

MEDICATION OCCURRENCE FORM INSTRUCTIONS

(Required fields are indicated with an asterisk * on the paper form)

- (1) Reporting Provider: Fill in name of Provider reporting medication occurrence.
- (2) Responsible Site: Choose site location where medication occurrence happened from the Data Repository Interface
- (3) Responsible Site Phone Number: Fill in phone number of site where medication occurrence happened
- (4A) Staff Responsible for MOR Follow-up First Name: This is the Certified Staff Supervisor.
- (4B) Staff Responsible for MOR Follow-up Last Name: Fill in last name of person in #4A above.
- (5) What Happened? This refers to the type of occurrence that is being reported. Select one choice.
- (6) Date of Medication Occurrence: Fill in the date the medication occurrence was found or discovered. This may not be the same date that it actually occurred. Fill in using the format: MM (Month)/DD (Day)/YYYY (Year)
- (7) Time of Medication Occurrence: Fill in the time of day that the medication occurrence was found or discovered. Fill in using the format: HH (Hours): MM (Minutes) AM/PM
- (8) Date of Discovery: Fill in the date that the occurrence actually happened. This may not be the same date as when it was discovered Use the format: MM/DD/YYYY
- (9) Time of Discovery: Fill in the time of day that the medication occurrence happened. Fill in using format: HH (Hour): MM (Minutes) AM/PM
- (10) Did the medication occurrence happen over multiple consecutive administrations? This refers to the possibility that the medication was not administered according to the HCP's orders for the same reasons several times in a row. Fill in "Yes" or "No".
- (11) Number of Doses: Fill in number of doses involved if answer to #10 was "Yes".
- (12) Staff Position of Person Giving Medication: Select one from Dictionary #1.
- (13) Medication Occurrence: This lists the reasons for the medication occurrence. Select at least one choice from Dictionary #2. Choose more than one if multiple reasons exist for the occurrence.
- (14) MAP Consultant's Title: Select one from choice:
Registered Nurse, Registered Pharmacist, Health Care Provider (HCP)

(15A) MAP Consultant Contacted (First Name): Fill in first name of MAP Consultant contacted for medication occurrence

(15B) MAP Consultant Contacted (Last Name): Fill in last name of MAP Consultant contacted for medication occurrence.

(16) Date Consultant Contacted: Fill in the date that the MAP Consultant was contacted regarding the medication occurrence. This date may be different from the date that the medication occurrence happened or was discovered. Use format: MM/DD/YYYY.

(17) Time Consultant Contacted: Fill in the time of day that the MAP consultant was contacted regarding the medication occurrence. Use format: HH:MM AM/PM.

(18) Was medical intervention recommended? Did the MAP Consultant recommend any type of medical intervention as a result of the medication occurrence? Fill in “Yes” or “No”

(19) If “Yes” was filled in line #18: If “Yes” was filled in to question “Was medical intervention recommended” then choose all that apply from the selections offered.

(20) Did any of these situations or conditions result from the medication occurrence? Select all that apply.

(21) If one resulted was DPH notified? 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. Fill in “Yes” or “No”.

(22) Date DPH was Notified: If the answer to # 21 was “Yes”, fill in date DPH was notified of hotline. Use format: MM/DD/YYYY.

(23) Time DPH was Notified: If answer to question #21 was “Yes” fill in time that DPH was notified of hotline. Use format: HH:MM AM/PM.

(24) Was an incident report filed as a result of the medication occurrence? The medication occurrence may also meet other criteria requiring an incident report to be filed as well. Fill in “Yes” or “No”.

(25) If “Yes” incident ID Number: If the answer to # 24 was “Yes” fill in Incident ID number, if known.

(26) What is the agency’s response to prevent this type of medication occurrence from happening in the future? This question refers to what action the provider took or will be taking in order to prevent such medication occurrences from happening again within their programs. Select all that apply from Dictionary # 3.

(27) Additional Comments: If “Other” was selected in question # 26 please explain further here. Describe what else contributed to the medication occurrence.

(28) Name of Medication (s) as ordered: Fill in the name of the medication(s) involved in the MOR as ordered by the HCP.

(29) Dosage: Fill in the dosage of the medication(s) involved as ordered by the HCP.

(30) Frequency/Time: Fill in how often and what times the medications involved were supposed to be given.

(31) Route: Fill in the method by which the medication(s) involved were supposed to be given as ordered by the HCP. Select a route from Dictionary #4.

(32) Medication as given: Fill in the name of the medication(s) involved in the MOR as given.

(33) Dosage: Fill in the dosage of the medication(s) involved .

(34) Frequency/Time: Fill in how often and what times the medications involved were actually given.

(35) Route: Fill in the method by which the medication(s) involved were actually given. Select a route 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. Select one from the given choices.

(37) Was there a recent change in the medication order for the medication(s) involved in the MOR? Fill in “Yes” or “No”.

(38) If Yes, date of medication order change? If “Yes” was the answer for question #37, fill in date. Use format MM/DD/YYYY

(39) Can this medication occurrence be connected to a single staff person?: Fill in “Yes” or “No” based on whether or not the actions or lack of action by a single individual led to the eventual medication occurrence.

(40A) If Yes, staff person first name: If answer to question #39 is Yes, first name of staff person connected to medication occurrence. This information will not be available to DSS. It will only be available to the Provider.

(40B) If Yes, Staff person last name: If answer to question # 39 is yes, fill in last name of person connected to medication occurrence. This information will not be available to DSS. It will only be available to the Provider.

(41) If Yes, is the staff person a regular staff member?: If the answer to question #39 is Yes, select a choice from the three provided that applies to the staff person connected to the occurrence. What is meant by “regular staff member” is that the person is regularly assigned to work at the site in which the occurrence happened.

(42) If Yes, does this person regularly administer medications as part of their routine responsibility?: If the answer to question # 39 is “Yes”, fill in “Yes” or “No” to this question.

(43) Was the person who caused the medication occurrence working their regular shift?: If the answer “Yes”, select a choice for this question from the selections offered.

(44) Was the person who caused the medication occurrence working at their routine site? Fill in “Yes” or “No” to this question.

(45) Submitted By: (Provider)

(46) Submitted Date:

Submit Medication Occurrence report to MAP Coordinator within 7 business days of discovery. Submit hotline reports within 24 hours of discovery.

(47) Review Status: Once the Map Coordinator is in receipt of the MOR, it will be reviewed and a status will be assigned. Select status from the options offered.

(48) Reason for Non-Approval: If “Not Approved” selected as answer to question #45, the MAP Coordinator will select the reason for non-approval.

(49) If Other, specify: If the answer to question # 46 is “Other”, the MAP Coordinator will explain the reason for non-approval in further detail here.

(50) Comments/Recommendations: If the follow-up information provided by provider still does not meet the criteria for approval, the MAP Coordinator will note the reason here along with recommendations.