CONFIDENTIAL FOR QUALITY ASSURANCE PURPOSES ONLY
TO BE COMPLETED BY THE MAS NURSE (RN/LPN)
SEND TO ADMH NDP OFFICE ONLY

Today's Date ______________ Occurrence Date ______________ Occurrence Time ________A/P

Check One: ☐ Level 2 ☐ Level 3 DIVISION: ☐ DD ☐ MI ☐ SA

Client Name/Number ______________________________________

Staff Involved ____ **RN/LPN/MAC/Other* (Circle One)**

Supervising Nurse ______________________________________ **MAS RN/LPN Contacted?** ☐ **Y** ☐ **N**

Agency ____ **Phone # ( )____ ________________**

Location ____ **(Agency/Group Home/Program Name/ County)**

Prescribing Practitioner Name/Credentials___________________________________ **Contacted?** ☐ **Y** ☐ **N**

TYPE of ERROR	**List all Medications Involved** **Provide detail description of what occurred including # of errors and cause of error**
☐ Wrong person	
☐ Wrong medicine	
☐ Wrong dose	
☐ Wrong route	
☐ Wrong time	
☐ No documentation	
☐ Wrong reason	
☐ Missed Dose	
☐ Other* (Explain)	

Consumer Outcome (What happened to the consumer? ***Be descriptive,*** from notification to resolution)

Action(s) Taken by the Nurse (What did the nurse do? ***Be descriptive,*** from notification to resolution)

ALL RETRAINING MUST BE DOCUMENTED ON THE MED ADMIN AUDIT FORM

Person completing report ______________________________________ RN/LPN DATE ____________

Definitions: Level 2- error occurred that required treatment through an ER/ED/ or unplanned MD visit
Level 3- Error occurred that required hospitalization, permanent Loss, or death

NDP OFFICE USE ONLY