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).

Date of event: [ dd/mm/yy ]
Time of event: [ hh/mm (24 hr) ]

Type of Facility: *
- MOH/ Other Government Facility/ Private
- Hospital
- Clinic
- Pharmacy
- Others: ____________________________

Location of event: *
- Ward (Please specify: Medical/Ped/Ortho/ ……………………………)
- Clinic (Please specify: Outpatient/Specialist/Dental/ …………
- Pharmacy (Please specify: Inpatient/Outpatient/Satellite/A&E/ …………)
- A&E
- Others (Please specify: ……………………)

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.

In which process did the error occur?
- Prescribing
- Dispensing (includes filling)
- Administration
- Others (Please specify): ____________________________

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

Indicate the possible error cause(s) and contributing factor(s)
- Staff factors
  - Inexperienced personnel
  - Inadequate knowledge
  - Distraction
- Medication related
  - Sound alike medication
  - Look alike medication
  - Look alike packaging
- Task and technology
  - Failure to adhere to work procedure
  - Use of abbreviations
  - Illegible prescriptions
  - Patient information/ record unavailable/ inaccurate
  - Wrong labeling/ instruction on dispensing envelope or bottle/ container
  - Incorrect computer entry
- Work and environment
  - Heavy workload
  - Peak hour
  - Stock arrangements/ storage problem
  - Others (please specify): ……………………

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

a. Specialist
b. Medical Officer (MO)
c. Houseman Medical Officer (HMO)
d. Pharmacist
e. Provisional Registered Pharmacist (PRP)

f. Nurse
g. Nurse (Trainee)
h. Assistant Medical Officer (AMO)
i. Assistant Medical Officer (AMO Trainee)
j. Pharmacist Assistant
k. Pharmacist Assistant (Trainee)
l. Patient/ Caregiver
m. Dentist
n. Others (Please specify in the box)

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: ____________________________

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

<table>
<thead>
<tr>
<th>Product Description</th>
<th>Product # 1 (intended)</th>
<th>Product # 1(error)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1 Generic Name (Active Ingredient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.2 Brand / Product Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.3 Dosage Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.4 Dose, frequency, duration, route</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.5 Manufacturer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.6 Strength / Concentration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.7 Type and Size of Container</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
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<td></td>
</tr>
</tbody>
</table>

* Please delete where not applicable
Medication Safety
Is Everyone’s Responsibility

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