# MEDICATION INCIDENT REPORT

*Use this form to report an incident involving medication administration errors or issues.*

*Support or care worker to complete – Incident Details.*

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| 1. **Details**
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| **Date:** |
| **Time :** | **Report Completed By:**  |
| **Client’s Name** |
| 1. **Details of Medication Incident**
 |
| **Date:** | **Time:** | **Location:** |
| **Describe what happened/could happen and how:** |
| 1. **Possible reason/s for incident**
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|  |
| 1. **Immediate action taken**
 |
|  |
| 1. **Notifications**
 |
| **Coordinator:** □ YES □ NO **Next of Kin** □ YES □ NO**GP:** □ YES □ NO **Hospital:** □ YES □ NO**Pharmacist :** □ YES □ NO |  |
| **Treatment ordered by Doctor or Pharmacist**  |
| **SUPPORT WORKER/COORDINATOR TO COMPLETE - INCIDENT ANALYSIS** **Category of Incident:** Incorrect client Incorrect medicine Incorrect dose Incorrect time Incorrect route  Split or dropped medicine Out of date medicine Missing medicine  Lack of documentation such as assessment, medication order, medication support plan, medication record sheet (if required) Request by a client/carer to not give medication Breach of the Organisation policy and guidelines Client refuses medication Incorrect storage of medications Incorrect supply of medications from the pharmacy Other (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Signature** |