**Purpose**

# To document the events of a medication error

# To provide information and statistics for the Safety Committee

# To provide information and statistics for the Quality Assurance Committee

# To reduce errors and improve resident care

**Confidentiality**

1. Medication error reports are completed by nurses or other facility personnel. The contents of such reports are to be kept confidential and used for quality assurance purposes.

# **Procedure**

\*NOTE: THIS IS NOT AN EMERGENCY CARE PROCEDURE. EMERGENCY CARE SHOULD BE PROVIDED IMMEDIATELY.

1. Stay with the resident and call for assistance
2. Provide emergency care as needed
3. Notify the physician
4. Notify responsible party of change in condition
5. Take vital signs and assess
6. Notify the nursing supervisor and/or Director of Nursing
7. Complete all information on Medication Error Report form-do not leave blanks
8. Forward the report to department supervisor immediately
9. After review, the department supervisor or Director of Nursing is to forward the report to the Administrator and notify the pharmacy per policy
10. This report is not a part of the resident's medical record
11. Check resident frequently
12. Carry out physician's orders for care
13. Report follow-up care needed to charge nurse on next shift
14. Follow-up documentation is to be done by the licensed nurse on each shift until the condition of the resident is stable