BPF/104/ME/02

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: ☐☐☐☐☐☐ dd/mm/yy

2 Time of event: ☐☐☐☐ hh/mm (24 hr)

3 Type of Facility: *MOH/ Other Government Facility/ Private

☐ Hospital ☐ Clinic ☐ Pharmacy

☐ Others: _____

4 Location of event:

☐ Ward (Please specify: Medical/Pead/Ortho/……)
☐ Clinic (Please specify: Outpatient/Specialist/Dental/……)
☐ Pharmacy (Please specify: Inpatient/Outpatient/Satellite/A&E/……)
☐ A&E
☐ 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?

☐ Prescribing
☐ Dispensing (includes filling)
☐ Administration
☐ Others (Please specify) :
_____

7 Did the error reach the patient?

☐ YES ☐ NO

8 Was the incorrect medication, dose or dosage form administered to or taken by the patient?

☐ YES ☐ 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)

☐ **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:** _____

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 : ☐☐☐☐☐
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.