



# MEDICATION ERROR (ME) REPORT FORM

Pharmaceutical Services Programme  
Ministry of Health Malaysia  
www.pharmacy.gov.my  
Tel: 03-78413200 mers@moh.gov.my

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)

MERS reference no:  
**ME/ref/**

<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 Setting 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.  
 Eg.: Prescribing error (wrong drug). Dr prescribed T.Prazosin 1mg OD instead of T.Prazosin 1mg BD. Error detected by pharmacist during dispensing.

<b>6</b> INITIAL process in which the error was initiated. <input type="checkbox"/> Prescribing <input type="checkbox"/> Data Entry System <input type="checkbox"/> Labelling (manual) <input type="checkbox"/> Filling <input type="checkbox"/> Dispensing <input type="checkbox"/> Administration <input type="checkbox"/> Others (Please specify) : _____	<b>7</b> Other processes involved in ME (Can choose more than one, DO NOT REPEAT PROCESS IN Q.6) <input type="checkbox"/> Prescribing <input type="checkbox"/> Data Entry System <input type="checkbox"/> Labelling (manual) <input type="checkbox"/> Filling <input type="checkbox"/> Dispensing <input type="checkbox"/> Administration <input type="checkbox"/> Others (Please specify) : _____	<b>8</b> Did the error reach the patient? <input type="checkbox"/> YES <input type="checkbox"/> NO <hr/> <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 Near Miss – did not reach patient	<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"/> Careless <input type="checkbox"/> Fatigue/Tired  <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 handwriting/prescription <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"/> Computerized System Error <input type="checkbox"/> Availability/Reliability of Information	<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"/> Disturbance at workplace <input type="checkbox"/> Working environment  <input type="checkbox"/> <b>Team Factor</b> <input type="checkbox"/> Communication <input type="checkbox"/> <b>Others (please specify):</b> _____
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Reference: Possible Error Cause(s) and Contributing Factor(s) as per QAP1 Form

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

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

**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:** \_\_\_\_\_

\* Please delete whichever not applicable

**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		

**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 : \_\_\_\_\_

**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).

(Fold here)

**Reporter's Details**

Name	
Profession	
Facility and Address	
	Postcode : <input type="text"/>
E-mail	
Telephone number	

**For official use :**

Date report received :       dd/mm/yy

Ref. No.

ME Type

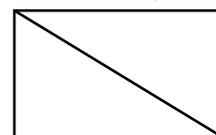
ME Category

*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**

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 Pharmaceutical Services Programme  
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