MEDICATION ERROR REPORTING SYSTEM (MERS) 2025

About

Purpose of this document	1. This document serves as a reference for healthcare professionals on how to report medication errors. 2. To emphasize on the quality reporting of medication errors.
Scope of reporting	Medication Error Reporting System (MERS) is used to report all medication errors (including near miss and actual error) involving any medicine used both in **public and private** healthcare facilities.
Reporting medium	Medication error reports can be submitted online or manually. However, reporters are encouraged to submit report online. • ONLINE : MERS BAPF KKM • MANUAL : Medication Error (ME) Report Form

Management of Medication Error

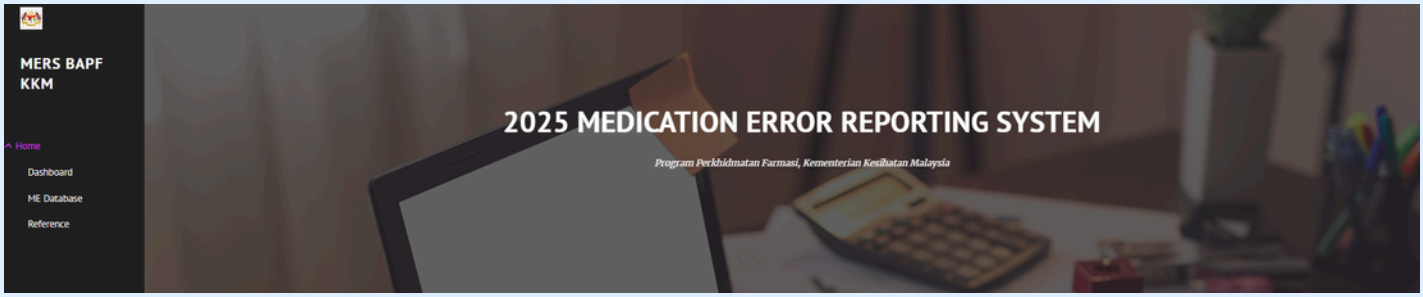
Reporting Medication Error (ME)	• Detect and report any medication error encountered. • Reportable events include both actual errors and the errors that have been detected and corrected before reaching the patient. • Document and report immediately after error detection, in accordance to the standard process/ workflow of the facilities.
Analysis and Monitoring of ME	• Analyze medication error reports regularly and the findings are shared with all the staff. • Conduct root cause analysis (RCA) to identify the root cause of the error and action(s) to eliminate it (refer to Guidelines on Implementation - Incident Reporting and Learning System 2.0 for Ministry of Health Hospitals 2017).
Establishing Error Preventive Strategies	• Establish Patient/Medication Safety Committee to discuss patient safety related issues. • Establish/Implement error prevention strategies that focus on system design/safe behavioral practices and are monitored continuously. • Include medication safety elements in the ward check list/ pharmacy visit list/audit.

Dissemination of Information	Organize continuous education/ learning sessions to share all the medication errors and the error preventive strategies among the staff.
Quality Improvement Programme	Record and analyze all the drug selection, preparation, labelling and filling errors identified during routine checking processes for the quality improvement activities in the facility (e.g. establishing policies/protocols/guidelines, staff awareness and education).
Adopt 'Just Culture'	• Facility adopts no-blame culture in managing medication error. • Good cooperation among healthcare professionals in order to work together and provide better care for patients. • Just Culture is a model of shared accountability for safe system design and behavioral changes supported by high level managements. Just Culture encourages individuals to speak up and to report a medication error, allows for the proper judgement of the medication error and provides learning opportunities for all healthcare professionals.

How to Report?

Google Site MERS 2025

Please select the correct link for reporting.



REPORT MEDICATION ERROR HERE:

MOH FACILITIES

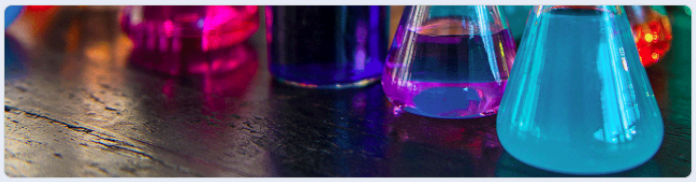
NON MOH FACILITIES

ME Reporting Form

A separate reporting form is available for public and private healthcare facilities.

MEDICATION ERROR REPORTING FORM (MERS) FOR MOH FACILITIES

Welcome to the Medication Error Reporting System (MERS)– a tool for healthcare professionals to report incidents, learn from mistakes, and prevent future errors. Every report you submit is valuable for improving patient care and saving lives. We encourage you to provide detailed information, and help make a difference.



MEDICATION ERROR REPORTING FORM (MERS) FOR NON MOH FACILITIES

Welcome to the Medication Error Reporting System (MERS)– a tool for healthcare professionals to report incidents, learn from mistakes, and prevent future errors. Every report you submit is valuable for improving patient care and saving lives. We encourage you to provide detailed information, and help make a difference.

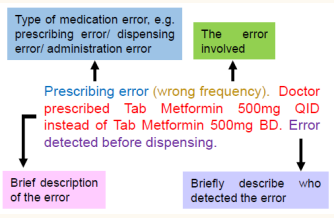
Initial Data

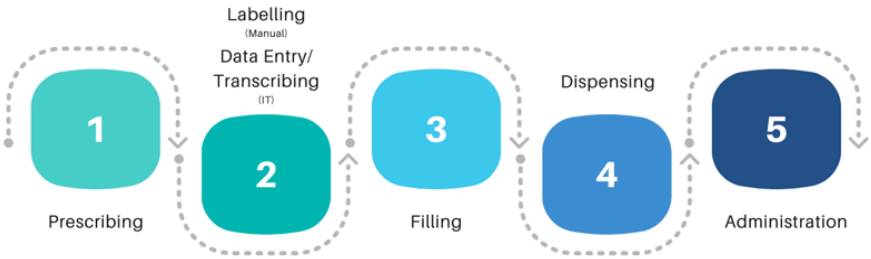
Please enter your valid e-mail address and facility details (State and name of facility). A valid email address is required to be contacted in case of any issues with your report.

Error Settings

1.Date of Event	Date when the error happened, not the date when the error was reported.
2.Time of Event (24 hour)	Time when the error occurred.
3.Type of Facility	Please select accordingly.
4.Setting of Event	Location where the error occurred (not where the error detected). Location of event is related to the process in which the error occur.

Details of Error

5.Error Description 	Please describe the error. Include description/ sequence of events and work environment (e.g. change of shift, short staffing, during peak hours).

6.Initial Process	Please choose only ONE initial process in which the ME was initiated.  The "initial process of error" refers to the very first activity where the error originated or was introduced
7.Other Processes	To be chosen if there are other processes involved in the error (can choose more than one). Please **do not** select the same process as INITIAL process of error.
8.Did the error reach the patient?	• Yes, if medication reaches the patient • No, if medication didn't reach the patient • An "error of omission" does reach the patient
9.Type of Error	Refers to the specific category or nature of the mistake that occurred during the medication use process. **01 Omission Error** Failure to administer an ordered dose before the next scheduled dose or failure to prescribe or dispense a drug product that is indicated for the patient. This excludes cases where the patient refuses and clinical decisions are made, or other valid reasons exist for not administering the medication **02 Wrong Time Error** Prescribing, dispensing (inc. transcribing) or administration of a medication outside a predefined time interval from its scheduled frequency **03 Wrong Drug Error** Prescribing, dispensing (inc. filling, transcribing) or administration of a drug that is not intended for the patient **04 Dose Error** Prescribing, dispensing (inc. filling, transcribing), or administering a dose of a drug that is incorrect for the patient, whether it is higher or lower than the intended dose **05 Dosage Form Error** Prescribing, dispensing (inc. filling, transcribing), or administration of a drug product in a dosage form different from what was intended **06 Drug Preparation Error** Drug product incorrectly formulated or manipulated before administration E.g. TPN, CDR, Extemporaneous preparation **07 Route of Administration Error** Use of wrong route of administration of the correct drug **08 Administration Technique Error** Inappropriate procedure or improper technique in the administration of a drug other than wrong route **09 Deteriorated Drug Error** Dispensing (inc. filling) or administration of a drug that has expired or for which the physical or chemical dosage-form integrity has been compromised **10 Other Medication Error** Any medication error that does not fall into one of the above predefined categories, i.e. Wrong patient
10.Sub-Type of Error	Refers to the specific type of error that occurred.
11.Error Outcome Category	Select only one of the categories, that best fits the error reported. A: Potential error, circumstances/ events have potential to cause incident B: Near Miss - did not reach patient C: Actual Error - caused no harm D: Additional monitoring required to preclude harm E: Treatment / intervention required - caused temporary harm F: Initial/ prolonged hospitalization - caused temporary harm G: Caused permanent harm H: Near-death event I: Death

12.Direct Result to the Patient	Please describe the direct result to the patient. Example: No harm, harm (please specify, e.g. tachycardia/ bradycardia/ seizure attack), additional patient monitoring includes, vital signs monitoring, sign & symptoms of toxicity, blood glucose monitoring, TDM level monitoring, Glasgow coma scale, etc.
13(a).Most Possible Error Cause & Factor *13(b),(c).Other Possible Error Cause & Factor*	Indicate the possible error cause(s) and contributing factor(s). Multiple options may be selected, if applicable.

Staff Factor	1	Inexperienced personnel
	2	Inadequate knowledge
	3	Distraction
	4	Careless
	5	Fatigue/ Tired
Medication related	1	Sound alike medication
	2	Look alike medication
	3	Look alike packaging
Work and environment	1	Heavy workload
	2	Peak hour
	3	Stock arrangements/ storage problem
	4	Disturbance at workplace
	5	Working environment

Task and Technology	1	Failure to adhere to work procedure
	2	Use of abbreviation
	3	Illegible handwriting
	4	Patient information/record/ unavailable/ inaccurate
	5	Wrong labeling/ instruction on dispensing envelope or bottle/ container
	6	Incorrect computer entry
	7	Computerized System Error
	8	Availability / Reliability of Information
Team Factor	1	Communication

14.Which category made the initial error?	Please select the personnel category that started the initial error. This personnel category must corresponds to the initial error process.
15.Other category also involved in the error?	Is there anyone else who was involved in causing the error to occur? (Please select only if applicable)
16.Which category discovered the error or recognized the potential error?	Please select the personnel/person who detected the error.

Patient Particulars

17.Age	Patient's particulars are optional fields but reporters are encouraged to fill in these particulars.
18.Gender	Patient's particulars are optional fields but reporters are encouraged to fill in these particulars.

Product Details

*19,20.Name of **Intended** Product*	Please select from the list provided, if the product is listed in FUKKM. If the product is a non-FUKKM item, please select 'Others' and state the name of the product at Q20.
*21.Dosage Form **Intended***	Please select from the list provided.
*22.Details of **Intended** Product*	Please state the dose/strength, frequency, duration and route of administration for the intended product.
*23,24.Name of **Error** Product*	Please select from the list provided, if the product is listed in FUKKM. If the product is a non-FUKKM item, please select 'Others' and state the name of the product at Q24.
*25.Dosage Form **Intended***	Please select from the list provided.
*26.Details of **Intended** Product*	Please state the dose/strength, frequency, duration and route of administration for the error product.
27.Look alike medications	Please state if the error was caused by similar product packaging.
28.Details of manufacturer & brand	Include the details of the manufacturer of the product and the brand name.

Relevant Materials & RCA

Please attach all relevant materials to complete the report.
Example:

1. Snapshot of the similar product packaging.
2. Prescriptions (i.e. if the error was caused by illegible handwriting).
3. Chronology of the events or error description.
4. RCA report.

Please combine all the necessary documents into ONE file, and the file size must not exceed **10MB,** preferably in pdf format. Once submitted, the file cannot be edited or removed.

Reporter Details

30.Reporter's Name	Name or initial of the reporter.
31.Reporter's Facility	The reporter's current workplace location.
32.Contact Details	Office telephone number or mobile phone number.

Once submitted, you will be notified with an e-mail containing the reference number for your submission.

For any inquiries, please reach us out at:

Ambulatory Pharmacy Section
Pharmaceutical Care Branch
Pharmacy Practice and Development Division
Ministry of Health
mers@moh.gov.my
03-7841 3200 (ext: 3622/3381)