GUIDELINE ON MEDICATION ERROR REPORTING SYSTEM (MERS)
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Publication date       July 2019

Summary               Medication Error Reporting System (MERS) is a national reporting system which was introduced by the Pharmaceutical Services Programme, Ministry of Health Malaysia since 2009. It serves as a platform to encourage healthcare professionals to report any medication error encountered. This guideline describes the management of medication error and the step-by-step process on how to fill and submit report to the Medication Error Reporting System (MERS).

Replaces Document
2) Medication Error Reporting System (MERS) User Manual 2017

Author                Medication Safety Section
                      Pharmacy Practice and Development Division
                      Pharmaceutical Services Programme
                      Ministry of Health Malaysia

Applies to            All government and private healthcare facilities

Audience              Healthcare professionals

Review Date           July 2021
<table>
<thead>
<tr>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acknowledgement</td>
</tr>
<tr>
<td>2. Introduction</td>
</tr>
<tr>
<td>3. Definitions</td>
</tr>
</tbody>
</table>
| 4. About this guideline  
  - Purpose of This Guideline  
  - Scope of Reporting  
  - Reporting Medium |
| 5. Management of Medication Error  
  - Reporting Medication Error  
  - Analysis and Monitoring of Medication Error  
  - Establishing Error Preventive Strategies  
  - Dissemination of Information  
  - Quality Improvement Programme  
  - Adopt Just Culture |
| 6. Medication Error Reporting System (Online)  
  - User Guide I : User Registration (Reporter)  
  - User Guide II: Forget Password/ Unblock Account  
  - User Guide III : Create Medication Error Report  
  - User Guide IV : Amend Report (Enquiry) |
| 7. Medication Error Reporting System (Manual) |
| 8. Appendices  
  - Flow Chart (MERS Online)  
  - Guide For Categorizing Medication Errors  
  - Types of Medication Error  
  - Case Examples  
  - Medication Error Reporting Form (Manual) |
First and foremost we like to express our sincere gratitude to the authors and individuals involved directly or indirectly for their valuable and constructive comments in the establishment of this guidelines.

We wish to thanks all Medication Safety Liaison Officers in the state level for their support and efforts towards promoting and improving medication safety practice in the hospitals and health clinics.

Not to forget, our extend appreciation to all the healthcare personnel in the hospitals and health clinics for their commitment, teamwork and initiative in ensuring safe medication practice.

Last but not least, we would like to acknowledge and thanks to all healthcare professionals for their constant reporting medication errors and every efforts taken to prevent medication errors in their facilities.

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INTRODUCTION
Medication safety is one of the vital components in patient safety. Unfortunately medication errors do occur and often go undetected. Some medication errors may result in serious patient morbidity and mortality. Error detection through an active management and effective reporting system discloses medication error and encourage safe practice. Hence, Medication Error Reporting System also known as MERS was introduced in 2009 as a mechanism tool and platform for monitoring medication errors at the national level. The reporting system will encourage all healthcare professionals to report any medication errors encountered. In 2013, MERS was upgraded to online system to provide easier access on reporting and sharing the lesson learnt from incident that happened.

The primary objective of medication error reporting is to obtain information and maintain a database on the occurrence of all medication errors related to medication use in prescribing, dispensing, administration, monitoring and others process involved in medication management system. The reports which submitted through MERS will be analysed to establish risk reduction strategies and promote safe medication use.

Findings from MERS will provide important knowledge that can be used as a guide in developing strategies, policies and action plan to strengthen the current healthcare system. This system requires a collective effort from various parties and a change in the way of management of medication errors. We need to be able to discuss errors openly, encourage reporting of errors and maintain a culture that is non-punitive and blamelessness.

All the report submitted will maintain confidentiality with regards to the identity of patients and the healthcare professionals involved.
DEFINITIONS

Medication Error

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.

Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labelling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

Actual Error

• Medication error occurred and reached the patient.

• If patient detected the error, it is consider as actual error.

Near Miss

• Medication error that has the potential to cause an adverse event (patient harm) but did not reach the patient because of chance or because it is intercepted in the medication use process.

• If the healthcare personnel detected and corrected the error BEFORE it reaches the patient, it is consider as near miss.

References
1. World Health Organization (WHO)
2. United States National Coordinating Council for Medication Error Reporting and Prevention
3. Agency for Healthcare Research and Quality (AHRQ)
ABOUT THIS GUIDELINE
PURPOSE OF THIS GUIDELINE

1. This guideline is served as a guidance for healthcare professionals to report medication error encountered.
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.

• Administrative errors such as no countersign for List A medications, doctor signed prescription without official chop, prescribed medication which is not available in the facility’s formulary shall not be reported to MERS.

• Other cases that not to be reported includes:
  a) Doctor prescribed drug that the patient is allergy to without previous patient history. In this case, please report to the National Centre for Adverse Drug Reactions Monitoring.
  b) Pharmacist’s intervention due to treatment optimization (e.g. suggest to increase insulin dose because the blood glucose is not well-controlled with the current dose).

REPORTING MEDIUM

Medication error report can be submitted online or manually.

a) ONLINE
   Report to be submitted online through https://mers.pharmacy.gov.my

b) MANUAL
   Refer Appendices: Medication Error (ME) Report Form

1. Reporters are encouraged to submit report via online.
2. The manual reporting form is to be submitted to the person-in-charge for medication error reporting in the facility.
3. If your facility is not listed in the system, especially the private healthcare facilities, kindly e-mail to mers@moh.gov.my.
MANAGEMENT OF MEDICATION ERROR
1) REPORTING MEDICATION ERROR

- Detect and report any medication error encountered.

- Reportable events include both actual errors and the errors that have been detected and corrected before reach the patient.

- Document and report immediately after detected the error in accordance to the standard process/ work flow of the facilities.

2) ANALYSIS AND MONITORING OF MEDICATION ERROR

- 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 & Learning System 2.0 for Ministry of Health Malaysia Hospital First Edition 2017)

3) ESTABLISHING ERROR PREVENTIVE STRATEGIES

- Establish Patient/ Medication Safety committee to discuss all patient safety related issues.

- Establish/ Implement error prevention strategies that focus on system design/ safe behavioural practices and are monitored continuously.

- Include medication safety elements in the ward check list/ pharmacy visit list/ audit.
4) DISSEMINATION OF INFORMATION

- Organize continuous education/learning sessions to share all the medication errors and the error preventive strategies among the staff.

5) QUALITY IMPROVEMENT PROGRAMME

- Record and analyse 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).

6) ADOPT JUST CULTURE

- Adopt JUST CULTURE model of shared accountability for safe system design and behavioural changes supported by the high level managements. Just culture encourages individuals to speak up and to report a medication error, allows for proper judgement of the medication error and provides learning opportunities to all healthcare professionals.

- There is a visible commitment on patient safety goals within the organization (e.g. specific medication safety indicators/ objectives are included in the facility’s plan).

- Facility adopt no-blame culture in managing medication error.

- There is a good cooperation among hospital/facility units in order to work together and provide best care for patients.
Who can report?

Only healthcare professionals can register to the online Medication Error Reporting System (MERS) and submit report.

How to report?

2. Log in using your username and password. If you haven’t register to the system, kindly do so and follow User Guide I: Registration.
3. Complete the form and submit.

How to complete the reporting form?

The medication error reporting form contains 6 parts:
Part A : Error Details
Part B : Location and Error Outcome
Part C : Patient’s Particulars
Part D : Product Details
Part E : Attachment
Part F : Reporter’s Details

For the step-by-step guide, kindly refer to:
• User Guide I : User Registration (Reporter)
• User Guide II : Forget Password/ Unblock Account
• User Guide III : Create Medication Error Report
• User Guide IV : Amend Report (Enquiry)
MEDICATION ERROR REPORTING SYSTEM (ONLINE)

User Guide I : User Registration (Reporter)
1. Go to https://mers.pharmacy.gov.my

2. Click on the link as shown below.

   ![User Login Form]

   - Username: [enter username]
   - Password: [enter password]
   - Login
   - Forget password?
   - Don't have Username? Register Here. (only for Healthcare Providers)
3. Fill in all the particulars.

- **Address**, **Tel no**, **Fax no** will be autofilled after selecting the facility.

<table>
<thead>
<tr>
<th><em>Facility:</em></th>
<th>Please Select</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Address:</em></td>
<td></td>
</tr>
<tr>
<td><em>Postcode:</em></td>
<td></td>
</tr>
<tr>
<td><em>Telephone No:</em></td>
<td>(Office) (Handphone)</td>
</tr>
<tr>
<td>Fax No:</td>
<td></td>
</tr>
<tr>
<td><em>Email:</em></td>
<td></td>
</tr>
</tbody>
</table>

A VALID & ACTIVE email address.

- Please fill at least 8 characters (combination of letters + numbers or symbol).
  - Example: P@ssword1234

- Please remember the security question and answer. You may need to use it to retrieve your password later.

| *User ID:*      |               |
| *Password:*     |               |
| *Verify Password:* |           |

**Security:** Please Select

- What Is Your Pet’s Name?
- What Is Your Mother’s First Name?
- What Was The Color Of Your First Car?
- What Is The Title Of Your Favorite Book?
- What Is The Name Of The First School You Attended?
- In What State Were You Born?
- What Is Your Favorite Animal?
- What Is Your Favorite Tv Program?
- Who Am I?
4. Click **SUBMIT** button after all the particulars are completely filled.

5. Message would appear upon successful registration.

6. Once registered successfully, key in your username and password.

1. If your facility is not listed, kindly e-mail to mers@moh.gov.my along with your facility’s details.
2. Please use a valid and active email
3. Avoid using IC No for user ID
4. Registration for user other than reporter such as Reporter HQ, Verifier, JKN Viewer etc will be done by Pharmacy Practice & Development Division, MOH. Kindly e-mail to mers@moh.gov.my.
Forget Password

1. If you forgot your password, click on the ‘forgot password’.

2. In order to obtain your password, you need to fill in your email, security question and answer. Make sure you remember the security question and answer. Then, click SUBMIT.

3. If all the details are correct, the system will automatically send a new password to your registered email.
Notification e-mail:

![User ID and Password for MERS](image)

Dear User,

Your password have been reset.

Your User ID and new password is shown below:

```
User ID : TESTING1
Password : Mz2ME7lt
```

Please be reminded that all characters are case-sensitive.

It is recommended that you login using the above details and change your new password.

Thank you.

Yours sincerely,

Administrator

4. You may now log in using the user ID and the default password.

![User Login](image)

Click Login

Fill in your username and your new password given by the system

5. You may change your password in the [User Profile] > [Change Password].

![Change Password](image)

Fill in the old and new password then click save.
Unblock Account

User access will be blocked if failed to log in after 3 attempts.

1. If your account has been blocked, kindly contact the administrator through email mers@moh.gov.my to reset your password.

2. E-mail details:

   Title: To unblock MERS user account

   Information to be included:
   a) Full name of the user/ Name registered for that account
   b) Username
   c) Facility name
   d) E-mail address
1. Go to https://mers.pharmacy.gov.my

2. Log in with your Username and Password

   Fill in the username and password.

   Click Login
3. Click on Menu [Create ME Report]

4. A pop-up window will appear. Choose either:
   a) **OWN FACILITY** (if you are reporting for your own facility).

By choosing “Own Facility”, the column location of facility and the all the reporter’s details will be auto-filled based on the user profile.
b) ON BEHALF (if you are reporting for other facilities)

By choosing “On Behalf”, you need to fill in the location of facility and the reporter’s details.
**Part A: Error Details**

* 1. **Date of Event**

   Date when the error happened, not the date when the report was key in.

* 2. **Time of Event**

   Time when the error occurred.

* 3. **Description of error**

   What happened? Sequence of event? When error was detected? (no need to include the name of the personnel who did the error / patient’s information).

   - Type of medication error, e.g. prescribing error/ dispensing error/ administration error
   - The error involved
   - Prescribing error (wrong frequency). Doctor prescribed Tab Metformin 500mg QID instead of Tab Metformin 500mg BD. Error detected before dispensing.
   - Brief description of the error
   - Briefly describe who detected the error

   **Example:**

   1. **Dispensing error (wrong drug).** Pharmacist dispensed Tab Akurit-2 instead of Tab Akurit-4. Patient had taken T Akurit-2 for 2 weeks.

   2. **Administration error (wrong patient).** Nurse wrongly administered 50ml of Metronidazole to patient A who is allergy to Metronidazole instead of Patient B. Error detected by the specialist during ward round.

   Fields marked with * are compulsory fields.
4. Contributing factor

Indicate the possible error cause(s) and contributing factor(s). More than one options may be selected.

5. Category made the initial error

Who caused the error to occur?

Example:

<table>
<thead>
<tr>
<th>Me Type</th>
<th>Category made the initial error (under normal circumstances)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing error</td>
<td>Specialist, MO, HMO, AMO, Dentist, Nurse</td>
</tr>
<tr>
<td>Dispensing error</td>
<td>Pharmacist, PRP, PA, PA(Trainee)</td>
</tr>
<tr>
<td>Administration error</td>
<td>Specialist, MO, HMO, AMO, Nurse, Nurse(Trainee)</td>
</tr>
<tr>
<td>Transcribing error</td>
<td>Specialist, MO, HMO, AMO, Dentist, Pharmacist, PRP, PA, PA(Trainee)</td>
</tr>
<tr>
<td>Monitoring error</td>
<td>Specialist, MO, HMO, AMO, Dentist, Pharmacist, PRP, PA, PA(Trainee)</td>
</tr>
<tr>
<td>Registration</td>
<td>Registration counter staff (e.g. PRA)</td>
</tr>
<tr>
<td>Preparation of Drugs</td>
<td>Pharmacist, PRP, PA, PA(Trainee), Nurse</td>
</tr>
<tr>
<td>Documentation</td>
<td>Pharmacist, PRP, PA, PA(Trainee), Nurse</td>
</tr>
</tbody>
</table>

6. Category also involved in the error

Who also involved causing the error to occur?

7. Category detected the error

Who detected the error occurred?

8. Recommendation/ Remedial action taken

Describe the corrective / preventive action taken to avoid the error so it would not occur.

Fields marked with * are compulsory fields.
Part B: Location and Error Outcome

* 9. Location of Facility

Facility where the error occurred.

<table>
<thead>
<tr>
<th>Agency Type</th>
<th>State</th>
<th>District</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>Selangor</td>
<td>Hulu Langat</td>
<td>- Please Select -</td>
</tr>
<tr>
<td>Private</td>
<td>- Please Select -</td>
<td>- Please Select -</td>
<td>- Please Select -</td>
</tr>
<tr>
<td>Non-MOHH</td>
<td>- Please Select -</td>
<td>- Please Select -</td>
<td>- Please Select -</td>
</tr>
</tbody>
</table>

If your facility is not listed in the system, kindly e-mail to mers@moh.gov.my.

* 10. Location of Event

Location where the error occurred (not where the error detected). Location of event is related with the process in which the error occur.

Example:

<table>
<thead>
<tr>
<th>Me Type</th>
<th>Location of event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing error</td>
<td>Clinic/ Ward/ A&amp;E</td>
</tr>
<tr>
<td>Dispensing error</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Administration error</td>
<td>Clinic/ Ward/ A&amp;E</td>
</tr>
<tr>
<td>Data entry system error</td>
<td>Clinic/ Ward/ A&amp;E/ Pharmacy</td>
</tr>
<tr>
<td>Monitoring error</td>
<td>Clinic/ Ward/ A&amp;E</td>
</tr>
<tr>
<td>Registration</td>
<td>Registration counter</td>
</tr>
<tr>
<td>Preparation of Drugs</td>
<td>Clinic/ Ward/ A&amp;E/ Pharmacy</td>
</tr>
<tr>
<td>Documentation</td>
<td>Clinic/ Ward/ A&amp;E/ Pharmacy</td>
</tr>
</tbody>
</table>

Fields marked with * are compulsory fields.
Part B: Location and Error Outcome

11. In which process did the error occur.
   
   (Note: You may select more than 1 option given).

Example:

<table>
<thead>
<tr>
<th>Location of event</th>
<th>In which process did the error occur</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>Prescribing, Dispensing, Administration, others</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Prescribing, Administration, others</td>
</tr>
<tr>
<td>Clinic</td>
<td>Prescribing, Administration, others</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Data Entry System, Labelling, Filling, Dispensing</td>
</tr>
<tr>
<td>Others</td>
<td>Registration</td>
</tr>
</tbody>
</table>

12. 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

13. Was the incorrect medication, dose or dosage form administered to or taken by the patient?
   
   - Yes, if medication reaches the patient and is administered
   - No, if medication reaches the patient but not administered

14. Error Outcome Category

In selecting the patient outcome category, select the highest level severity that applies during the course of the event. For example, if a patient suffers a severe anaphylactic reaction (Category H) and requires treatment (Category F) but eventually recovers completely, the event should be coded as Category H.

Select only one of the medication error categories or subcategories, whichever best fits the error that is being reported.

Fields marked with * are compulsory fields.
**Error Outcome Category**

<table>
<thead>
<tr>
<th>Category A</th>
<th>Circumstances or events that have the capacity to cause error. Example: Illegible handwriting, use of abbreviation, incorrect quantity wrongly fill floor stock (error did not happen but might happen if no checking or clarification made)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category B</td>
<td>An error occurred but the error did not reach the patient (An “error of omission” does reach the patient). Example: Error detected before dispensing to the patient.</td>
</tr>
</tbody>
</table>
| Category C | An error occurred that reached the patient but did not cause patient harm.  
- Medication reaches the patient and is administered.  
- Medication reaches the patient but not administered.  
Example: Pharmacist dispensed incorrect medication to the patient. But the patient realized that the medicine is incorrect and return it back to pharmacy. |
| Category D | An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm. Example: Other patient's profile was accidentally placed inside patient's file which has lead to wrong medications prescribed during previous visit. MO was informed. Close glucose monitoring was planned for this patient. Blood glucose level was reported as mild elevation only. |

*Fields marked with * are compulsory fields.*

**ERROR, NO HARM**

[Note: Harm is defined as temporary or permanent impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom requiring intervention.]
## Error Outcome Category

<table>
<thead>
<tr>
<th>ERROR, HARM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Root cause analysis (RCA) reports are required and should be attached (Refer 20.)</td>
<td></td>
</tr>
<tr>
<td>Category E</td>
<td>An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.</td>
</tr>
<tr>
<td>Category F</td>
<td>An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalisation.</td>
</tr>
<tr>
<td>Category G</td>
<td>An error occurred that may have contributed to or resulted in permanent patient harm.</td>
</tr>
<tr>
<td>Category H</td>
<td>An error occurred that required intervention necessary to sustain life.</td>
</tr>
<tr>
<td>ERROR, DEATH</td>
<td></td>
</tr>
<tr>
<td>Category I</td>
<td>An error occurred that may contributed to or resulted in the patient's death.</td>
</tr>
</tbody>
</table>

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

15. **Describe the direct result on the patient** *(e.g. death, type of harm, additional patient monitoring)*.

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.
**Part C: Patient’s Particulars**


Click on the Patient’s Particulars tab and complete the form, then click save. Patient’s particulars are optional fields but reporters are encouraged to fill this particulars.

![Patient's Particulars Tab and Form](image)

**Part D: Product Details**

17.1 & 17.2 Generic Name ± Brand Name

* i) Tick the “Generic Name” and type in the first few alphabet, then choose from the dropdown list.

17. *Product(s) involved*
ii) Choose a Brand Name of the product from the dropdown list and the Generic Name will be auto filled. *(Brand name is optional).*

1. Generic name is **MANDATORY** to be fill up in the report.
2. Brand name is **OPTIONAL**. If the brand name is not listed, please untick the brand name and proceed with other product particulars.
3. If you wish to add in any product in the system, kindly e-mail the product details to mers@moh.gov.my.

### 17.3 Dosage Form

Type in the first few alphabet in the dosage form column, then choose from the dropdown list.
17.4 Dose, Frequency, Duration, Route

Fill in the dose, frequency, duration, route column. Then, click SAVE.

What if the error involved more than one product?

Click on ‘Add another product’ button if more than one product is involved and repeat the above steps.
17.5 Is the error involved similar packaging?

If similar packaging is involved, click YES and fill in the details (17.5.1, 17.5.2, 17.5.3). Then, click ADD.

Example:

a) Incorrect drug

b) Incorrect frequency
Example:

c) Incorrect patient

<table>
<thead>
<tr>
<th>No.</th>
<th>Product</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Dosage form</th>
<th>Dose, frequency, duration, route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intended</td>
<td>Perindopril Erbumine</td>
<td></td>
<td>Tablet</td>
<td>INCORRECT PATIENT 4mg OD</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>Perindopril Erbumine</td>
<td></td>
<td>Tablet</td>
<td></td>
</tr>
</tbody>
</table>


d) Incorrect dosage form

<table>
<thead>
<tr>
<th>No.</th>
<th>Product</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Dosage form</th>
<th>Dose, frequency, duration, route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intended</td>
<td>Chloramphenicol</td>
<td>CHLORAMPHENICOL EAR DROPS 5%</td>
<td>Drops, ear</td>
<td>2 Drops BD</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>Chloramphenicol</td>
<td>CHLORAMPHENICOL EYE DROPS 0.5% W/V</td>
<td>Drops, Eye</td>
<td>2 Drops BD</td>
</tr>
</tbody>
</table>


e) Incorrect dose

<table>
<thead>
<tr>
<th>No.</th>
<th>Product</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Dosage form</th>
<th>Dose, frequency, duration, route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intended</td>
<td>Rantidine Hydrochloride</td>
<td></td>
<td>Tablet</td>
<td>150mg BD</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>Rantidine Hydrochloride</td>
<td></td>
<td>Tablet</td>
<td>50mg BD</td>
</tr>
</tbody>
</table>

f) Incorrect quantity

<table>
<thead>
<tr>
<th>No.</th>
<th>Product</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Dosage form</th>
<th>Dose, frequency, duration, route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intended</td>
<td>Gliclazide</td>
<td></td>
<td>Tablet</td>
<td>60 Tablets</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>Gliclazide</td>
<td></td>
<td>Tablet</td>
<td>30 Tablets</td>
</tr>
</tbody>
</table>

g) Polypharmacy

<table>
<thead>
<tr>
<th>No.</th>
<th>Product</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Dosage form</th>
<th>Dose, frequency, duration, route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intended</td>
<td>Perindopril Erbumine</td>
<td></td>
<td>Tablet</td>
<td>4mg OD</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>Losartan Potassium</td>
<td></td>
<td>Tablet</td>
<td>Polypharmacy</td>
</tr>
</tbody>
</table>

Fields marked with * are compulsory fields.
Example:

h) Omission (*not filled/not prescribed/not served)

<table>
<thead>
<tr>
<th>No.</th>
<th>Product</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Dosage form</th>
<th>Dose, frequency, duration, route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intended</td>
<td>Amlodipine Besylate</td>
<td></td>
<td>Tablet</td>
<td>10mg OD</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>Amlodipine Besylate</td>
<td></td>
<td>Tablet</td>
<td>* Not Prescribed</td>
</tr>
</tbody>
</table>

i) Illegible handwriting

<table>
<thead>
<tr>
<th>No.</th>
<th>Product</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Dosage form</th>
<th>Dose, frequency, duration, route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intended</td>
<td>Metformin Hydrochloride</td>
<td></td>
<td>Tablet</td>
<td>500mg BD</td>
</tr>
<tr>
<td></td>
<td>Error</td>
<td>Metformin Hydrochloride</td>
<td></td>
<td>Tablet</td>
<td>Illegible Handwriting</td>
</tr>
</tbody>
</table>

Part E: Attachment

18. Relevant materials such as product label, copy of prescription/order.
19. Attachment for error description.
To upload the attachment, click on the ‘Choose File’ button and choose your file.

Once uploading process is 100%, the attachment name will be written on the section where you attach your file/photo as shown below.
If file size is exceed 20MB, the system will notify as shown below

Attachment for Error Description. (Include description/ sequence of events and work environment (e.g. ch hours)


Choose file Description.pptx

Total file size is over 20MB. Please select other file

1. Supporting file type: png, jpeg, MS Word, MS Powerpoint, pdf.
2. Make sure your file size not exceed 20MB.
3. Kindly upload the relevant attachment based on the question.
Part F: Reporter’s Details

21. Reporter’s Details

a) For individual account, the reporter’s details will be auto-filled.

b) For centralised account (Reporter HQ), the reporter’s details will be blank. Kindly fill in all particulars.
Click **SUBMIT** once all the tabs are completely filled.

"ME Report has been successfully sent" notification will appear, displaying your submission details.
Click **SUBMIT** once all the tabs are completely filled.

“My ME Report has been successfully sent” notification will appear, displaying your submission details. The report can be retrieved from ME Report Status > New Submission.
The report will be processed once submitted and reporter may be asked for clarification and amendment by the committee if necessary. If so, reporter will receive a notification e-mail and the report can be retrieved from ME Report Status> Enquiry. (Kindly refer to User Manual 4: Amend Report (Enquiry)).

Report that have been saved but have not submitted will be keep as DRAFT. (ME Report Status> Draft)

**Medication Error Report Status**

<table>
<thead>
<tr>
<th>Report Status</th>
<th>Action to be taken</th>
<th>Action by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft</td>
<td>ME Report saved but not submitted yet.</td>
<td>Reporter</td>
</tr>
<tr>
<td></td>
<td>Reporter have to complete the ME report and <strong>SUBMIT</strong>.</td>
<td></td>
</tr>
<tr>
<td>New Submission</td>
<td>ME Report have been submitted.</td>
<td>Verifier</td>
</tr>
<tr>
<td></td>
<td>Reporter is allow to edit ME report during this phase.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Report may be returned for clarification and amendment.</td>
<td></td>
</tr>
<tr>
<td>Enquiry</td>
<td>Report is not verified/ not approved/ not endorsed and returned to reporter for</td>
<td>Reporter</td>
</tr>
<tr>
<td></td>
<td>clarification and amendment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reporter must edit, save and <strong>SUBMIT</strong> the ME report</td>
<td></td>
</tr>
<tr>
<td>Amendment</td>
<td>Report have been edited, awaiting verification.</td>
<td>Verifier</td>
</tr>
<tr>
<td>Verified</td>
<td>Report have been verified, awaiting approval.</td>
<td>Approver</td>
</tr>
<tr>
<td>Approved</td>
<td>Report have been approved, awaiting endorsement.</td>
<td>Endorser</td>
</tr>
<tr>
<td>Endorsed</td>
<td>Report have been endorsed.</td>
<td>-</td>
</tr>
</tbody>
</table>
Medication Error Report Status

<table>
<thead>
<tr>
<th>Report Status</th>
<th>Action to be taken</th>
<th>Action by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft</td>
<td>ME Report saved but not submitted yet. Reporter have to complete the ME report and SUBMIT.</td>
<td>Reporter</td>
</tr>
<tr>
<td>New Submission</td>
<td>ME Report have been submitted. Reporter is allow to edit ME report during this phase.</td>
<td>Verifier</td>
</tr>
<tr>
<td>Enquiry</td>
<td>Report is not verified/ not approved/ not endorsed and returned to reporter for feedback and amendment. Reporter must edit, save and SUBMIT the ME report</td>
<td>Reporter</td>
</tr>
<tr>
<td>Amendment</td>
<td>Report have been edited, awaiting verification.</td>
<td>Verifier</td>
</tr>
</tbody>
</table>

A notification e-mail will be send to the reporter if the ME report is not verified/ not approved/ not endorsed. Thus, please ensure the registered e-mail address is valid.

1) Click on the link in the e-mail to access the report to make amendment(s).

![Link](https://mers.pharmacy.gov.my/MESStatus/Update/?id_mederr=135013)

Click on this link to access the report.
2) You will be directed to the MERS home page. Log in the system and you will be directed to the report. Your details must match with the reporter’s account, if not, your access will be denied.

OR  Alternatively, you can also access the report by choose form the menu bar [ME Report Status] > [Enquiry] after you log in to your account.
3. Read the remarks and click **EDIT** to amend report

4. Click **EDIT** tab at the bottom of the page to make the necessary amendment(s).

5. Click **SAVE** after making every changes/amendments.
Example:

Notification for report not approved/ not endorsed.

REMINDER : Report Not Approved

Administrator MERS [admin@mers.moh.gov.my]

To: ONG SU HUA

Dear Reporter,

Your report(s) sent through MERS Online is highly appreciated. Kindly take action upon the enquired report(s).

Reference No : ME/ref/2018/32211

Link : https://mers.pharmacy.gov.my/MEStatus/Update?id_mederr=135013

Remarks : Prescribing error. Location of event=ward/clinic/a&e. Kindly amend. Tq

Thank you

Administrator
Medication Error Reporting System
Pharmaceutical Services Division
Ministry of Health
http://mers.moh.gov.my

REMINDER : Report Not Endorsed

Administrator MERS [admin@mers.moh.gov.my]

To: ONG SU HUA

Dear Reporter,

Your report(s) sent through MERS Online is highly appreciated. Kindly take action upon the enquired report(s).

Reference No : ME/ref/2018/32211

Link : https://mers.pharmacy.gov.my/MEStatus/Update?id_mederr=135013

Remarks : Prescribing error. Location of event=ward/clinic/a&e. Kindly amend. Tq

Thank you

Administrator
Medication Error Reporting System
Pharmaceutical Services Division
Ministry of Health
http://mers.moh.gov.my
Who can report?

Only healthcare professionals can submit report to Medication Error Reporting System (MERS).

How to report?

Complete the Medication Error Reporting Form (refer appendices) and submit to the following address:

Medication Safety Section
Pharmacy Practice and Development Division
Ministry of Health Malaysia
Lot 36, Jalan Universiti,
46200 Petaling Jaya,
Selangor.

How to fill in the Medication Error Reporting Form?

* No 1-5 Describe the error occurred (date, time, type of facility, location of event and the brief description).

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DTE</td>
<td>Date of event: dd/mm/yyyy</td>
</tr>
<tr>
<td>2 TTE</td>
<td>Time of event: hh/mm (24 hr)</td>
</tr>
</tbody>
</table>
| 3 TF | Type of Facility: *Government/ Private
- Hospital
- Clinic
- Pharmacy
- Others: |
| 4 LOE | 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:)
| 5 PDE | 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. |

Fields marked with * are compulsory fields.
6. In which process did the error occur.
(Note: You may select more than 1 option given).

Example:

<table>
<thead>
<tr>
<th>Location of event</th>
<th>In which process did the error occur</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>Prescribing, Dispensing, Administration, others</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Prescribing, Administration, others</td>
</tr>
<tr>
<td>Clinic</td>
<td>Prescribing, Administration, others</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Data Entry System, Labelling, Filling, Dispensing</td>
</tr>
<tr>
<td>Others</td>
<td>Registration</td>
</tr>
</tbody>
</table>

7. Did the error reach the patient?
- Yes, if medication reaches the patient
- No, if medication didn’t reaches the patient
- An “error of omission” does reach the patient

8. Was the incorrect medication, dose or dosage form administered to or taken by the patient?
- Yes, if medication reaches the patient and is administered
- No, if medication reaches the patient but not administered

9. Describe the direct result on the patient (e.g. death, type of harm, additional patient monitoring).
   Example: Additional patient monitoring includes, vital signs monitoring, sign & symptoms of toxicity, blood glucose monitoring, TDM level monitoring, Glasgow coma scale, etc.

Fields marked with * are compulsory fields.
*10. Error Outcome Category*

In selecting the patient outcome category, select the highest level severity that applies during the course of the event. For example, if a patient suffers a severe anaphylactic reaction (Category H) and requires treatment (Category F) but eventually recovers completely, the event should be coded as Category H.

Select only one of the medication error categories or subcategories, whichever best fits the error that is being reported.

<table>
<thead>
<tr>
<th>NO ERROR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ERROR, NO HARM</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Note: Harm is defined as temporary or permanent impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom requiring intervention.]</td>
</tr>
<tr>
<td>Category B</td>
</tr>
</tbody>
</table>
| Category C | An error occurred that reached the patient but did not cause patient harm.  
- Medication reaches the patient and is administered.  
- Medication reaches the patient but not administered.  
Example: Pharmacist dispensed incorrect medication to the patient. But the patient realized that the medicine is incorrect and return it back to pharmacy. |

Fields marked with * are compulsory fields.
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm. Example: Other patient's profile was accidentally placed inside patient's file which has lead to wrong medications prescribed during previous visit. MO was informed. Close glucose monitoring was planned for this patient. Blood glucose level was reported as mild elevation only.</td>
</tr>
<tr>
<td>E</td>
<td>An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.</td>
</tr>
<tr>
<td>F</td>
<td>An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalisation.</td>
</tr>
<tr>
<td>G</td>
<td>An error occurred that may have contributed to or resulted in permanent patient harm.</td>
</tr>
<tr>
<td>H</td>
<td>An error occurred that required intervention necessary to sustain life.</td>
</tr>
<tr>
<td>I</td>
<td>An error occurred that may contributed to or resulted in the patient's death.</td>
</tr>
</tbody>
</table>

**ERROR, HARM**
Root cause analysis (RCA) reports are required and should be attached (Refer 20.)

**ERROR, DEATH**
An error occurred that may have contributed to or resulted in the patient's death.

---

**11. Contributing Factor(s)**

What caused the described error to occur?
*(Note: You may select more than 1 option given).*

- [ ] Staff factors
- [ ] 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):
  - [ ]

*Fields marked with * are compulsory fields.*
12. Category made the initial error

Who caused the error to occur?

Example:

<table>
<thead>
<tr>
<th>Me Type</th>
<th>Category made the initial error (under normal circumstances)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing error</td>
<td>Specialist, MO, HMO, AMO, Dentist, Nurse</td>
</tr>
<tr>
<td>Dispensing error</td>
<td>Pharmacist, PRP, PA, PA(Trainee)</td>
</tr>
<tr>
<td>Administration error</td>
<td>Specialist, MO, HMO, AMO, Nurse, Nurse(Trainee)</td>
</tr>
<tr>
<td>Data Entry System error</td>
<td>Specialist, MO, HMO, AMO, Dentist, Pharmacist, PRP, PA, PA(Trainee)</td>
</tr>
<tr>
<td>Monitoring error</td>
<td>Specialist, MO, HMO, AMO, Dentist, Pharmacist, PRP, PA, PA(Trainee)</td>
</tr>
<tr>
<td>Registration</td>
<td>Registration counter staff (e.g. PRA)</td>
</tr>
<tr>
<td>Preparation of Drugs</td>
<td>Pharmacist, PRP, PA, PA(Trainee), Nurse</td>
</tr>
<tr>
<td>Documentation</td>
<td>Pharmacist, PRP, PA, PA(Trainee), Nurse</td>
</tr>
</tbody>
</table>

13. Category also involved in the error

Who also involved causing the error to occur?

* 14. Category detected the error

Who detected the error occurred?

* Fields marked with * are compulsory fields.
15. Patient’s particulars: age, gender and diagnosis.

Patient’s particulars are optional fields but reporters are encouraged to fill this particulars.

16. Product details. (Fill in the relevant column).

Fill in 16.5-16.7 if the error involved similar packing.

17. Attachment.

You are encouraged to attach the relevant materials such as product label, copy of prescription/order, etc., can be reviewed. Can these materials be provided?

- [ ] No
- [ ] Yes, Please specify

______________________________

18. Recommendation/ Remedial action taken

Describe the corrective / preventive action taken to avoid the error so it would not occur.

Fields marked with * are compulsory fields.
APPENDICES

- Flow Chart (MERS Online)
- Types of Medication Error
- Case Examples
Flow Chart (MERS Online)

1. Registration
   - Refer User Guide I: User Registration (Reporter)

2. Amendment
   - Refer User Guide IV: Amend Report (Enquiry)

3. Registered to MERS online?
   - Yes
     - Create ME Report
       - Refer User Guide III: Create Medication Error Report
       - Verification
     - No
       - Medication error encountered
         - No
         - Yes

4. Approval
   - (Not endorsed)
   - Endorsed Report
     - No
     - Yes

5. Endorsement
   - (Not endorsed)
   - Endorsed Report
     - No
     - Yes

Legend:
- Responsibility Reporter
- Responsibility Verifier State
- Responsibility Pharmacy Practice & Development Division, MOH

(Return To Reporter)
Guide For Categorizing Medication Errors

Classification of Medication Error Severity

NO ERROR
- Category A: Potential error, circumstances/events have potential to cause incident

ERROR, NO HARM
- Category B: Actual Error – did not reach patient
- Category C: Actual Error – caused no harm
- Category D: Additional monitoring required – caused no harm

ERROR HARM
- Category E: Treatment/intervention required – caused temporary harm
- Category F: Initial/prolonged hospitalization – caused temporary harm
- Category G: Caused permanent harm
- Category H: Near death event

ERROR, DEATH
- Category I: Death

** An error of omission does reach the patient

© 2001 National Coordinating Council for Medication Error Reporting and Prevention
<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prescribing Error</td>
<td>Incorrect drug product selection (based on indications, contraindications, known allergies, existing drug therapy, and other factors), dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician (or other legitimate prescriber); illegible prescriptions or medication orders that lead to errors that reach the patient</td>
</tr>
<tr>
<td>b. Omission error</td>
<td>The failure to administer an ordered dose to a patient before the next scheduled dose or failure to prescribe a drug product that is indicated for the patient. The failure to administer an ordered dose excludes patient’s refusal and clinical decision or other valid reason not to administer.</td>
</tr>
<tr>
<td>c. Wrong time error</td>
<td>Administration of medication outside a predefined time interval from its scheduled administration time (this interval should be established by each individual health care facility)</td>
</tr>
<tr>
<td>d. Unauthorised drug error</td>
<td>Dispensing or administration to the patient of medication not authorised by a legitimate prescriber</td>
</tr>
<tr>
<td>e. Dose error</td>
<td>Dispensing or administration to the patient of a dose that is greater than or less than the amount ordered by the prescriber or administration of duplicate doses to the patient, i.e. one or more dosage units in addition to those that were ordered or prescribing more or less than standard dose defined in practice</td>
</tr>
<tr>
<td>f. Dosage-form error</td>
<td>Dispensing or administration to the patient of a drug product in a different dosage form than that ordered by the prescriber</td>
</tr>
<tr>
<td>Type</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>g. Drug-preparation error</td>
<td>Drug product incorrectly formulated or manipulated before administration</td>
</tr>
<tr>
<td>h. Route of administration</td>
<td>Use of wrong route of administration of the correct drug.</td>
</tr>
<tr>
<td>i. Administration-technique</td>
<td>Inappropriate procedure or improper technique in the administration of a drug other than wrong route</td>
</tr>
<tr>
<td>j. Deteriorated drug error</td>
<td>Dispensing or administration of a drug that has expired or for which the physical or chemical dosage-form integrity has been compromised</td>
</tr>
<tr>
<td>k. Monitoring error</td>
<td>Failure to review a prescribed regimen for appropriateness and detection of problems, or failure to use appropriate clinical or laboratory data for adequate assessment of patient response to prescribed therapy</td>
</tr>
<tr>
<td>l. Compliance error</td>
<td>Inappropriate patient behaviour regarding adherence to a prescribed medication regimen</td>
</tr>
<tr>
<td>m. Other medication error</td>
<td>Any medication error that does not fall into one of the above predefined categories</td>
</tr>
<tr>
<td>No</td>
<td>Scenario</td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Prescribing error detected by the pharmacy staff before dispense the medication to the patient at the dispensing counter.</td>
</tr>
<tr>
<td>2</td>
<td>Prescribing error detected by the patient at the dispensing counter.</td>
</tr>
<tr>
<td>3</td>
<td>Prescriber did not prescribe the medication that is indicated for the patient. Error detected by the pharmacy staff before dispensing.</td>
</tr>
<tr>
<td>4</td>
<td>Prescriber did not prescribe the medication that is indicated for the patient. Error detected by the patient at the dispensing counter.</td>
</tr>
<tr>
<td>5</td>
<td>Prescriber did not prescribe the medication that is indicated for the patient. Error detected by the patient and return to the pharmacy for clarification.</td>
</tr>
<tr>
<td>6</td>
<td>Medication error detected by the pharmacy staff at the dispensing counter.</td>
</tr>
<tr>
<td>7</td>
<td>Pharmacist enter wrong drug in the computerized system. Label printed out wrongly and the pharmacist assistant filled the drug based on the wrong label. Error detected before dispensing.</td>
</tr>
<tr>
<td>8</td>
<td>Medication error detected by the patient at the dispensing counter.</td>
</tr>
<tr>
<td>No</td>
<td>Scenario</td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9</td>
<td>Wrong medication dispensed to the patient and patient return to the pharmacy for clarification.</td>
</tr>
<tr>
<td>10</td>
<td>Wrong medication/ dosage supplied by the in-patient pharmacy and the error detected by nurse / doctor / pharmacist before / during drug administration.</td>
</tr>
<tr>
<td>11</td>
<td>Medication not filled by the pharmacy and the error detected by nurse</td>
</tr>
<tr>
<td>12</td>
<td>Wrong medication/ dosage given to the patient and the error detected by the patient</td>
</tr>
<tr>
<td>13</td>
<td>Medication not supplied by the pharmacy and the error detected by nurse during administration. Patient didn't missed the dose.</td>
</tr>
<tr>
<td>14</td>
<td>Medication not supplied by the pharmacy and patient missed the dose.</td>
</tr>
<tr>
<td>15</td>
<td>Medication not served in the ward.</td>
</tr>
</tbody>
</table>
MEDICATION ERROR (ME) REPORT FORM

1. Date of event: ___________ dd/mm/yy
2. Time of event: ___________ hh/mm (24 hr)

3. Type of Facility: * Government/ Private
   - Hospital
   - Clinic
   - Pharmacy
   - Others: __________________________

4. 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:……………………………………………….)

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
   - Data Entry System
   - Filling
   - Dispensing
   - 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)
    - A  Potential Error, circumstances/ events have potential to cause incident
    - B  Actual Error – did not reach patient (near miss)
    - C  Actual Error - caused no harm
    - D  Additional monitoring required - caused no 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

11. Indicate the possible error cause(s) and contributing factor(s).
    - Staff factors
      - Inexperienced personnel
      - Inadequate knowledge
      - Distraction
    - Task and technology
      - Failure to adhere to work procedure
      - Use of abbreviations
      - Illegible prescriptions
    - Medication related
      - Sound alike medication
      - Look alike medication
      - Look alike packaging
    - Work and environment
      - Heavy workload
      - Peak hour
      - Stock arrangements/ storage problem
    - Others (please specify): …………………………………………………

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 |                     |                    |
    | 16.5 Manufacturer |                         |                    |
    | 16.6 Strength / Concentration |                 |                    |
    | 16.7 Type and Size of Container |                       |                    |

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