Follow Up Medication Error/ Inservice Form

Staff's Name:_____ Date of Inservice:_____

Date of Medication Error: _____

Time of Medication Error: _____am/pm

Client's Name: _____

Program Name: _____

Medication: _____

_____

Name of Person and Title Doing Inservice: _____

_____ First Review _____Verbal Warning _____ Written Warning

_____ Final Warning _____ Suspension

Medication Error Review:

- ☐ **The medication administration policy and procedure were reviewed and included some simple techniques staff could complete to check themselves. Staff understood the importance of not having any more medication errors and felt meeting and going over the procedure helped.**
- ☐ **A simulated med pass was completed with 100% accuracy and documentation was reviewed.**

Details discussed:_____

_____

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☐ **Check here if UI report was written**

Staff's Signature_____

Manager's Signsture_____