

MEDICATION ERROR (ME) REPORT FORM

For PSD, MOH use

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)

| | |
|---|--|
| 1 Date of event: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> dd/mm/yy | 2 Time of event: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hh/mm (24 hr) |
| 3 Type of Facility: *MOH/ Other Government Facility/ Private <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Pharmacy <input type="checkbox"/> Others: _____ | 4 Location of event: <input type="checkbox"/> Ward (Please specify: Medical/Pead/Ortho/.....) <input type="checkbox"/> Clinic (Please specify: Outpatient/Specialist/Dental/.....) <input type="checkbox"/> Pharmacy (Please specify: Inpatient/Outpatient/Satellite/A&E/.....) <input type="checkbox"/> A&E <input type="checkbox"/> Others (Please specify:.....) |

5 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.

| | | |
|---|--|---|
| 6 In which process did the error occur? <input type="checkbox"/> Prescribing <input type="checkbox"/> Dispensing (includes filling) <input type="checkbox"/> Administration <input type="checkbox"/> Others (Please specify) : _____ | 7 Did the error reach the patient? <input type="checkbox"/> YES <input type="checkbox"/> NO 8 Was the incorrect medication, dose or dosage form administered to or taken by the patient? <input type="checkbox"/> YES <input type="checkbox"/> NO | 9 Describe the direct result on the patient (e.g. death, type of harm, additional patient monitoring e.g. BP, HR, glucose level etc.). |
|---|--|---|

10 Please tick the appropriate Error Outcome Category (Select one)

NO ERROR

A Potential error, circumstances/ events have potential to cause incident

ERROR, NO HARM

B Actual Error - did not reach patient

C Actual Error - caused no harm

D Additional monitoring required - caused no harm

ERROR, HARM

E Treatment/ intervention required - caused temporary harm

F Initial/ prolonged hospitalization - caused temporary harm

G Caused permanent harm

H Near death event

ERROR, DEATH

I Death

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

| | | |
|--|---|---|
| <input type="checkbox"/> Staff factors <input type="checkbox"/> Inexperienced personnel <input type="checkbox"/> Inadequate knowledge <input type="checkbox"/> Distraction <input type="checkbox"/> Medication related <input type="checkbox"/> Sound alike medication <input type="checkbox"/> Look alike medication <input type="checkbox"/> Look alike packaging | <input type="checkbox"/> Task and technology <input type="checkbox"/> Failure to adhere to work procedure <input type="checkbox"/> Use of abbreviations <input type="checkbox"/> Illegible prescriptions <input type="checkbox"/> Patient information/ record unavailable/ inaccurate <input type="checkbox"/> Wrong labeling/ instruction on dispensing envelope or bottle/ container <input type="checkbox"/> Incorrect computer entry | <input type="checkbox"/> Work and environment <input type="checkbox"/> Heavy workload <input type="checkbox"/> Peak hour <input type="checkbox"/> Stock arrangements/ storage problem <input type="checkbox"/> Others (please specify): |
|--|---|---|

For question 12-14, please fill each box with one of the following option.

- | | | |
|--|--|---------------------------------------|
| a. Specialist | f. Nurse | k. Pharmacist Assistant (Trainee) |
| b. Medical Officer (MO) | g. Nurse (Trainee) | l. Patient/ Caregiver |
| c. Houseman Medical Officer (HMO) | h. Assistant Medical Officer (AMO) | m. Dentist |
| d. Pharmacist | i. Assistant Medical Officer (AMO Trainee) | n. Others (Please specify in the box) |
| e. Provisional Registered Pharmacist (PRP) | j. Pharmacist Assistant | |

12 Which category made the initial error? (If "n. others", please specify:.....)

13 Other category also involved in the error? (If "n. others", please specify:.....)

14 Which category discovered the error or recognised the potential error? (If "n. others", please specify:.....)

15 If available, please provide patient's particulars (Do not provide any patient identifiers).
Age: *years/ months/ days **Gender:** Male Female **Diagnosis:** _____

16 Product Details: Please complete the following for the product(s) involved. Kindly attach a separate page for additional products.

| Product Description | Product # 1 (intended) | Product # 1(error) |
|---------------------------------------|------------------------|--------------------|
| 16.1 Generic Name (Active Ingredient) | | |
| 16.2 Brand / Product Name | | |
| 16.3 Dosage Form | | |
| 16.4 Dose, frequency, duration, route | | |

Please fill in 16.5-16.7 if error involved similar product packaging:

| Product Description | Product # 1 (intended) | Product # 1(error) |
|---------------------------------|------------------------|--------------------|
| 16.5 Manufacturer | | |
| 16.6 Strength / Concentration | | |
| 16.7 Type and Size of Container | | |

* Please delete where not applicable

17 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

18 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 : | |
| Profession : | |
| Facility and Address : | |
| | Postcode : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| E-mail : | |
| Telephone number : | Fax Number : |

For official use :

Date report received :

dd/mm/yy

ME Type

ME Category

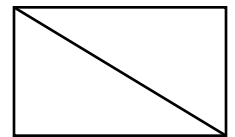
(Fold here)

*Medication Safety
Is Everyone's Responsibility*

www.pharmacy.gov.my
E-mail: mers@moh.gov.my

(Fold here)

NO STAMP REQUIRED



SETEM POS TIDAK DIPERLUKAN

**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.