Medication Incident and Near Miss report

Section 1 Incident Report				
Date of Incident:	Time :	Place:		
Name of person reporting Incident :		Role:	Signature:	
Witness to Incident:		Role:	Signature:	
Name of Client:				
Error category	☐ Near Miss	☐ Incident	☐ Other:	
Type of Error ☐Medication omission ☐Wrong Client ☐ Wrong dose/strength ☐ Wrong Route ☐ Wrong time ☐ Medication Refusal			☐ Medication contamination/Unusable ☐ Medication not available ☐ Adverse reaction ☐ Medication given without order /Authorisation Time given:_____ Time due:_____	
Medication(s) involved:				
Incident description: Details must be a factual and detailed account of the incident. E.g. contributing factors, staff involved, client outcome.				
Immediate action taken:				
Nurse Manager Notified : ☐ Yes ☐ No		Report Checked by Nurse Manager : ☐ Yes ☐ No		
Date:	Time:	Signature:		
Section 2: Incident review				
Review conducted by: Name:		Role:	Date:	
Action Taken: Please describe what actions have been taken to address the causes/safety risks to the Client.				
Recommendations: Please describe any recommendations/corrective actions to be taken to prevent a recurrence:				
Corrective action completed : ☐ Yes ☐ NA				
Name:	Signature:		Date:	