Yukon
Health and Social Services
Continuing Care

CRP SS	❒	109 Copper Road	❒
CRP A/B	❒	Home Care	❒
CRP C/D	❒	Macaulay Lodge	❒
CRP E/F	❒	TC #2	❒
CRP H/K	❒	TC #3	❒
McDonald Lodge	❒	TC #4	❒

Resident Label
or
Client name: _____
YHIP: _____
DOB: _____

MEDICATION INCIDENT REPORT *(PLEASE PRINT LEGIBLY)*

❒ Wrong person

❒ Wrong medication

❒ Wrong dose:
- ❒ Extra Dose(s)
- ❒ Omission(s)
- ❒ MAR signed as given and medication still in medication cart/WOW (Workstation on Wheels)
- ❒ Automatic stop date not followed
- ❒ Medication(s) found in client/resident room

❒ Wrong Route ❒ Wrong Time

❒ Processing Error ❒ Discontinuing Error

❒ Incomplete/Documentation:
- ❒ Missing signatures on MAR
- ❒ Narcotic Control Sheet missing signature(s)

❒ Illegible documentation

❒ Narcotic Control Sheet missing

❒ Missing medications
- ❒ Missing controlled medications ❒ Missing non-controlled medications

❒ Pharmacy error

❒ Allergic reaction

❒ Near miss

❒ Other (please explain)

MEDICATION INCIDENT REPORT

Date of Incident: _____ Time of incident: _____

Report initiated by: _____ Initials: _____ Date: _____ Time: _____

A. Involved in Incident *(specify names)*:

Staff: _____ Client/Resident: _____

Other Staff Witness: _____ Visitor: _____

Volunteer: _____ Other: _____

B. Description of Incident: *(Include location, observed details, action taken, witnesses & outcome.)*

Please print legibly attach GC PN or personal note: _____

Staff Name *(print)*: _____ Signature: _____ Date: _____

C. Follow-up Action: *(include actions taken, comments, referrals, physician's orders where applicable, etc.)*

Physician Notified: ❒ Yes ❒ No Date/Time: _____

Family Notified: ❒ Yes ❒ No Date/Time: _____

Pharmacy Notified: ❒ Yes ❒ No Date/Time: _____

Team Leader/Supervisor: _____

Name *(print)*: _____ Signature: _____ Date: _____

Program Manager:

Name *(print)*: _____ Signature: _____ Date: _____

Manager, Quality/Risk and Clinical Practice: _____

Name *(print)*: _____ Signature: _____ Date: _____

Print Clear