Connecticut Department of Children and Families
MEDICATION INCIDENT REPORT
DCF-2277
5/19 (Rev.)

ALL CLASS B & C ERRORS MUST BE REPORTED TO DCF RISK MANAGEMENT
DCF.RISKMANAGEMENT@CT.GOV / Fax: 860-550-6482

Is this a DCF committed child/youth?: ☐ Yes ☐ No. If Child is Not Committed to DCF – DO NOT INCLUDE CHILD'S NAME OR DATE OF BIRTH.

Client LAST Name:	First Name:	DOB:	LINK#:	Gender: Select One or enter your own

Incident Date:	Incident Time: ☐ AM ☐ PM	Error by: ☐ Nurse ☐ Staff ☐ Guardian

DCF Social Worker Name (if applicable):	DCF Office (if applicable)::: Please Select DCF Office

Staff Assigned to Administer Medication

Agency:	Program Name:

Staff LAST Name:	Staff FIRST Name:	Staff Title:

ERROR TYPE (Check all that apply)

CLASS A Directions: Record Class A errors on Monthly Summary (DCF-2272) and report must be kept on file at facility

- ☐ Administration of medication not documented on MAR / Kardex
- ☐ Inadequate supply of medication (pharmacy error)
- ☐ Medication not given by a parent / guardian while on home visit/LOA
- ☐ Transcription error
- ☐ Other pharmacy error (please briefly explain):

CLASS B Directions: Completed Medication Incident Report (DCF-2274) MUST be submitted to the DCF Risk Management within 48 hours of medication incident

- ☐ Incorrect client given medication
- ☐ Incorrect dose
- ☐ Incorrect medication
- ☐ Improper medication storage
- ☐ Improper medication disposal
- ☐ Medication given at the wrong time
- ☐ Medication given by wrong route
- ☐ Medication given without LP order
- ☐ Medication not given to parent/guardian for home visit/LOA
- ☐ Missing medication
- ☐ No report written for medication incident
- ☐ Omission

CLASS C Directions: Completed Medication Incident Report (DCF-2274) MUST be submitted to DCF Risk Management within 12 hours of medication incident

- ☐ Error resulting in client requiring emergency room visit
- ☐ Error resulting in child requiring hospitalization
- ☐ Error resulting in death of a child
- ☐ Error resulting in harm to child (but not requiring emergency room visit or hospitalization)
- ☐ Falsification of documentation (does NOT require a call to the DCF Careline)

Medication Involved in Incident

Medication Name	Dose	Directions

Description of Incident – please include factors leading to incident

Impact on Child

Did the client require medication attention? ☐ Yes ☐ No.
If "Yes"-please provide details including what care was administered to the child and were there any side effects or adverse reactions?:

Was Supervising Nurse notified? ☐ Yes ☐ No. If "Yes" please complete information below:

Nurse's Name:	Title:	Date:	Time:

Directions given by Nurse:

Was Licensed Practitioner notified? ☐ Yes ☐ No. If "Yes" please complete information below:

Practitioner's Name:	Title:	Date:	Time:

Directions given by Licensed Practitioner:

Other Notifications (if applicable)

N/A	Who was notified?	Name	Date	Time	AM	PM
☐	DCF Social Worker				☐	☐
☐	DCF Careline				☐	☐
☐	Client Guardian				☐	☐

Staff Completing Report

LAST Name:	FIRST Name:	Title:

Signature	Date:

Facility Investigation and Follow-up Directions: If unable to be completed in the required timeframe (12 hours for Class C and 48 hours for Class B), please document required information as soon as the investigation is completed and re-submit to DCF Risk Management

Program Director Name:	Supervising Program Director Name:

Description of findings – NEW information discovered from investigation:

Steps to be taken to address incident/avoid similar incidents

Were any medication certified staff suspended? ☐ Yes ☐ No If yes, list name(s) and dates employee(s) notified of suspension below:

Name of Suspended Employee:	Date notified of suspension:

Please provide description of retraining plan for suspended employees and include the projected date of completion:

Program Director Signature:	Date:	Supervising Program Director Signature:	Date: