

## Guidance Document for incidents that involve a medication

Important considerations when recording a medication incident in Datix CIMS

This document should be read in conjunction with the Datix CIMS Notifier User Guide.

#### Introduction

A medication incident is any preventable event which could have, or did lead to patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Medication incidents may be related to professional practice, drug products, procedures, and systems. They include incidents involving prescription, order communication, product labelling/packaging/nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

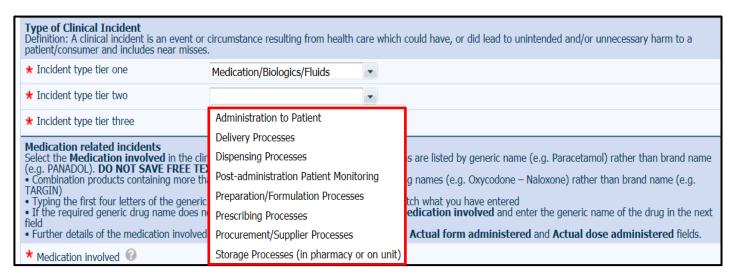
#### Choosing the correct type of medication incident<sup>1</sup>

It is important to select the correct part of the medication process where the incident occurred from the tier 2 drop-down list as different tier 3 options are available depending on the tier 2 option chosen (See Appendix 1 for a full list).

This may not necessarily be the root cause of the incident but reflects the outcome to the patient. For example the nurse administers the medication in error based on what was written on the prescription on the medication chart. The prescriber made an error on the prescription which is the root cause of the incident; however the patient received the medication which resulted in an administration error.

**Incident type tier one (1):** select 'Medication/Biologics/Fluids' when recording a medication incident.

### 1. What medication incident type do I select for tier two (2)?



<sup>&</sup>lt;sup>1</sup> A full list of definitions for all medication-related clinical incidents is available in Appendix 1.

Two incident types that are often confused are 'Administration to Patient' and 'Dispensing Process'.

Example of incorrect allocation as 'Dispensing Process':

- Patient's 2200 Tazocin® dose was omitted. Not realised until giving 0600 dose.
- Protophane<sup>®</sup> dose not given as charted. Novorapid<sup>®</sup> doses on 26/1 at breakfast and lunch not given.

Both of these incidents were listed as a 'Dispensing Process' incident when they should have been 'Administration to Patient' incidents.

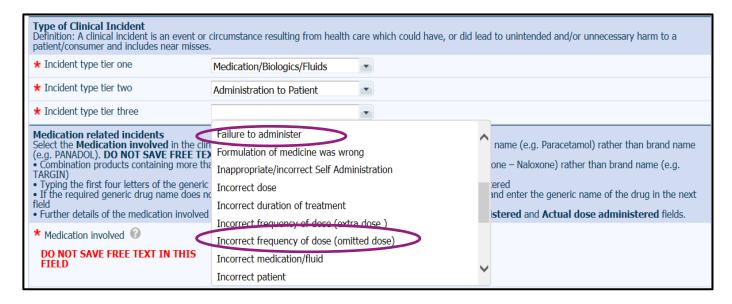
Tier 2 Incident Type	Description
Administration to Patient	If the patient has been administered a medication then it is an 'Administration to Patient' incident type. It involves the 6 rights of medication administration, encompassing re-assessment of the need for the medicine, the selection of the correct medicine and appropriate preparation and administration of the medicine by a suitably skilled clinician to the correct patient on each occasion. This includes a record of administration as well.
Dispensing Process	This step includes the process of dispensing the medication from a pharmacy undertaken by a pharmacist.  The correct medicine should be manufactured or selected, then labelled fully and clearly, in line with legislative requirements and a record is made in the pharmacy's dispensing software.  Medication can be dispensed by a pharmacist for inpatient use, discharge medication supply and outpatient prescription supply.

#### 2. What medication incident type do I select for tier three (3)?



#### Tip to avoid confusion!

The two incident types 'Failure to Administer' and 'Incorrect Frequency of dose (omitted dose)' as part of the 'Administration to Patient' process are also often confused.



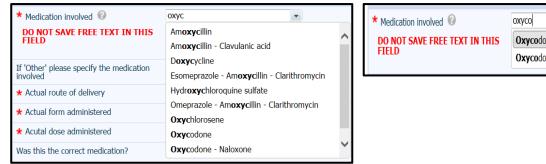
Tier 3 Incident Type	Description	
Failure to administer	<ul> <li>When a medication is due and acknowledged/prepared for administration but is not given.</li> <li>Examples</li> <li>Patient charted for medication however ward did not stock this medication; therefore patient did not receive medication.</li> <li>When staff were showering patient, it was noticed that the silver backing of the patch was not removed completely and as a consequence the patient was not receiving the correct dose.</li> <li>Nurse went to patient room at 2200hr and noticed a tablet by bedside. Patient had stated that previous afternoon nurse had given medication to help him sleep, but patient had not taken as he wasn't ready to sleep.</li> </ul>	
Frequency of dose (omitted dose)	<ul> <li>A dose of a medication is not administered to the patient as prescribed. This is usually due to oversight or not being aware that the medication has been prescribed.  Examples  Pain patch was required to be changed at 08:00 hour, nursing staff forgot to change patch and this was identified during PM shift change</li> <li>Medication charts checked at 15:00 hour medication round, and it was noticed that the patient 08:00 hour medication was not administered.</li> <li>Patient on BD medication, nursing staff went to administer 20:00 hour dose and noticed that 08:00 hour dose was not administered.</li> </ul>	

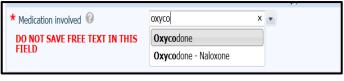
#### 3. Choosing the medication involved



#### Tip

The medication involved section is listed by the medication's **generic name**, the more letters of the medication name you provide the more refined the search outcome will be. Avoid using free text entry. You must type in the first four characters at a minimum for the search function to work.





Trade names for medications are not currently listed in the Datix CIMS library, and as such there are no options available to choose by trade name.



Free text medication names will not be captured in the reporting function of Datix CIMS. Therefore please take the time to ensure you search for the medication name according to its generic name.



#### Clinical Incident details

When submitting a clinical incident it is important to include as much information as possible about

- what happened, and
- why the incident may have occurred / what factors contributed to the incident occurring (i.e. was an administration incident caused by a prescribing error?)

These details will assist the review of the incident by your hospital's medication safety committee to develop strategies to reduce the risk of these incidents occurring again.

#### For example - Incident: An insulin dose was omitted prior to lunch for a patient

- Rather than just documenting this, explain what happened and whether this incident affected the patient's care.
- Was the reason for the omission because:
  - There was no stock available on the ward
  - The patient was not on the ward
  - The nurse was busy with another patient and the dose was overlooked
  - The insulin order had not been prescribed on the chart
  - The insulin chart was missing from the medication chart folder
  - Or another reason?

Each of these causes will require a different strategy to address the problem.

## Appendix 1 - Guidance for Tier 2 and Tier 3 Incident Types

**Table 1 – Definitions for Tier 2 Incident Types** 

Tier 2 Incident Type	Definition
Administration to Patient	When a nurse, midwife or doctor administers a medication to a patient. It involves the 6 rights of medication administration, encompassing reassessment of the need for the medicine, the selection of the correct medicine and appropriate preparation and administration of the medicine by a suitable skilled clinician to the correct patient on each occasion. This also includes a record of administration as well.  Self-administration Process: This process step relates to a patient self-administering a medication.
Delivery Process	This step involves the medication being transferred from one setting to another (i.e. from pharmacy department to the ward, or from ward to ward)
Dispensing Process	When a pharmacist dispenses a medication for a patient.  This step includes the process of dispensing the medication from a pharmacy undertaken by a pharmacist. The correct medicine should be manufactured or selected, then labelled in line with legislative requirements and a record is made in the pharmacy's dispensing software.  Medication can be dispensed by a pharmacist for inpatient use, discharge medication supply and outpatient prescription supply.  It is important to note that if a patient is administered the medication, even if the cause of the event is due to a dispensing or prescribing error; the error must be recorded as an administration incident.
Post-administration Patient Monitoring	This process step encompasses a suitable skilled clinician to assess the patient and the effect that the prescribed medication is having.
Preparation/Formulation Processes	This process step involves choosing the correct preparation or formulation of the medication for administration. Some medications are available in different formulation, for example regular release and slow release product. It can also involve choosing the correct formulation for the route of administration (i.e. oral liquid, suppository, oral tablets).  Preparation process is when the medication cannot be administered in its original form. It usually involves dilution of the product so that it can be administered parenterally (i.e. diluting a powered medication in a vial with diluent and then adding this solution to an intravenous infusion bag). Sometimes different dilutions are required for a specific medication, and it is important that the correct dilution is followed for the preparation of the medication.
Prescribing Process	When a doctor or nurse practitioner prescribers a medication for a patient. This step relates to the prescriber and their need for accurate, comprehensive, complete and up-to-date patient specific information to assess the most suitable treatment option in light of the best available evidence and the patient's treatment goal. This step also includes the record of the medicine order on the medication chart or prescription by the prescriber. The medicine order needs to be legible, unambiguous and contain enough information to support the use of the medication as intended. It is important to note that if a patient is administered the medication, even if the cause of the event is due to a prescribing error; the error must be recorded as an administration incident.
Procurement/Supplier Processes	This step involves the distribution of medication to the ward or unit.
Storage Process (in pharmacy or on unit)	This process relates to the storage of the medication and encompasses any special storage conditions related to stability of the medication or legislative requirements.

Some medication incidents involve documentation in the patient's medical record. This process step relates to incomplete or incorrect documentation in the medical record or the medication order/prescription. **These are recorded until Tier 1 – Documentation.** 

# Table 2 – Definitions for Tier 3 Incident Types

Tier 2	Tier 3	Definition
Administration		When a medication is administered to a patient but the
	Administered but drug chart not	medication chart is not signed to confirm the medication
	signed	has been administered.
		When a medication is administered to the patient and
	Administered but not prescribed	there is no prescription on the medication chart authorising the medication being required for the patient.
	Administered but not presenbed	When checking the correct dose for a patient or
		preparing a dose of medication (i.e. calculating volume
		of an oral liquid required for a dose) a calculation error is
		made resulting in the patient receiving the incorrect
	Calculation error	dose.
		A medication is administered to a patient who has a
	Contraindication due to history of	known allergy (previous history of allergy or adverse drug reaction) documented for the medication in the
	allergy	medical record or on the medication chart
		A medication is administered that is contraindicated due
		to an interaction with another medication which may
		result in sub-therapeutic levels or toxic levels of a
	Occident to the order of the total and the	medication. This may be a result of a prescribing error,
	Contraindication due to interaction with another medication	but is considered an administration error if the patient has been administered the medication.
	with another medication	A medication is administered that is contraindicated due
		to a medical complication which may increase chance of
		toxicity and/or side-effects. For example renal or hepatic
		impairment may impair the clearance of a medication.
		This may be a result of a prescribing error, but is
	Contraindication due to medical	considered an administration error if the patient has
	conditions	been administered the medication.
		The medication/fluid administered had passed its expiry date. This can be the original expiry date provided by the
		drug company or for sterile preparations such as
		chemotherapy, eye drops, or TPN that are provided by
		the pharmacy department that have short expiries. It is
		important to include the reason the medication has
	Evnirad madication/fluid	expired if it is related to delivery/storage of the medication/fluid.
	Expired medication/fluid	The leakage of intravenously (IV) infused, and
		potentially damaging, medications into the extravascular
	Extravasation	tissue around the site of infusion.
		When a medication is due and acknowledged/ prepared
		for administration and the patient is unavailable to
		administer the medication and no reason is documented
		for not administering the medication. (E.g. this may be due to the patient not being on the ward at the time of
	Failure to administer	administration)
		The incorrect formulation of a medication was
	Formulation of medication was	administered to the patient (i.e. slow release instead of
	wrong	regular release formulation)
	Inappropriate/Incorrect Self	Patient self-administers medication resulting in incorrect
	Administration	dose, frequency etc.  The patient was administered the incorrect dose of a
	Incorrect dose	medication.
		The duration of the administration of the medication was
		incorrect (e.g. administered for 3 days instead of 2, or
		intravenous infusion time was longer than prescribed
	Incorrect duration of treatment	duration).
	Incorrect frequency of dose (extra	The patient received an extra dose that was not
	dose)	prescribed.

		A dose of a medication is not administered to the patient
	Incorrect frequency of dose	as prescribed. This is usually due to oversight or not
	(omitted dose)	being aware that the medication has been prescribed.
		The patient was administered the incorrect medication or
	Incorrect medication/fluid	incorrect fluid replacement
	Incorrect patient	The patient was administered medications that were prescribed for another patient
	moon oot patient	When preparing the dose of a medication, the incorrect
		quantity of medication form is administered resulting in
	Incorrect quantity	an incorrect dose.
		The intravenous medication was administered at an
		incorrect rate - the volumetric infusion pump rate was set
		too fast or too slow compared to the prescribed/protocol
	Incorrect rate of administration	rate of administration.
		The medication was administered via the incorrect route.
		For example a medication might incorrectly be administered intravenous via the route instead of oral
		liquid. This can also account for confusion of parental
	Incorrect route of administration	routes (e.g. epidural instead of intravenous)
		When preparing the dose of a medication, the incorrect
		strength of the medication is chosen resulting in an
	Incorrect strength	incorrect dose.
		The administration of a medication dose was delayed as
		to the time it was meant to be administered (> 30
	Incorrect timing of door (doloved)	minutes for time critical medications and >2 hours for
	Incorrect timing of dose (delayed) Incorrect timing of dose	non-time critical medications)  The administration of a medication dose was given prior
	(premature)	to the dose being due.
	(promission)	Medication prepared but unable to administer as patient
	Refusal by patient	refuses therapy.
		The patient self-administered their own medication
	He soft and a deal and a deal at a deal at a deal and a deal at a deal and a deal at a	without being observed by nursing/midwifery staff. (this
Dolivory	Unauthorised self-administration  Damaged/contaminated during	can either be as per prescribed or self-prescribed)  A medication was damaged/contaminated during the
Delivery	delivery	delivery process
Process	Convery	Medication delivery was delayed to appropriate
	Delayed delivery to unit/ward	unit/ward
	Delivered to wrong destination	Medication was delivered to the wrong unit/ward
Dispensing		A damaged/contaminated medication was dispensed by
Processes	Damaged/contaminated product	a pharmacist for a patient.
	Dispensed in fact of know	A medication is dispensed that is contraindicated due to a medical complication or an existing allergy/adverse
	contraindication	drug reaction.
		Medication/s was dispensed by a pharmacist for the
	Dispensed to incorrect patient	incorrect patient.
		An expired medication was dispensed by a pharmacist
	Expired product	for a patient.
	Incorrect doss	The incorrect dose of a medication was dispensed by a
	Incorrect dose	pharmacist for a patient.  The incorrect frequency instructions on a medication
	Incorrect frequency	label that was dispensed by a pharmacist for a patient.
		The incorrect medication/fluid was dispensed by a
	Incorrect medication/fluid	pharmacist for a patient.
	Incorrect patient information	The incorrect patient information leaflet for a medication
	leaflet	was provided to the patient by the pharmacist
	Incorrect product due to cimile	The incorrect medication was dispensed by a
	Incorrect product due to similar packaging	pharmacist for a patient which was due to similar packaging
	paring	The incorrect medication was dispensed by a
	Incorrect product not due to	pharmacist for a patient which was not due to similar
	similar packaging	packaging
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		The incorrect quantity of a medication was dispensed by
	Incorrect quantity	a pharmacist for a patient.
		The incorrect route formulation of a medication was
	Incorrect route	dispensed by a pharmacist for a patient.
		The incorrect strength of a medication was dispensed by
	Incorrect strength	a pharmacist for a patient.
		The patient was provided with incorrect verbal directions
	Incorrect verbal patient directions	about their medications from the pharmacist
		The patient did not receive a patient information leaflet
		from a pharmacist required to assist the patient in taking
	Omitted patient information leaflet	the medication correctly.
		The patient was not provided with the appropriate verbal
		directions from a pharmacist to assist adhering with
	Omitted verbal patient directions	medication treatment
		The directions on the label of the medication container
	Product label illegible	dispensed by a pharmacist are illegible.
		The medication or directions on the label of the
		medication container dispensed by a pharmacist are
	Product label incorrect	incorrect.
Post-	Blood level monitoring not	Failure to action blood level monitoring (e.g. aPTT levels
administration	actioned	for managing the rate of infusion for heparin infusions)
Patient		Failure to check/acknowledge blood level monitoring
Monitoring	Blood level monitoring not	resulting in adverse outcomes for the patient's
Worldoning	reviewed	medication management
	Failure to activate rapid	Failure to escalate care in response to medication
	response/resuscitation team	management
	Egilure to discontinue treatment	Failure to discontinue treatment as prescribed by the
	Failure to discontinue treatment	doctor/nurse practitioner
		Failure to review the appropriateness of continuation of a medication in accordance with the prescription and
	Failure to review medication	monitoring parameters.
	Tanare to review medication	Failure or insufficient response to a change in patient
		status which would affect medication management for
	Failure/insufficient response to	the patient.
	significant change in patient	For example patient's blood sugar level is low and
	status	patient administered insulin.
	Failure/insufficient/incomplete	Monitoring for medication therapy was either insufficient
	monitoring	or not undertaken
		When the monitoring/laboratory results for another
	Incorrect patient	patient are used to manage the incorrect patient.
		This type of incident involves inadequate, incomplete or
		non-existent clinical handover of a patient's medication
	Incorrect/insufficient	requirements including monitoring patient parameters
	handover/transition	and blood levels.
		This type of incident involves incorrect/insufficient
		assessment and triaging of patient incident types involve inadequate assessment, escalation and management of
	Incorrect/insufficient triage in	patient's medication requirements including monitoring
	emergency situations	patient s medication requirements including morntoning patient parameters and blood levels.
	chief disastorio	When patient deterioration results in transfer to intensive
		care setting (e.g. ICU) due to insufficient/inadequate
	Unplanned elevation of care to	monitoring of the patient post-administration of
	intensive care setting	medication.
	_	When patient deterioration results in referral/transfer to
		specialised care due to insufficient/inadequate
	Unplanned transfer of care to	monitoring of the patient post-administration of
	other institution or clinical service	medication.
		Date of administration has surpassed the expiry date
		provided on the label of the container of the
		medication/fluid and has been administered to the
	Expired constituents	patient

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Preparation/	Incorrect properties/formulation	When preparing a medication/fluid for administration, the
Formulation	Incorrect preparation/formulation (dose/concentration)	incorrect medication, strength, dose, or diluent is chosen prior to administration of the medication.
Processes	(dose/concentration)	The administration of the medication was delayed due to
	Medication delayed	difficulties during the preparation process.
	Wedication delayed	A medication/fluid/electrolyte was omitted/not included in
		the preparation unintentionally when preparing a product
	Omitted Ingredient	for administration
		Medication integrity has been damaged or contaminated
	Use of damaged/contaminated	such that it is not suitable for administration, but has
	ingredients	been administered to the patient
Prescribing	ingrouionio	A medication is prescribed to a patient who has a known
1 rescribing		allergy (previous history of allergy or adverse drug
		reaction) documented for the medication in the medical
	Contraindication due to history of	record or on the medication chart, but is not
	allergy	administered to the patient
		A medication is prescribed that is contraindicated due to
	Contraindication due to	an interaction with another medication which may have
	interactions with other	increased the chance of toxicity and/or side-effects, but
	medications	has not administered to the patient.
		A medication is prescribed that is contraindicated due to
		a medical complication which may increase the toxicity
		of a medication which may result in increased side-
	Contraindication due to medical	effects/toxicity. For example renal or hepatic impairment
	condition	may impair the clearance of a medication.
		When medications are not prescribed in a timely manner
		such that a dose that is required to be administered is
	Delay in prescribing	missed.
		Medication is unintentionally prescribed twice for the
	<b>5</b>	patient resulting in possible duplicate dosing of a
	Duplicate prescription	medication.
		The frequency of administration of a medication is
	Incorrect frequency of dose	prescribed incorrectly but is not administered to the
	incorrect frequency of dose	patient The incorrect dose is prescribed for the patient but is not
	Incorrect dose	administered
	incorrect dose	The duration of treatment is prescribed incorrectly but is
	Incorrect duration of treatment	not administered to the patient.
	moorroot daration or troutmont	The incorrect formulation of a medication was prescribed
		for the patient (i.e. slow release instead of regular
		release formulation), but is not administered to the
	Incorrect formulation	patient
		The incorrect medication/fluid is prescribed for the
	Incorrect medication/fluid	patient but is not administered
		The medication is prescribed for the incorrect patient,
		but is not administered. Could involve the wrong patient
	Incorrect patient	addressograph attached to medication chart
		Incorrect quantity of a medication is prescribed for a
	Incorrect quantity	patient, but not administered
		The rate of administration is prescribed incorrectly but is
	Incorrect rate of administration	not administered to the patient.
	In an area of ways to	The incorrect route of administration is prescribed but is
	Incorrect route	not administered to the patient
		Incorrect dilution of a medication is prescribed (i.e.
		incorrect dilution of a medication or strength of a topical
	Incorrect strength	cream/ointment etc.) but is not administered to the
	Incorrect strength	patient, but is not administered to the patient.  The time of administration documented for the
		medication is prescribed incorrectly but is not
	Incorrect timing of dose	administered to the patient
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		Medication is not prescribed on the medication chart for
		administration to the patient. This may be a result of
		inadequate medication reconciliation or poor clinical
	Medication not prescribed	handover of information
	Not prescribed required	After undertaking a medication reconciliation on
	medication (reconciliation error)	admission a regular medication is not prescribed.
		The prescription is poorly documented on the chart
		resulting in either an illegible/difficult to read order or an
	Prescription illegible	incomplete order.
		Most medications are prescribed on the WA Hospital
		Medication Chart; however there are some exceptions
		which require a medication to be prescribed on a
	Wrong type of medication chart	specialised chart (e.g. anticoagulants, insulins, opioid
İ	used	infusions etc.)
Procurement/		Medication/fluid integrity has been damaged or
		contaminated such that it is not suitable for
Supplier	Damaged/contaminated product	administration
Process		Date of administration has surpassed the expiry date
		provided on the label of the container of the
		medication/fluid, but has not been administered to the
	Expired product	patient.
	ZAPITOU PITOUGO	Medication not available in the clinical are for
	Product not available	administration
Storage	1 1 ou doct not detailed	Medication/fluid integrity has been damaged or
_		contaminated such that it is not suitable for
Processes	Damaged/contaminated product	administration
(in pharmacy	Damagoaroomanii atoa produot	Date of administration has surpassed the expiry date
or on unit)		provided on the label of the container of the
		medication/fluid, but has not been administered to the
	Expired product	patient.
		Medication has not been stored appropriate as per
		requirements. For example a medication requiring
		protection from light is stored outside of packaging
	Incorrect storage environment	resulting in the product degrading being ineffective.
	<b></b>	Schedule 8 (S8) and Restricted Schedule 4 (S4R) are
		not stored in correct safe location according to
	Non-secure storage of controlled	Medicines and Poisons Regulations 2016 and hospital
	substances	policy
		Medication requiring refrigeration has not been stored in
		the refrigerator or cold chain has been breached
		(refrigerator temperature has not been maintained within
	Refrigeration failure	required range)