MEDICATION PATIENT SAFETY REPORT

UNIT: _____ **DATE:** _____ **TIME:** _____

TITLE OF INDIVIDUAL(S) INVOLVED IN ERROR: [We are looking at staffing effectiveness]

RN LPN MD SECRETARY PHARMACIST OTHER _____

NAME OF DRUG/DOSE/ROUTE/FREQUENCY THAT WAS *ORDERED:*

SEVERITY OF EVENT (MUST *CIRCLE* ONE CATEGORY)

NO ERROR	
Category A	Circumstances that could have caused an error. *[ie: two patients with same name in same room; look alike drugs in same drawer]*
ERROR, NO HARM	
Category B	An error occurred but the error did not reach the patient. *[ie: wrong med sent but corrected before giving; transcribed on wrong chart but fixed before dose due; missing dose given within reasonable time]*
Category C	An error occurred that reached the patient but did not cause harm. *[No additional care or treatment rendered as a result. ie: stool softener given to wrong patient; med given po instead of IV; dose omitted but no harm to pt.]*
Category D	An error occurred that reached the patient and required monitoring to make sure patient not harmed or required intervention to preclude harm. *[ie: Extra dose of IV MS given requiring frequent vitals. Digoxin given to wrong patient requiring a heart monitor be used.]*
ERROR, HARM	
Category E	An error occurred that possibly resulted in temporary harm to the patient and required intervention. *[ie: Resp. depressed after extra dose of MS requiring Narcan]*
Category F	An error occurred that may have contributed or resulted in temporary harm to the patient and required initial or prolonged hospitalization. *[ie: IV dig on wrong pt. – ICU x 2 days.]*
Category G	An error occurred that may have contributed to or resulted in permanent patient harm. *[ie: IM med given in vein vs. muscle causing paralysis]*
Category H	An error occurred that required intervention necessary to sustain life. *[ie: IM dose of Demorol given IV requiring intubation]*
ERROR, DEATH	
Category I	An error occurred that may have contributed or resulted in patient's death. *[ie: potassium given IV push-lethal arrhythmia-death]*

TURN OVER AND COMPLETE THE CHECKLIST TO FINISH THE REPORT!

ST. VINCENT CHARITY
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A Ministry of the Sisters of Charity Health System

PATIENT LABEL

MR.ORDER

MEDICATION PATIENT SAFETY REPORT

TYPE OF ERROR

- ☐ Not determined
- ☐ Expired Product
- ☐ Improper dose or quantity
- ☐ Prescribing error
- ☐ Wrong administration technique
- ☐ Wrong drug preparation
- ☐ Wrong route
- ☐ Deteriorated product
- ☐ Extra dose
- ☐ Omission error
- ☐ Unauthorized drug
- ☐ Wrong dosage form
- ☐ Wrong patient
- ☐ Wrong time

CONTRIBUTING FACTORS

(check all that apply)

- ☐ Not determined
- ☐ Computer down
- ☐ Distractions
- ☐ No 24-hour pharmacy
- ☐ None
- ☐ Poor lighting
- ☐ Staff, agency
- ☐ Staff, inexperienced
- ☐ Staff, insufficient
- ☐ Code situation
- ☐ Cross coverage
- ☐ Emergency situation
- ☐ No access to pt. info
- ☐ Pt. transfer
- ☐ Shift change
- ☐ Staff, floating
- ☐ Staffing, alternative hours
- ☐ Workload increase

POSSIBLE CAUSES

(check all that apply)

- ☐ Not determined
- ☐ Brand names look alike
- ☐ Brand/generic names look alike
- ☐ Brand names sound alike
- ☐ Brand/generic names sound alike
- ☐ Calculation error
- ☐ Computer entry
- ☐ Computer software
- ☐ Computerized Prescriber Order Entry
- ☐ Contradicted, drug/allergy
- ☐ Contradicted, drug/food
- ☐ Contraindicted, drug/drug
- ☐ Contraindicted in disease
- ☐ Diluent wrong
- ☐ Documentation
- ☐ Drug distribution system
- ☐ Equipment design
- ☐ Generic names look alike
- ☐ Generic names sound alike
- ☐ Handwriting illegible or unclear
- ☐ IS
- ☐ Label (manufacturer) design
- ☐ Labeling (SVCH)
- ☐ Label (SVCH) design
- ☐ Measuring device
- ☐ Non-formulary drug
- ☐ Packaging or container design
- ☐ Prefix/suffix misinterpreted
- ☐ Procedure/protocol not followed
- ☐ Pump, improper use
- ☐ Repackaging by other facility
- ☐ Similar packaging or labeling
- ☐ System safeguard
- ☐ Transcription inaccurate/omitted
- ☐ Written order
- ☐ Abbreviations
- ☐ Communication
- ☐ Decimal point
- ☐ Dispensing device involved
- ☐ Dosage form confusion
- ☐ Drug shortage
- ☐ Fax/scanner involved
- ☐ Incorrect medication activation
- ☐ Knowledge deficit
- ☐ Leading zero missing
- ☐ Monitoring lacking or inadequate
- ☐ Non-metric units used
- ☐ Performance (human) deficit
- ☐ Preprinted med order form
- ☐ Pump, failure/malfcn.
- ☐ Reference material
- ☐ Repackaging by SVCH
- ☐ Storage proximity
- ☐ Trailing/terminal zero
- ☐ Verbal order

PATIENT CARE REQUIRED DUE TO ERROR

(check all that apply)

- ☐ Dialysis
- ☐ Hospitalization, initial
- ☐ Hospitalization, prolonged 6-10 days
- ☐ Hospitalization, prolonged 1-5 days
- ☐ Narcotic antagonist
- ☐ O2 administered
- ☐ Transferred to higher level of care
- ☐ Diagnostic test done
- ☐ Antidote adm.
- ☐ Drug therapy started or changed
- ☐ Lab test done
- ☐ Observation started or increased
- ☐ Surgery performed
- ☐ VS monitoring started or increased

Thank you for your assistance in preventing medication errors and ensuring patient safety!

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SVPOD-156