

Drug Incident Report Form



Drug incident - patient safety report

1. As per Standard 1.9 of the Standards of Practice for Pharmacists and Pharmacy Technicians, **each pharmacist and pharmacy technician must participate in the quality assurance processes** required by the Standards for the Operation of Licensed Pharmacies.
2. Use this form for all related drug incidents.
3. As per Standard 6.4(b), the regulated member involved in the drug error must document an account of the error as soon as possible after the discovery. If the regulated member involved is not on duty at the time of discovery, the regulated member or employee who discovers the drug error must initiate the documentation.
4. Notify all regulated health professionals and caregivers whose care for the patient may be affected by the drug error.
5. Attach **Rx & transaction record** – photocopies or originals are acceptable.
6. Retain this report for **10 years** from discovery date.
7. This form is for drug incidents, drug errors and adverse drug events only; not adverse drug reaction reporting (ADRs).
8. All reports must be reviewed at least **quarterly** to evaluate success of changes implemented (Standard 6.6).

What is a drug incident? (Standard 6)

- a. **Drug incident** means any preventable event that may cause or lead to inappropriate drug use or patient harm. Drug incidents may be related to the practice of pharmacists or the practice of pharmacy technicians, drugs, health care products, aids and devices, procedures or systems, and include:
 - i. prescribing;
 - ii. order communications;
 - iii. product labeling, packaging, nomenclature;
 - iv. compounding;
 - v. dispensing;
 - vi. distribution;
 - vii. administration;
 - viii. education;
 - ix. monitoring; and
 - x. use.
- b. **Adverse drug event** means an unexpected and undesired incident related to drug therapy that results in patient injury or death or an adverse outcome for a patient, including injury or complication.
- c. **Drug error** means an adverse drug event or a drug incident where the drug has been released to the patient.

Patient information

Name: _____	D.O.B.: _____ <small>day / month / year</small>
Address: _____ _____ _____	Other relevant demographic data: _____ _____
Phone: _____	Rx #: _____
Email: _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> New Rx <input type="checkbox"/> Repeat Rx

Incident date & discovery date

Incident date: _____
hour *day / month / year*

Discovery date: _____
hour *day / month / year*

Name of reporter & incident discoverer

Discovered by: _____
name / position title

Report completed by: _____
name / position title

Drug ordered

State: drug/dose/form/route/directions for use. Remember to attach Rx & transaction record!

Incident description

State only the facts as known at the time of discovery of the incident. Additional detail about the incident may be appended to this form as it becomes available (e.g., final understanding/time line and incident analysis findings).

Severity

Check off the applicable scenario.

None: Patient is not symptomatic or no symptoms detected and no treatment required.

Mild: Patient is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review or minor treatment) is required.

Moderate: Patient is symptomatic, requiring intervention (e.g., additional operative procedure; additional therapeutic treatment), an increased length of stay, or causing permanent or long term harm or loss of function).

Severe: Patient is symptomatic, requiring life-saving intervention or major surgical/medical intervention, shortening life expectancy or causing major permanent or long term harm or loss of function.

Death: On balance of probabilities, death was caused or brought forward in the short term by the incident.



If no harm occurred in this case, was there significant potential for harm? **Yes** **No**



If the patient received incorrect medication, or did not receive medication that should have been received, **how many doses were involved?**

Type of incident

Check off each applicable item.

- | | | | |
|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | Incorrect drug | <input type="checkbox"/> | Omission (drug not supplied/untreated condition) |
| <input type="checkbox"/> | Incorrect patient | <input type="checkbox"/> | Drug interaction not followed up |
| <input type="checkbox"/> | Incorrect dose/strength | <input type="checkbox"/> | Therapeutic duplication |
| <input type="checkbox"/> | Documented allergy/ADR to drug dispensed | <input type="checkbox"/> | Outdated product |
| <input type="checkbox"/> | Incorrect/inappropriate packaging (e.g., child-resistant packaging not used, or packaged without regard to nature of drug including light and temperature requirements) | <input type="checkbox"/> | Incorrect quantity |
| <input type="checkbox"/> | Incorrect label/directions | <input type="checkbox"/> | Incorrect generic substitution/incorrect brand supplied |
| <input type="checkbox"/> | Incorrect dosage form/incorrect route | <input type="checkbox"/> | Incorrect indication/incorrect or improper administration (e.g., injection provided to a child under 5 years) |
| | | <input type="checkbox"/> | Other - please specify: |

Contributing factors

To be completed by the staff member(s) with the most knowledge of the incident.

Check off each applicable item.

- | | | | |
|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | Patient identification process | <input type="checkbox"/> | Compounding process (e.g., assignment of incorrect beyond-use-date, complex formula, formula not available, drug stability problem, procedure unhygienic, cross-contamination) |
| <input type="checkbox"/> | Transcription/order entry process | <input type="checkbox"/> | Prescribing problem (e.g., problematic abbreviations, legibility issues) |
| <input type="checkbox"/> | Patient assessment process (e.g., questions to gather information on new and refill medications incomplete or lacking) | <input type="checkbox"/> | Checking process (e.g., pharmacist working alone, ingredient check omitted/failed, final check omitted/failed) |
| <input type="checkbox"/> | Counselling process (e.g., hearing/visual impairment, low literacy skills, language barrier, availability/provision of written materials) | <input type="checkbox"/> | Documentation process (incomplete/unclear) |
| <input type="checkbox"/> | Monitoring process (e.g., follow-up not completed, lab values not available/not reviewed) | <input type="checkbox"/> | Drug storage/security (e.g., narcotic safe left unlocked) |
| <input type="checkbox"/> | Drug order interpretation (e.g., misread/misheard/misinterpreted) | <input type="checkbox"/> | Environmental factors (e.g., pharmacist working alone, fatigue due to extended shift/short-staffing, interruptions, higher than normal Rx volume, look-alike packaging, look-alike/sound-alike drug names, technology) |
| <input type="checkbox"/> | Drug unavailable (e.g., supply shortage and no alternative drug obtained on behalf of patient) | <input type="checkbox"/> | Other - please specify: |
| <input type="checkbox"/> | Education/training/skills/experience (e.g., unfamiliarity with drug product, device, or process) | | |

Notifications

Complete the following in accordance with SOLP 6.5(b) and (c)

Patient: _____
hour day / month / year

Prescriber: _____
hour day / month / year

Licensee: _____
hour day / month / year

Others: _____
specify hour day / month / year

_____ specify hour day / month / year

Staff involved notified

_____ name / position / signature

_____ name / position / signature

_____ name / position / signature

_____ name / position / signature

_____ name / position / signature

_____ name / position / signature

Outcome of investigation

Problems identified: Use the **causal statement format** to describe underlying problems/contributing factors identified through incident analysis.

A = Antecedent (A) This set of circumstances
B = Bridging (B) increased/decreased the likelihood
C = Consequences (C) that this set of consequences would/would not occur.

Actions to be implemented

Favour higher leverage (effectiveness) change options where possible. Note that the actions below are in descending order of leverage. Actions should be **SMART**: Specific, Measurable, Attainable, Relevant and Time-based.

Forcing functions/constraints:

Automation/computerization:

Reminders, checklists, double checks:

continued on next page

Actions to be implemented (continued)

Simplifications/standardization:

Policy/procedure change:

Education or training provided/course(s) taken:

Other (please specify):

Evaluation

Please describe whether the actions taken have resolved the issue. Is the patient satisfied with the outcome?
Has the potential for recurrence been mitigated?

Date: _____
hour *day / month / year*

Signature: _____

Name: _____
please print

Position
title: _____

Drug incident - patient safety report - addendum

Please attach details of drug incident investigation including initial/final understanding, time lines, and incident analysis findings, including causal chains as applicable.