**MEDICATION INCIDENT/ERROR REPORT**

**FORM**

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| --- | --- |
| Name of Person Reporting |  |
| Position |  |
| Date Incident/Error occurred |  |
| Time of Incident/Error |  |
| Date Incident/Error reported |  |

|  |  |
| --- | --- |
| **Client/Care Recipient Name** |  |
| Location of Incident/Error |  |
| Name of person responsible for the Incident/Error (if not the person reporting this incident) |  |
| **Type of Incident/Error:** | |
| Wrong Client/Care Recipient  Wrong Date  Wrong Time  Wrong Type of Medication  Wrong Route  Wrong Dose  Incorrect Documentation  Pharmacy Error  Other – (please specify): | |

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| **Details of Incident/Error (including Client/Care Recipient observations during and following):** |

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| **Cause(s) or Contributing Factor(s):**  Missing Information  Missing Labels  Storage  Delivery Device issues  Environmental  Training Deficit  Other – (please specify): |
| **Immediate Action Taken:**  Notified <clinic> [Position Title]  Notified Client/Care Recipient (and/or Authorised Representative)  Notified Pharmacy  Notified General Practitioner  Telephoned Ambulance  Other – (please specify): |

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| --- | --- | --- |
| **Follow Up Action(s) - please include detailed explanation below:**  Resolved with Pharmacy  Resolved with General Practitioner  Further training provided  Environmental factors resolved  Other | | |
| **Person Responsible for the above** | **Date Completed** | **Signature** |
|  |  |  |

**OFFICE USE ONLY**

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| Incident/Error Reported to |  |
| Position |  |
| Date Form Received |  |