	**Does the person receiving services independently administer his/her own medications?** ___**Yes** ___**No**

Notification:
Supervisor (name):_____ Date:_____ Time:_____
RN-Trainer (name): _____ Date:_____ Time:_____
Pharmacy (name): _____ Date:_____ Time:_____
Physician (name): _____ Date:_____ Time:_____
O.I.G. (name): _____Date:_____Time:_____Case #:_____

Description of Events:	**Contributing Factors:** _____ Unlocked Medications _____ Lack of Staff Concentration _____ Emergency Situation _____ Insufficient Staff _____ OTC meds purchased _____ Inexperienced Staff _____ Transcription incorrect _____ Pharmacy unavailable _____ Medication's not ordered/unavailable _____ Other (*explain*):
Medication Error Type: _____ Wrong Consumer _____ Unauthorized Staff _____ Wrong Drug _____ Med. Change/not trained _____ Wrong Dose _____ Transcription Error _____ Wrong Time _____ Pharmacy Error _____ Wrong Route _____ Documentation Error _____ Wrong Consistency _____ Omission _____ Wrong Technique _____ Refusal _____ 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 medical 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)_____

Revised 2/2017