# MEDICATION OCCURRENCES *Department of Developmental Services*



*Individual: First Name: *Last Name:

***(* = Required Field)***

*(1) Reporting Agency:

*(2) Responsible Site:

*(3) Responsible Site Phone Number:

*(4) Supervisor Responsible for MOR Follow-up:

(4A) First Name: (4B) Last Name:

*(5) What Happened? Choose from the following:

(Omission, Wrong individual, Wrong time, Wrong medication, Wrong route, Wrong dose)

*(6) Date of Medication Occurrence: * (7) Time:

*(8) Date of Discovery: * (9) Time:

*(10) Did the Medication Occurrence Happen Over Multiple Consecutive Administrations? ☐YES ☐ NO

*(11) If Yes in #10, Number of Doses:

*(12) Staff Position of Person Giving Medication: Choose from Dictionary #1

*(13) Why Did Medication Occurrence Happen: Choose from Dictionary #2

*(14) MAP Consultant's Title: ☐Registered Nurse ☐Registered Pharmacist ☐Health Care Provider (HCP)

*(15) MAP Consultant Contacted: ☐ Yes ☐ No
(15A) First Name: (15B) Last Name:

*(16) Date Consultant Contacted: *(17) Time Consultant Contacted:

*(18) Was Medical Intervention Recommended? ☐ YES ☐ NO

(19) If Yes in 18, Check All That Apply:
☐ Lab Work ☐ Other Tests ☐Health Care Provider (HCP) Visit
☐ Clinic Visit ☐ Emergency Room Visit ☐ Hospitalization

*(20) Did any of the following situations or conditions result from the medication occurrence (Check All That Apply)?
☐ Illness ☐ Injury ☐ Death

(21) Was DPH Notified? ☐ YES ☐ NO

According to MAP Policy, DPH must be notified if any medical intervention occurred as a result of the medication occurrence. Such medication occurrences are called "HOTLINES". Answering "Yes" to Question # 18 and selecting any of the choices in Question #20 requires that DPH be notified immediately. **Submit "HOTLINES" within 24 hours of discovery.**

(22) Date DPH was Notified: (23) Time:

Individual: First Name: Last Name:

*(24) Was an Incident Report Filed as a Result of the Medication Occurrence? ☐ YES ☐ NO

(25) If Yes in 24, Incident ID, if known:

*(26) What is the agency's response to prevent this type of occurrence from happening in the future?

Choose from Dictionary #3

(27) Additional Comments (Also use if "Other" is selected in #26):

*(28) Name of Medication(s) as Ordered: (29) Dosage: (30) Frequency/Time: (31) Route

| | | | |
|---|---|---|---|
| | | | Choose from Dictionary #4 |
| | | | Choose from Dictionary #4 |
| | | | Choose from Dictionary #4 |

*(32) Name of Medication(s) as Given: (33) Dosage: (34) Frequency/Time: (35) Route

| | | | |
|---|---|---|---|
| | | | Choose from Dictionary #4 |
| | | | Choose from Dictionary #4 |
| | | | Choose from Dictionary #4 |

*(36) Number of medications supposed to be given at same time as the medication occurrence including the medication(s) involved in the medication occurrence (check one): 0
(0, 1, 2, 3, 4, 5, 6-10, 11-15)

*(37) Was there a recent change in the medication order for the medication(s) involved in the MOR? ☐ YES ☐ NO

(38) If "Yes" in #37, Date of Medication Order Change:

*(39) Can this medication occurrence be connected to a single staff person? ☐ YES ☐ NO

(40) If Yes in #39, (40A) Staff Person First Name:
OPTIONAL
(40B) Staff Person Last Name:

(41) If Yes in #39, is the staff person a regular staff member? (Select one)
☐YES ☐ NO, Contracted Relief Staff ☐ NO, Agency Relief Staff

(42) If Yes in #39, does this person regularly administer medications as part of their routine responsibility? ☐YES ☐ NO

(43) Was the person who caused the medication occurrence working their regular shift?

☐YES ☐ NO – Different Shift ☐ NO – Overtime Shift

(44) Was the person who caused the medication occurrence working at their routine site? ☐ YES ☐ NO

(45) Submitted by:

(46) Submitted date:

**SUBMIT MOR TO MAP COORDINATOR WITHIN 7 BUSINESS DAYS OF DISCOVERY**

Individual: First Name: Last Name:

## ***MAP COORDINATOR REVIEW***

*(47) Review Status: ☐ Approved ☐ Not Approved

*(48) Reason for Non-Approval: ☐ Referred to Provider for follow-up

☐ Other

(49) If "Other" in #46, explain:

(50) Comments/Recommendations: