Sustain Health

MEDICATION INCIDENT REPORT FORM

Confidentiality Notice: This document contains sensitive information intended for internal use only. Unauthorized disclosure is strictly prohibited.

Personal Details:

Name:_____

Occupation: _____

Employment type: _____

Date of report: _____

Incident Details:

Date of Incident:_____

Time of Incident:_____

Facility Name:_____

Location (e.g., ward/unit):_____

Manager on duty:_____

Medication Incident Category: (Check all that apply)

☐ Incorrect Medication Given
☐ Incorrect Dosage Administered
☐ Missed Dose
☐ Other: (detail below)
☐ Wrong Patient
☐ Wrong Time
☐ Adverse Reaction

Description of Incident:
(Please provide a detailed account of what happened, including medication name, dose prescribed, dose administered, method of administration, and any factors that contributed to the incident)

_____

_____

_____

Actions taken:

- **Was the error identified before administration?** ☐ Yes ☐ No
- **Was there any adverse effects for the client/resident?** ☐ Yes ☐ No
- **If yes, please describe:**

_____

_____

_____

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Immediate Actions Taken: (Check all that apply)

☐ Notified Supervisor

- Date & Time Notified: _____

☐ Notified Client Facility

☐ Notified Doctor

☐ Patient Monitored

☐ On-site incident form completed

☐ Other: _____

Further Action Required? ☐ Yes ☐ No

If yes, describe: _____

Preventative measures:

(What steps will you take to prevent similar incidents from occurring in the future?)

_____

_____

STAFF MEMBER DECLARATION

I confirm that the information provided is accurate to the best of my knowledge.

Staff Member Completing Report: _____

Signature: _____ **Date:** _____

*This form is to be completed immediately following any medication-related incident involving agency staff. Please submit to Risk & Compliance within 24 hours of the incident.

For Internal Use Only

- Has the staff member been involved in previous medication incidents? ☐ Yes ☐ No
- Any corrective actions/suggestions, who will implement this and when?

_____

_____

- Corrective Actions Implemented?

_____

_____

- Final Comments:

_____

_____

Signatures

WHS Coordinator: _____

Signature: _____ **Date:** _____

Risk & Compliance Representative (if applicable): _____

Signature: _____ **Date:** _____