



# MEDICATION ERROR (ME) REPORT FORM

MERS reference no:

ME/ref/

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)

<b>1 Date of event:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> dd/mm/yy	<b>2 Time of event:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> hh/mm (24 hr)
<b>3 Type of Facility:</b> * Government/ Private <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Pharmacy <input type="checkbox"/> Others: _____	<b>4 Location of event:</b> <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.

<b>6</b> In which process did the error occur? <input type="checkbox"/> Prescribing <input type="checkbox"/> Data Entry System <input type="checkbox"/> Filling <input type="checkbox"/> Labelling <input type="checkbox"/> Dispensing <input type="checkbox"/> Administration <input type="checkbox"/> Others (Please specify) : _____	<b>7</b> Did the error reach the patient? <input type="checkbox"/> YES <input type="checkbox"/> NO  <b>8</b> Was the incorrect medication, dose or dosage form administered to or taken by the patient? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>9</b> Describe the direct result on the patient (e.g. death, type of harm, additional patient monitoring e.g. BP, HR, glucose level etc.).
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**10** Please tick the appropriate Error Outcome Category (Select one)

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

Reference: © 2001 National Coordinating Council for Medication Error Reporting and Prevention

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

<input type="checkbox"/> <b>Staff factors</b> <input type="checkbox"/> Inexperienced personnel <input type="checkbox"/> Inadequate knowledge <input type="checkbox"/> Distraction  <input type="checkbox"/> <b>Medication related</b> <input type="checkbox"/> Sound alike medication <input type="checkbox"/> Look alike medication <input type="checkbox"/> Look alike packaging	<input type="checkbox"/> <b>Task and technology</b> <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"/> <b>Work and environment</b> <input type="checkbox"/> Heavy workload <input type="checkbox"/> Peak hour <input type="checkbox"/> Stock arrangements/ storage problem <input type="checkbox"/> <b>Others (please specify):</b> ..... .....
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For question 12-14, please fill each box with one of the following option.

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

**12** Which category made the initial error?

**13** Other category also involved in the error?

**14** Which category discovered the error or recognised the potential error?

**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		

If error involved similar product packaging, please fill in 16.5-16.7.

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"/>
E-mail :	
Telephone number :	Fax Number :

**For official use :**

Date report received :

dd/mm/yy

Ref. No.

ME Type

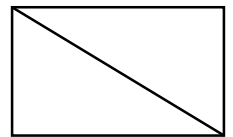
ME Category

(Fold here)

*Medication Safety*  
*Is Everyone's Responsibility*

(Fold here)

NO STAMP REQUIRED



SETEM POS TIDAK DIPERLUKAN

**REPLY PAID / JAWAPAN BERBAYAR  
MALAYSIA  
No. Lesen : BRS 0915 SEL**

Medication Safety Section  
Pharmacy Practice and Development Division  
Pharmaceutical Services Programme  
Ministry of Health Malaysia  
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46790 Petaling Jaya, Selangor.