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 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, email BCS at DHS.ClinicalServices@illinois.gov

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 _____ Wrong Drug _____ Wrong Dose _____ Wrong Time _____ Wrong Route _____ Wrong Consistency _____ Wrong Technique _____ Other (*explain*): _____ Unauthorized Staff _____ Med. Change/not trained _____ Transcription Error _____ Pharmacy Error _____ Documentation Error _____ Omission	**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)_____