



Medication Error Notification Form



*To err is human
Notification without
blame.*

All Medication Errors Should Be Notified. This Information is Strictly Confidential		
A) Region:	Health facility name: Hospital <input type="checkbox"/> Health center <input type="checkbox"/> Clinic <input type="checkbox"/>	Name: <i>Optional</i>
B) Date and time of the incident: DD/MM/YY Time 00:00	Patient Age: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Was the medicine actually administered To the patient? <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> Unknown
C) Place of Incident: <input type="checkbox"/> ARV Pharmacy <input type="checkbox"/> Outpatient pharmacy <input type="checkbox"/> Inpatient Ward <input type="checkbox"/> Casualty		
D) Name of Medicine prescribed: <i>(Write exactly as the prescriber has written)</i>	E) Name of the other medicine involved (prescribed/ dispensed) in error. <i>(If applicable):</i>	
F) *Type of incident: <input type="checkbox"/> In correct medicine <input type="checkbox"/> Incorrect formulation <input type="checkbox"/> In correct route of administration <input type="checkbox"/> Known allergic patient <input type="checkbox"/> In correct IV rate <input type="checkbox"/> Expired medication <input type="checkbox"/> In correct IV/SC solution preparation <input type="checkbox"/> Dose omitted <input type="checkbox"/> In correct patient <input type="checkbox"/> In correct time <input type="checkbox"/> Incorrect duration of treatment <input type="checkbox"/> Incorrect dose <input checked="" type="radio"/> Longer <input checked="" type="radio"/> Higher <input checked="" type="radio"/> Shorter <input checked="" type="radio"/> Lower <input type="checkbox"/> Other: _____		G) *At what stage did the incident occur? <input type="checkbox"/> Prescribing <input type="checkbox"/> Transcribing <input type="checkbox"/> Counseling <input type="checkbox"/> Labeling <input type="checkbox"/> Dispensing <input type="checkbox"/> Administering <input type="checkbox"/> Using/ Taking <input type="checkbox"/> Monitoring <input type="checkbox"/> Other: _____
H) *Person that detected the incident: <input type="checkbox"/> Pharmacist <input type="checkbox"/> Pharmacist assistant <input type="checkbox"/> Pharmacist (intern) <input type="checkbox"/> Doctor <input type="checkbox"/> Doctor (intern) <input type="checkbox"/> Nurse <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Other _____	I) Origin/ source of the incident : <input type="checkbox"/> Pharmacist <input type="checkbox"/> Pharmacist assistant <input type="checkbox"/> Pharmacist (intern) <input type="checkbox"/> Doctor <input type="checkbox"/> Doctor (intern) <input type="checkbox"/> Nurse <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Other _____	J) *Contributing factors: <input type="checkbox"/> Unclear prescription <input type="checkbox"/> Unclear patient identification <input type="checkbox"/> "Sound-a-like" medicine names <input type="checkbox"/> look-alike packaging or pills <input type="checkbox"/> Storage problems <input type="checkbox"/> Inadequate knowledge <input type="checkbox"/> Competing distractions <input type="checkbox"/> Work load <input type="checkbox"/> Unclear instructions Others _____
K) *Outcome (tick only one outcome: the most appropriate one).The incident: <input type="checkbox"/> Did not reach the patient. <input type="checkbox"/> Reached the patient but did not result in patient harm and there was <u>no need</u> for <u>patient monitoring</u> . <input type="checkbox"/> Reached the patient but did not result in patient harm however there <u>was need</u> for <u>patient monitoring</u> . <input type="checkbox"/> Resulted in ineffective treatment of the health problem. <input type="checkbox"/> Resulted in adverse medicine reaction but there was <u>no need</u> for <u>treatment</u> with another medicine. <input type="checkbox"/> Resulted in adverse medicine reaction that <u>required treatment</u> with another medicine. <input type="checkbox"/> Resulted in <u>permanent</u> patient harm. <input type="checkbox"/> Resulted in patient death.		
L) Description of the incident(if needed):		
M) What do you recommend to help prevent a similar incident from occurring again?		

NB: If patient experienced any Adverse Medicine Reaction please also completes the Adverse Medicine Reaction forms (Safety Yellow form)

* **Mandatory information**

Send/ Fax/Fax2Mail/Email to:
 Therapeutics Information and Pharmacovigilance Centre (TIPC)
 15 Ruhr Street Northern Industry, Windhoek
 Tel: 061 203 2406/203 2312:
 Fax: 061 22 66 31
 Fax2Mail: 088 6606781
 Email: Info.TIPC@mhss.gov.na