



MEDICATION ERROR (ME) REPORT FORM

Reporters do not necessarily have to provide any individual identifiable health information, including names of practitioners, names of patients, names of healthcare facilities, or dates of birth (age is acceptable)

<p>1 Date of event: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> dd/mm/yy</p> <p>Time of event: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hh/mm (24 hr)</p>	<p>Type of Facility: * Government/ Private</p> <p><input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Pharmacy</p> <p><input type="checkbox"/> Others: _____</p>	<p>Location of event:</p> <p><input type="checkbox"/> Ward <input type="checkbox"/> A&E <input type="checkbox"/> Clinic <input type="checkbox"/> Pharmacy</p> <p><input type="checkbox"/> Others: _____</p>
<p>2 Please describe the error. Include description/ sequence of events and work environment (e.g. change of shift, short staffing, during peak hours). If more space is needed, please attach a separate page.</p>		<p>3 In which process did the error occur?</p> <p><input type="checkbox"/> Prescribing</p> <p><input type="checkbox"/> Dispensing (includes filling)</p> <p><input type="checkbox"/> Administration</p> <p><input type="checkbox"/> Others (Please specify) : _____</p>

4 Did the error reach the patient? YES NO

Was the incorrect medication, dose or dosage form administered to or taken by the patient? YES NO

4.2 Please tick the appropriate ** Error Outcome Category (Select one)

<p>NO ERROR</p> <p><input type="checkbox"/> A Potential error, circumstances/ events have potential to cause incident</p> <p>ERROR, NO HARM</p> <p><input type="checkbox"/> B Actual Error - did not reach patient</p> <p><input type="checkbox"/> C Actual Error - caused no harm</p> <p><input type="checkbox"/> D Additional monitoring required - caused no harm</p>	<p>ERROR, HARM</p> <p><input type="checkbox"/> E Treatment/ intervention required - caused temporary harm</p> <p><input type="checkbox"/> F Initial/ prolonged hospitalization - caused temporary harm</p> <p><input type="checkbox"/> G Caused permanent harm</p> <p><input type="checkbox"/> H Near death event</p> <p>ERROR, DEATH</p> <p><input type="checkbox"/> I Death</p>
--	---

** © 2001 NCCMERP. All rights reserved.

4.1 Describe the direct result on the patient (e.g. death, type of harm, additional patient monitoring).

5 Indicate the possible error cause(s) and contributing factor(s)

<input type="checkbox"/> Inexperienced Personnel	<input type="checkbox"/> Peak hour	<input type="checkbox"/> Stock arrangement/ storage problem
<input type="checkbox"/> Failure to adhere to work procedure	<input type="checkbox"/> Illegible prescription	<input type="checkbox"/> Sound alike medication
<input type="checkbox"/> Look alike medication/ packaging	<input type="checkbox"/> Patient information/ record unavailable/ inaccurate	<input type="checkbox"/> Wrong labelling/ instruction on dispensing envelope or bottle/container
<input type="checkbox"/> Others (Please specify) : _____		

6 Which category made the initial error?

<input type="checkbox"/> Doctor	<input type="checkbox"/> Pharmacist
<input type="checkbox"/> Nurse	<input type="checkbox"/> Pharmacist Asst.
<input type="checkbox"/> Asst. Medical Officer	<input type="checkbox"/> Others : _____

7 Other category also involved in the error?

<input type="checkbox"/> Doctor	<input type="checkbox"/> Pharmacist
<input type="checkbox"/> Nurse	<input type="checkbox"/> Pharmacist Asst.
<input type="checkbox"/> Asst. Medical Officer	<input type="checkbox"/> Others : _____

8 Which category detected the error or recognised the potential error?

<input type="checkbox"/> Doctor	<input type="checkbox"/> Pharmacist
<input type="checkbox"/> Nurse	<input type="checkbox"/> Pharmacist Asst.
<input type="checkbox"/> Asst. Medical Officer	<input type="checkbox"/> Others : _____

9 If available, please provide patient's particulars (Do not provide any patient identifiers).

Age: * years/ months **Gender:** Male Female **Diagnosis:** _____

10 Please complete the following for the product(s) involved. If more space is needed for additional products, kindly attach a separate page. For similar packaging, please fill 10.4 to 10.7

Product Description	Product # 1 (intended)	Product #1 (error)
10.1 Brand/ Product Name		
10.2 Generic Name (Active Ingredient)		
10.3 Dose, frequency, duration, route		
10.4 Manufacturer		
10.5 Dosage Form		
10.6 Strength/ Concentration		
10.7 Type and Size of Container		

* Please delete where not applicable

11 Reports are most useful when relevant materials such as product label, copy of prescription/ order, etc., can be reviewed. Can these materials be provided?

- No
- Yes, Please specify:

12 Suggest any recommendations, or describe policies or procedures you instituted or plan to institute to prevent future similar errors. If available, kindly attach investigational report e.g. Root Cause Analysis (RCA).

Reporter's Details

Name and Profession :				
Facility/ Address :				
		Postcode :	<input type="text"/>	
E-mail :				
Telephone number :			Fax Number :	

For official use :

Date report received : dd/mm/yy

Ref. No.

ME Type

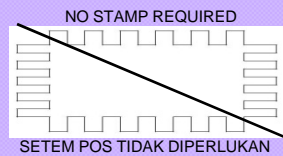
ME Category

(Fold here)

Medication Safety

Is Everyone's Responsibility

(Fold here)



REPLY PAID / JAWAPAN BERBAYAR

MALAYSIA

No. Lesen : BRS 0915 SEL

Medication Safety Centre (MedSC),
 Pharmaceutical Services Division,
 Ministry Of Health Malaysia,
 P.O. Box 924, Jalan Sultan,
 46790 Petaling Jaya, Selangor.