CONFIDENTIAL

PUBLIC HEALTH MEDICATION ERROR REPORTING FORM

Complete the items that are applicable and use information available at time of Form submission.

Patient Information

Name: _____Medical Record Number: _____DOB:_____

Error Information:

Date of Error: _____Time of Error: _____Date Error discovered: _____

Location where error occurred: _____ _____

Prescribing physician notified: ❑ Yes ❑ No Name, title & contact information of individual completing form:_____

Describe the error, how it occurred, how it was discovered:

_____
_____
_____
_____
_____
_____

Category of the Error Based on Harm to the Patient: Check the ONE that applies

	NO ERROR	NO HARM
	Category A	Circumstances or events have the capacity to cause error
	ERROR	NO HARM
	Category B	Error occurred but it did not reach patient
	Category C	Error occurred that reached the patient, but did not cause harm (includes errors of omission)
	Category D	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 prevent harm
	ERROR	HARM
	Category E	Error occurred that may have contributed to, or resulted in, temporary harm to the patient and required intervention
	Category F	Error occurred that may have contributed to, or resulted in, temporary harm to the patient and required initial or prolonged hospitalization
	Category G	Error occurred that may have contributed to, or resulted in, permanent harm to patient
	Category H	Error occurred that required intervention necessary to sustain life
	ERROR	DEATH
	Category I	Error occurred that may have contributed to, or resulted in, patient death

National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) (Level of Harm) Severity Category Index, 2004

Type(s) of Medication Errors: Check ALL that apply

Prescribing errors:

- ☐ Medication prescribed not indicated for the disease stated
- ☐ Medication prescribed not indicated for the patient

Ordering errors:

- ☐ Medication prescribed with wrong, missing or unusual strengths, dosage or duration
- ☐ Medication prescribed with wrong route of administration

Dispensing errors:

- ☐ Wrong dosage, dosage form or strength dispensed
- ☐ Wrong drug dispensed
- ☐ No drug dispensed
- ☐ Mislabeled
- ☐ Wrong compounding or preparation
- ☐ Missing warning labels

Transcription errors:

- ☐ Incorrect entry to the Medication Administration Record
- ☐ Incorrect orders transcribed when patient transferred from one site to another
- ☐ Incorrect patient identification placed on the orders
- ☐ Incorrect copying of orders

Administration errors:

- ☐ Dose omission
- ☐ Administered medication at the wrong time
- ☐ Administered the wrong medication
- ☐ Administered by the wrong route
- ☐ Administered to the wrong patient
- ☐ Administered wrong strength or dosage

Other error: ☐ (see description)

NCCMERP Taxonomy of Medication Errors, 1998

Error Cause(s): Check all that apply

	Abbreviations		Contraindicated in disease		MAR variance		Storage proximity
	Brand/generic names look alike		Contraindicated in pregnancy		Monitoring inadequate/lacking		Trailing/terminal zero
	Brand/generic names sound alike		Contraindicated in breastfeeding		Packaging/container design		Transcription inaccurate/omitted
	Calculation error		Decimal point		Patient identification		Unlabeled syringe
	Communication		Dosage form confusion		Preprinted order form		Verbal/Telephone order confusion
	Computer entry		Equipment		Performance (human) deficit		Verbal/Telephone order incomplete
	Computer software		Handwriting illegible/unclear		Procedure not followed		Weight missing/inaccurate
	Contraindicated drug allergy		Knowledge deficit/training		Reference Material		Written order confusing
	Contraindicated drug/drug		Labeling		Repackaging		Written order incomplete
	Contraindicated drug/food		Leading zero missing		Similar products		Other

Error Factor(s): Check all that apply

	Contributing factor not determined		Fatigue		Patient names similar/same		Shift change
	Computer system/network down		Imprint, identification failure		Patient transfer		Staffing: explain
	Distractions/disruptions		No 24-hour pharmacy		Poor lighting		Workload increase
	Emergency situation		No access to patient information		Range orders		Other

Actions Taken or to be Taken to Prevent Errors: Check all that apply

	Communication process improved		Formulary changed/modified		Informed patient of event		Policy/procedure instituted
	Education/training provided		Informed staff event occurred		Informed caregiver of event		Staff practice modified
	Environment modified		Informed staff involved in event		Policy/procedure changed		Staff policy modified

Further suggestions regarding system changes to prevent this error:_____

_____

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DO NOT SEND THIS FORM VIA EMAIL
PLEASE FORWARD HARD COPY TO PH QUALITY IMPROVEMENT COORDINATOR
Quality Improvement: Not part of the medical record. Not discoverable by California state law (Evidence Code 1157)