Release Notes RTI 5122
Patient Safety and Quality Improvement Service

Right to Information application 5122 –

*Documents related to any cases where ieMR systems and software have been **investigated** because of:*
(a) the incorrect amount of drugs administered to patients and/or
(b) the incorrect recording of the amount of drugs administered to patients
(c) documents related to any cases where this has resulted in harm to patients

Purpose of report

Provide applicant of RTI 5122 details of incidents reported in the RiskMan system meeting the search as detailed below.

Data source

- Any data presented was extracted from RiskMan and is self-reported by Hospital and Health Service (HHS) staff;
- Data is based on the ieMR being *investigated.* HHSs have confirmed that these matters may have resulted in an investigation of the ieMR, however the incident may not be related to use of the ieMR.
- Riskman is designed to enable reporting, investigation and management of clinical incidents and consumer feedback reported/received by HHS staff.
- The data was current in RiskMan as of 31 May 2019.

Search Criteria

- Date range: 1 January 2018 to 23 April 2019 (Incident Date)
- Incident type = Medication
- Medication Process = Administration and Prescribing
- Contributing factors = eHealth/ieMR

Search Methodology

- RiskMan data was extracted and checked by Systems team, Patient Safety and Quality Improvement Service (PSQIS).
- Duplicate records were removed
- Records were then reviewed by Systems team, PSQIS for relevance based on information recorded in RiskMan.

Search Results

- Out of 95 records that met the search criteria the following were deemed relevant based on information recorded in RiskMan
  - ieMR incorrect Medication recording – 49 records
  - ieMR incorrect Medication amount – 46 records
  - ieMR not used correctly – 45 records
  - ieMR difficult to use – 32 records

Interpretation notes

The vast majority of care delivered in hospitals and by other health services in Queensland is very safe and effective. However, despite excellent skills and best intentions of our staff, occasionally things do not go as expected. When this happens, it is distressing for patients, families and staff, particularly when the consequence is severe. Publicity around these events can also cause the community to lose trust in their healthcare system.

Queensland Health has worked hard to develop a patient safety culture that actively encourages staff to report clinical incidents and see these as opportunities to learn about and fix problems. The analysis of these incidents helps us better understand the factors that contribute to patient incidents, and implement changes aimed at improving safety. While some people may interpret reports of clinical incidents as a sign of poor safety, we view incident reporting as an indicator of a good patient safety culturethat ultimately leads to better patient care i.e. staff are willing to report incidents to actively pursue implementation of actions in order to minimise the potential for the reoccurrence of a similar incident in the future.

Interpreting numbers of clinical incidents, comparing the number of clinical incidents between HHSs, or using the number of clinical incidents as indicators of performance is not advised due to:

- a degree of clinical subjectivity in deciding whether an adverse outcome is a clinical incident i.e. what is reasonably expected is different from one clinician to the next, as well as what is expected by the patient/family. For example, a death may not have been reasonably expected and therefore met the definition of a SAC1 incident, but is later determined to have been the result of an underlying condition. Consistent with best practice across the world, it is important to us to have a reporting system that captures a broad scope of adverse patient outcomes that *could* be potentially preventable so that we can continue to learn and improve.
- Classification of an adverse patient outcome as a clinical incident does not describe ‘negligence’ or ‘fault’ on behalf of our staff or systems.
- Not all clinical incidents are preventable.
- Higher incident reporting rates are generally accepted as an indicator of a positive and transparent safety culture, rather than a marker of less safety care.
- SAC 2, SAC 3 and SAC 4 clinical incidents are not mandatorily required to be reported.

Severity Assessment Code (SAC) Definitions

SAC 1 - Death or permanent harm which is not reasonably expected as an outcome of healthcare

SAC 2 - Temporary harm which is not reasonably expected as an outcome of healthcare

SAC 3 - Minimal harm which is not reasonably expected as an outcome of healthcare

SAC 4 - Near miss which is not reasonably expected as an outcome of healthcare

Incident ID	Incident date	Hospital and Health Service	Facility	Confirmed level of harm	Summary	Primary incident type	Classification	Medication: Process	Medication: Issue	Contributing factors
[redacted]	Apr 2018	CAIRNS AND HINTERLAND	Innisfail Hospital	Harm - temporary (minor)	Pt found unresponsive with 'low' blood sugar level	Deterioration	Clinical communication Deterioration Medication	Administration	Ceased medicine administered	Communication / documentation | Inadequate documentation Communication / documentation | Inadequate verbal communication / handover eHealth / ieMR | Access to information Haemovigilance factors | Administration of product Haemovigilance factors | Prescribing / ordering
[redacted]	Aug 2018	CAIRNS AND HINTERLAND	Cairns Hospital	Harm - temporary (minor)	Patient charted for another patients medication list - patient received these medications	Medication	Medication	Prescribing	Incorrect patient	eHealth / ieMR | Inappropriate My Health Record management Workforce | Time pressure Workforce | Workload
[redacted]	Jan 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Pt usual carb ratio at home is 1 unit of novorapid per serve of carbhohydrate. However insulin medication chart was prescrobed as 2 units per serve of carbohydrate	Medication	Medication	Administration	Incorrect dose	Care plan | Inappropriate care plan Communication / documentation | Inadequate documentation Communication / documentation | Ineffective verbal communication / handover eHealth / ieMR | Incorrect IeMR Haemovigilance factors | Administration of product Haemovigilance factors | Prescribing / ordering
[redacted]	Mar 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	incorrect dose of sodium phenylbutyrate given	Medication	Clinical communication Clinical process Medication	Administration	Incorrect dose	Assessment | Assessment not completed Care plan | Care plan not followed Communication / documentation | Inadequate documentation Communication / documentation | Inadequate verbal communication / handover Communication / documentation | Ineffective verbal communication / handover Communication / documentation | Missing documentation Consent | Incomplete eHealth / ieMR | Access to information eHealth / ieMR | Incomplete IeMR information Haemovigilance factors | Administration of product Haemovigilance factors | Prescribing / ordering Knowledge / skills | Decision support not used Knowledge / skills | Training inadequate Procedures / guidelines | Could not locate policy / guideline Procedures / guidelines | No relevant procedures / guidelines to follow
[redacted]	Apr 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	ieMR Advanced - Clonidine administered at incorrect times 2x days in a row	Medication	Medication	Administration	Incorrect time or frequency of administration	eHealth / ieMR | Access to information
[redacted]	Apr 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Pts rapid rehydration fluid was given at a higher amount than required. Pt ended up getting 40ml/kg of fluid	Medication	Medication	Administration	Incorrect dose	eHealth / ieMR | Incorrect IeMR Knowledge / skills | Skill gap not recognised
[redacted]	Apr 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	IeMR Advanced - Commencement date for PCA incorrectly ordered	Medication	Medication	Prescribing	Incorrect time for administration	Communication / documentation | Missing documentation eHealth / ieMR | Incomplete IeMR information
[redacted]	May 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	ieMR Advanced - Possible prescribing error. Possible dosage max exceeded. Difficult to identify through ieMR MAR/ MAR Summary total doses in 24h	Medication	Medication	Prescribing	Other prescribing issue	eHealth / ieMR | Incorrect IeMR Equipment / consumable | Unfamiliar Equipment / consumable | User error Procedures / guidelines | Incorrect process used
[redacted]	Jun 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	IeMR Advanced - Missed dose 20 units Levemir at 2000hrs 25/6/18	Medication	Medication	Administration	Omitted dose	eHealth / ieMR | Incorrect IeMR Workforce | Inattention / distraction Workforce | Time pressure
[redacted]	Jun 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	IeMR Advanced - Nil task in MAR in iEMR for 0400 dosage to be administered	Medication	Medication	Prescribing	Other prescribing issue	Communication / documentation | Missing documentation eHealth / ieMR | Incomplete IeMR information
[redacted]	Jul 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Missed dose of Thyroxine over weekend	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Incomplete IeMR information
[redacted]	Aug 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Dosage error in prednisone	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | Incorrect IeMR

	Sep 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Issues with medicine - confusion with product, capsules missing, ?wrong dose given.	Medication	Medication	Administration	Incorrect dose	Communication / documentation | Missing documentation eHealth / ieMR | Incomplete IeMR information Procedures / guidelines | No relevant procedures / guidelines to follow
	Sep 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Patient given second gentamicin dose too early and precribed incorrectly	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | ieMR decision support unavailable Procedures / guidelines | Incorrect process used
	Sep 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	2pm dose of clonidine was ordered on the MAR to start at 2pm /9 but ordered as 'daily' instead of 24 hourly therefore task for next dose drops at 8am each day (default daily time). Clonidine 100mcg was given at approx 6am and a further 75mcg was given at 8am for 3 days.	Medication	Medication	Prescribing	Incorrect time for administration	eHealth / ieMR | Decision support overruled eHealth / ieMR | ieMR - Alarm / alert fatigue eHealth / ieMR | Staff training inadequate Haemovigilance factors | Prescribing / ordering Knowledge / skills | Lack of or inadequate safety awareness Knowledge / skills | Training inadequate
	Sep 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Patient on ketogenic diet. Noted on rounding to be prescribed liquid medications.	Medication	Medication	Prescribing	Other prescribing issue	eHealth / ieMR | Access to information Knowledge / skills | Decision support unavailable Knowledge / skills | Lack of or inadequate safety awareness
	Oct 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Weaning planresults in 7 hour of no presription for 4 hourly medication	Medication	Medication	Prescribing	Other prescribing issue	eHealth / ieMR | Incomplete IeMR information
	Oct 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	PCA: INCORRECT MORPHINE NCA DOSE RUNNING FOR APPROX 1 DAY IN PICU	Medication	Medication	Administration	Incorrect rate of administration	eHealth / ieMR | Incomplete IeMR information
	Oct 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	night time levemir dose signed off as given in the morning in PICU	Medication	Medication	Administration	Incorrect time or frequency of administration	eHealth / ieMR | Access to information eHealth / ieMR | Staff training inadequate Haemovigilance factors | Deliberate clinical decision Haemovigilance factors | Other
	Nov 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	5 units of Levemir administered - Order is for 0.5 Units of Levemir	Medication	Medication	Administration	Incorrect dose	Communication / documentation | Inadequate documentation eHealth / ieMR | ieMR decision support unavailable
	Nov 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Patient was not administered evening dose of Tacrolimus and morning dose was not charted and administered late.	Medication	Clinical communication Clinical process Medication	Prescribing	Medicine not prescribed	Communication / documentation | Inadequate documentation Communication / documentation | Missing documentation eHealth / ieMR | Access to information eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | Incorrect IeMR
	Nov 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Phase 2 of the NAC infusion was made up correctly but input into the pump incorrectly, therefore patient was receiving significantly lower dose	Medication	Clinical process Medication	Administration	Incorrect rate of administration	eHealth / ieMR | Staff training inadequate eHealth / ieMR | Workflow Workforce | Time pressure
	Dec 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Pt was given extra dose of lorazepam	Medication	Medication	Administration	Incorrect time or frequency of administration	Communication / documentation | Missing documentation eHealth / ieMR | Incorrect IeMR Physical environment | Environmental distractions
	Dec 2018	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Long term medication not charted	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | ieMR decision support unavailable eHealth / ieMR | Incomplete IeMR information
	Jan 2019	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Patient reviewed by QSIS registrarf on /01/2019, Inactivated vaccines prescribed, approved, iemr notes state vaccines should preferably be given as an inpatient.Same not administered.Pharmacist flagged in ieMR note inactatived vaccines due. Vaccines prescribed on a cross encounter ? not seen.	Medication	Medication	Administration	Omitted dose	eHealth / ieMR | Access to information eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | Staff training inadequate
	Feb 2019	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Pt with ALL (2YO) admitted to ED with ?PORT infection - weight documented in iemr in ED 25.5kg (actual body weight 15.5kg). Piptaz and Vanc doses calculated on 25.5kg and 5 doses of each administered before dosing error was identified.	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | Decision support overruled eHealth / ieMR | ieMR decision support unavailable eHealth / ieMR | Staff training inadequate eHealth / ieMR | System defect experienced eHealth / ieMR | Workflow
	Feb 2019	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Epidural orders completed against the wrong patient encounter, prepared using order from order screen not MAR	Medication	Clinical communication Medication	Prescribing	Other prescribing issue	eHealth / ieMR | Incorrect IeMR

	Feb 2019	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	(None Entered)	patient admitted to PICU post operative after 18:00, with pain buster. The pain buster only has ropivaciane 0.2% - and not charted in the iemR by theatre staff	Medication	Medication	Prescribing	Medicine not prescribed	Communication / documentation | Inadequate documentation Communication / documentation | Missing documentation eHealth / ieMR | Incomplete IeMR information Equipment / consumable | Inadequate presentation / packaging
	Apr 2019	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Discharge: Patient discharged from PICU to 11A on Sunday afternoon. Regular medicine Levetiracetam was not prescribed on iemr	Clinical process	Clinical process Medication	Prescribing	Medicine not prescribed	Communication / documentation | Missing documentation eHealth / ieMR | Incorrect IeMR eHealth / ieMR | Workflow Knowledge / skills | Decision support unavailable Person factors | Social history
	Apr 2019	CHILDREN'S HEALTH QUEENSLAND	Queensland Children's Hospital	Harm - temporary (minor)	Medication: 2 doses of paracetamol given within 20mins	Medication	Medication	Prescribing	Duplicate order	eHealth / ieMR | Staff training inadequate eHealth / ieMR | Workflow
	Apr 2019	GOLD COAST	Gold Coast University Hospital	Harm - temporary (minor)	Pt was incorrectly given 100mg of Sildenafil at 1400hrs	Medication	Medication	Administration	Incorrect dose	eHealth / ieMR | Staff training inadequate Procedures / guidelines | Not followed
	Feb 2018	MACKAY	Mackay Base Hospital	Harm - temporary (minor)	On ward round pip-taz planned to be ceased and meropenem prescribed. Order discontinued, confirmed by Pharmacist that yes, patient is only on Lincomycin, meropenem and vancomycin. Yet pip-taz order remained active and continued to be administered unnecessarily.	Medication	Medication	Prescribing	Medicine not ceased	Access | Unable to access at time required Communication / documentation | Missing documentation eHealth / ieMR | Incorrect IeMR
	Mar 2018	MACKAY	Mackay Base Hospital	Harm - temporary (minor)	Medication not given this morning due to dose not ordered	Medication	Clinical communication Medication	Administration	Omitted dose	Communication / documentation | Inadequate verbal communication / handover Communication / documentation | Missing documentation eHealth / ieMR | Access to information
	Aug 2018	MACKAY	Mackay Base Hospital	Harm - temporary (minor)	No night time order for lantus	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Access to information eHealth / ieMR | Staff training inadequate
	Oct 2018	MACKAY	Mackay Base Hospital	Harm - temporary (minor)	Patient given a total of 7000mg in a 24 hour period	Medication	Medication	Administration	Incorrect time or frequency of administration	Assessment | Screening not completed eHealth / ieMR | Decision support overruled Procedures / guidelines | Not current best practice Procedures / guidelines | Not followed
	Oct 2018	MACKAY	Mackay Base Hospital	Harm - temporary (minor)	could not order stat dose of IV insulin	Medication	Medication	Prescribing	Other prescribing issue	eHealth / ieMR | Access to information eHealth / ieMR | Staff training inadequate
	Nov 2018	MACKAY	Mackay Base Hospital	Harm - temporary (minor)	Patient given 18 units instead of 8 units of novorapid penfill at dinner. Carbs counted correctly but correction given when not needed	Medication	Clinical process Medication	Administration	Incorrect dose	eHealth / ieMR | Staff training inadequate Workforce | Inappropriate staff levels Workforce | Skill mix Workforce | Workload
	Dec 2018	MACKAY	Mackay Base Hospital	Harm - temporary (minor)	Pt given wrong medication and wrong dose	Medication	Medication	Administration	Incorrect medicine	eHealth / ieMR | Workflow Procedures / guidelines | Not followed
	Jan 2019	MACKAY	Mackay Base Hospital	Harm - temporary (moderate)	Metformin order (1000mg/day) suspended - medication continued to be administered for multiple days. Patient now has new injury.	Medication	Medication	Prescribing	Ceased medicine prescribed	eHealth / ieMR | System defect experienced eHealth / ieMR | Workflow Equipment / consumable | Suitability for purpose Equipment / consumable | Usability
	Jan 2019	MACKAY	Mackay Base Hospital	Harm - temporary (minor)	No Novorapid doses charted for /1/18 when doing chart review	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Staff training inadequate eHealth / ieMR | Workflow Knowledge / skills | Skill gap not recognised
	Jan 2019	METRO NORTH	Caboolture Hospital Campus	Harm - temporary (minor)	medication not given for 24 hours	Medication	Clinical process Medication	Administration	Omitted dose	eHealth / ieMR | Access to information
	Apr 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	Dose for /4 mane and nocte not prescribed and Nursing staff did not pick up error so no insulin was given for /4	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Incomplete IeMR information Procedures / guidelines | Checklist not followed Workforce | Inattention / distraction

[redacted]	[redacted] Apr 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	pt missed dose of novarapid	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Incomplete IeMR information Procedures / guidelines | Checklist not followed Workforce | Inattention / distraction
[redacted]	[redacted] Apr 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	nil insulin ordered	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Incorrect IeMR Procedures / guidelines | Checklist not followed Workforce | Inattention / distraction
[redacted]	[redacted] Apr 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	Pt administered buscopan rather than the ordered glucagon for a PSMA scan. Only clinical reason for glucagon over buscopan was due to the pt having a CABG previously, nil arrhythmias.	Medication	Medication Patient identification	Administration	Incorrect medicine	Assessment | Assessment not completed Assessment | Screening not completed eHealth / ieMR | Incorrect IeMR
[redacted]	[redacted] Apr 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	High dose of warfarin for therapeutic INR	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | Incomplete IeMR information
[redacted]	[redacted] May 2018	METRO SOUTH	Redland Hospital - Main Building	Harm - temporary (minor)	Patient was charted for a double dose of 320mg of Gentamicin	Medication	Medication	Prescribing	Incorrect dose	Assessment | Assessment not completed Communication / documentation | Inadequate documentation eHealth / ieMR | Incorrect IeMR Procedures / guidelines | Not current best practice
[redacted]	[redacted] Jun 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	Patient received wrong dose of Lantus & Novorapid.	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | Incomplete IeMR information
[redacted]	[redacted] Jun 2018	METRO SOUTH	Redland Hospital - Main Building	Harm - temporary (minor)	insulin dose not charted and not give Monday morning	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | Incorrect IeMR Knowledge / skills | Induction not adequate Knowledge / skills | Skill gap not recognised Knowledge / skills | Training inadequate
[redacted]	[redacted] Jul 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	Patient ordered 100mg Tramadol IR. Same administered. Patient narcotised and naloxone administered.	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | Incomplete IeMR information Person factors | Medical history
[redacted]	[redacted] Jul 2018	METRO SOUTH	Logan Hospital - Building 1	Harm - temporary (minor)	Prescribed quantity of 250mL and put quantity as 1 bottle.	Medication	Clinical process Medication	Prescribing	Other prescribing issue	eHealth / ieMR | Incorrect IeMR Knowledge / skills | Lack of or inadequate safety awareness
[redacted]	[redacted] Jul 2018	METRO SOUTH	Logan Hospital - Building 1	Harm - temporary (minor)	Prescribed quantity of 250mL and put quantity as 1 bottle.	Medication	Medication	Prescribing	Other prescribing issue	eHealth / ieMR | Incorrect IeMR Knowledge / skills | Lack of or inadequate safety awareness
[redacted]	[redacted] Aug 2018	METRO SOUTH	QEII Hospital	Harm - temporary (minor)	Patient had this administered but it was not documented in MAR	Medication	Medication	Administration	Administration not recorded / signed	Communication / documentation | Inadequate documentation eHealth / ieMR | Staff training inadequate
[redacted]	[redacted] Aug 2018	METRO SOUTH	Logan Hospital	Harm - temporary (minor)	Regular order for 50mg mane dose of clozapine not ceased and con-current powerplan started	Medication	Medication	Prescribing	Duplicate order	eHealth / ieMR | Incomplete IeMR information
[redacted]	[redacted] Aug 2018	METRO SOUTH	Logan Hospital	Harm - temporary (minor)	Regular order for 50mg mane dose of clozapine not ceased and con-current powerplan started	Medication	Medication	Prescribing	Duplicate order	eHealth / ieMR | Incomplete IeMR information
[redacted]	[redacted] Aug 2018	METRO SOUTH	Logan Hospital	Harm - temporary (minor)	Regular order for 50mg mane dose of clozapine not ceased and con-current powerplan started	Medication	Medication	Prescribing	Duplicate order	eHealth / ieMR | Incomplete IeMR information
[redacted]	[redacted] Aug 2018	METRO SOUTH	Logan Hospital	Harm - temporary (minor)	Regular order for 50mg mane dose of clozapine not ceased and con-current powerplan started	Medication	Medication	Prescribing	Duplicate order	eHealth / ieMR | Incomplete IeMR information
[redacted]	[redacted] Aug 2018	METRO SOUTH	Logan Hospital	Harm - temporary (minor)	Clozapine titration where powerplan and regular orders were charted	Medication	Medication	Prescribing	Duplicate order	eHealth / ieMR | Incomplete IeMR information
[redacted]	[redacted] Aug 2018	METRO SOUTH	Logan Hospital	Harm - temporary (minor)	Dalteparin doses not given by nurse as they recorded patient was mobilising. Treatment was prescribed due to superficial thrombophlebitis	Medication	Medication	Administration	Omitted dose	eHealth / ieMR | Incomplete IeMR information
[redacted]	[redacted] Aug 2018	METRO SOUTH	Logan Hospital	Harm - temporary (minor)	Dalteparin doses not given by nurse as they recorded patient was mobilising. Treatment was prescribed due to superficial thrombophlebitis	Medication	Medication	Administration	Omitted dose	eHealth / ieMR | Incomplete IeMR information

	Sep 2018	METRO SOUTH	Logan Hospital - Building 1	Harm - temporary (minor)	Incorrect methotrexate dose prescribed, dispensed and administered	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | Incorrect IeMR Knowledge / skills | Lack of or inadequate safety awareness Knowledge / skills | Skill gap not recognised Procedures / guidelines | Incorrect process used Procedures / guidelines | Organisational change Workforce | Inattention / distraction
	Sep 2018	METRO SOUTH	Logan Hospital	Harm - temporary (moderate)	Patient admitted to ED on /9/18. Patient was on clozapine in community (450mg nocte). Dose not charted /9/18. Dose charted for /9/18 but not given. Dose re-titration as dose withheld >48 hours.	Medication	Medication	Administration	Omitted dose	eHealth / ieMR | Incorrect IeMR
	Sep 2018	METRO SOUTH	Logan Hospital	Harm - temporary (minor)	omitted dose of supplementary insulin	Medication	Medication	Administration	Omitted dose	eHealth / ieMR | Incorrect IeMR
	Nov 2018	METRO SOUTH	QEII Hospital	Harm - temporary (minor)	Incorrect Bolus of heparin given	Medication	Clinical process Medication	Administration	Incorrect dose	eHealth / ieMR | ieMR - Alarm / alert fatigue eHealth / ieMR | Staff training inadequate
	Nov 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	medication prescribed on outpatient encounter and did not come across to inpatient encounter	Medication	Medication	Prescribing	Other prescribing issue	Communication / documentation | Inadequate verbal communication / handover Communication / documentation | Missing documentation eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | Workflow
	Dec 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	MAR issue: medication variation on dialysis days	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | Incorrect IeMR eHealth / ieMR | Staff training inadequate eHealth / ieMR | Workflow
	Dec 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (moderate)	missed dose	Medication	Medication	Prescribing	Other prescribing issue	eHealth / ieMR | Access to information eHealth / ieMR | System defect experienced
	Dec 2018	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	patient charted for 32mg of hydromorphone for 0800hrs, N/S given the dose as charted. patient however had the dose last at 1600hrs of previous day.	Medication	Medication	Prescribing	Incorrect time for administration	eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | Incorrect IeMR Knowledge / skills | Lack of or inadequate safety awareness
	Jan 2019	METRO SOUTH	Redland Hospital	Harm - temporary (minor)	pt not charted for regular medications. no clear instructions or documentation for insulin order	Clinical communication	Clinical communication Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Incomplete IeMR information Procedures / guidelines | Checklist not followed Procedures / guidelines | Incorrect process used Workforce | Inattention / distraction Workforce | Skill mix Workforce | Use of temporary staff Workforce | Workload
	Jan 2019	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	PRN med charted contraindicated to pt med hx. med charted PRN & also listed as allergy	Medication	Medication	Administration	Administered with known allergy	eHealth / ieMR | ieMR - Alarm / alert fatigue eHealth / ieMR | Incorrect IeMR
	Jan 2019	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	Duplicated order	Medication	Medication	Administration	Incorrect dose	Communication / documentation | Inadequate verbal communication / handover eHealth / ieMR | Workflow
	Jan 2019	METRO SOUTH	QEII Hospital	Harm - temporary (moderate)	Heparin 25000 Unit/50ml infusion administered over 30mins	Medication	Medication	Administration	Incorrect rate of administration	eHealth / ieMR | ieMR decision support unavailable eHealth / ieMR | Incorrect IeMR eHealth / ieMR | Staff training inadequate
	Jan 2019	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	AM n/s checked pt had discontinued insulin order from yesterday novoMix30/70, pt had 40-40-35-0. Treating team paged in the AM if they could pls chart the insulin, however no insulin was charted. Pt ended up not getting AM insulin.	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Access to information eHealth / ieMR | Incorrect IeMR eHealth / ieMR | Workflow Knowledge / skills | Lack of or inadequate safety awareness
	Feb 2019	METRO SOUTH	QEII Hospital	Harm - temporary (minor)	Vancomycin and concurrent NSAIDs and ARB --> AKI	Medication	Medication	Prescribing	Drug-Drug interaction	eHealth / ieMR | ieMR decision support unavailable eHealth / ieMR | Incomplete IeMR information Knowledge / skills | Lack of or inadequate safety awareness
	Feb 2019	METRO SOUTH	QEII Hospital	Harm - temporary (minor)	Double dose of medication	Medication	Medication	Administration	Incorrect time or frequency of administration	eHealth / ieMR | System defect experienced eHealth / ieMR | Workflow

	Mar 2019	METRO SOUTH	Logan Hospital - Building 3	Harm - temporary (minor)	Medication error	Medication	Medication	Administration	Self / carer administration	eHealth / ieMR | Workflow Person factors | Literacy / comprehension Workforce | Inattention / distraction Workforce | Use of temporary staff
	Mar 2019	METRO SOUTH	PAH-Building 1	Harm - temporary (minor)	Wrong rate for heparin infusion/confusing medication order.	Medication	Medication	Prescribing	Other prescribing issue	eHealth / ieMR | ieMR - Alarm / alert fatigue Procedures / guidelines | Not followed
	Apr 2019	METRO SOUTH	Redland Hospital - Main Building	Harm - temporary (minor)	Patient given 5mg IV Midazolam	Medication	Medication	Administration	Incorrect dose	Communication / documentation | Ineffective verbal communication / handover eHealth / ieMR | Incomplete IeMR information Procedures / guidelines | Not current best practice
	Feb 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Missed dose medicaiton during ieMR conversion form paper chart to digital.	Medication	Medication	Administration	Omitted dose	eHealth / ieMR | Access to information
	Feb 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Ward call RMO unclear about how to order insulin in ieMR and inadvertantly ordered medication twice	Medication	Medication	Prescribing	Duplicate order	eHealth / ieMR | ieMR decision support unavailable eHealth / ieMR | Staff training inadequate eHealth / ieMR | Workflow
	Feb 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	ieMR documentation lacking regarding order and administration of IV fluids	Medication	Clinical communication Medication	Administration	Administration not recorded / signed	eHealth / ieMR | Incomplete IeMR information
	Feb 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Patient has not been prescribed or administered regular Lantus (iEMR contributed to error)	Medication	Medication	Prescribing	Medicine not prescribed	eHealth / ieMR | Workflow Procedures / guidelines | Documents not supportive of work processes Procedures / guidelines | Organisational change Procedures / guidelines | Work instruction not understood
	Feb 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Patient did not receive ordered bag of Magnesium	Medication	Medication	Administration	Omitted dose	Communication / documentation | Inadequate documentation Communication / documentation | Ineffective verbal communication / handover eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | Staff training inadequate
	Feb 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Heparin rate increased to 21u/kg/hr instead of 18u/kg/hr due to incorrect interpretation of order in ieMR. Order withheld for longer than clinically indicated.	Medication	Medication	Prescribing	Incorrect dose	eHealth / ieMR | Staff training inadequate eHealth / ieMR | Workflow
	Feb 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Mismanagement of elevated APPT/heparin infusion	Medication	Medication	Prescribing	Incorrect or incomplete calculation	eHealth / ieMR | Staff training inadequate Procedures / guidelines | Checklist not followed
	Mar 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	(None Entered)	patient given 2 administrations of 1 g paracetamol within 1.5 hour timeframe	Medication	Medication	Administration	Incorrect time or frequency of administration	eHealth / ieMR | Decision support overruled Procedures / guidelines | Incorrect process used Procedures / guidelines | Not followed
	Mar 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Incorrect dose of intrathecal morphine precribed on IEMR in Mg instead of Micrograms and no spinal Morphine obs request	Clinical communication	Clinical communication Medication	Prescribing	Other prescribing issue	Communication / documentation | Inadequate verbal communication / handover eHealth / ieMR | Access to information eHealth / ieMR | ieMR - Alarm / alert fatigue eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | Incorrect IeMR eHealth / ieMR | Workflow
	Apr 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Mismanagement of elevated APPT/heparin infusion	Medication	Clinical process Medication	Prescribing	Incorrect dose	eHealth / ieMR | Staff training inadequate Knowledge / skills | Decision support not used Knowledge / skills | Training inadequate
	Apr 2019	SUNSHINE COAST	SUNSHINE COAST UNIVERSITY HOSPITAL	Harm - temporary (minor)	Patient discharge process was delayed due to complexities associated with discharge process on iemr and delays in O& G discharge and disjointed and complex process.	Clinical process	Clinical process Medication Patient flow	Administration	Omitted dose	eHealth / ieMR | Access to information eHealth / ieMR | Incomplete IeMR information eHealth / ieMR | System unavailable or slow eHealth / ieMR | Workflow
	Jan 2019	WEST MORETON	Ipswich Hospital	Harm - temporary (minor)	Patient in severe pain unable to be given pain relief, unable to perform required procedure due to copmuter system failure.Nursing staff unwilling to administer any medications as unable to be documented as computer system was down	Clinical process	Clinical process Deterioration Medication Patient flow	Administration	Omitted dose	eHealth / ieMR | Incorrect IeMR eHealth / ieMR | Staff training inadequate

	Feb 2019	WEST MORETON	Ipswich Hospital	Harm - temporary (minor)	Failure to document chronic conditions and medications led to not being prescribed for 4 days. No scanned into iEMR	Medication	Clinical communication Clinical process Medication	Prescribing	Medicine not prescribed	DOH RTI 5122 Communication / documentation | Inadequate verbal communication / handover Communication / documentation | Missing documentation eHealth / ieMR | Incomplete IeMR information
	Feb 2019	WEST MORETON	Ipswich Hospital	Harm - temporary (minor)	PCA not connected.	Medication	Medication	Administration	Omitted dose	eHealth / ieMR | Workflow Workforce | Time pressure
	Mar 2019	WEST MORETON	Ipswich Hospital	Harm - temporary (minor)	pt given paracetamol within 6hour time frame as dose given in OT	Medication	Medication	Administration	Incorrect time or frequency of administration	eHealth / ieMR | Staff training inadequate Procedures / guidelines | Not followed
	Apr 2019	WEST MORETON	Ipswich Hospital	Harm - temporary (minor)	Incorrect dose of administered	Medication	Medication	Administration	Incorrect rate of administration	Access | Unable to access service Communication / documentation | Ineffective verbal communication / handover eHealth / ieMR | Security of information eHealth / ieMR | Staff training inadequate Knowledge / skills | Training inadequate Procedures / guidelines | Incorrect process used Teamwork | Individual responsibilities not clear Teamwork | Supervision inadequate Teamwork | Unfamiliar team