

**Medication System Worksheet**

Patient MR# \_\_\_\_\_

Incident # \_\_\_\_\_

(if error reached patient)

√ if no callback identified: \_\_\_\_\_

Date of error: \_\_\_\_\_

Date information obtained: \_\_\_\_\_

Patient age: \_\_\_\_\_

Drug(s) involved in error: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| Non-formulary drug(s)?  | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No  |
| Drug sample(s)?   | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No  |
| Drug(s) packaged in unit dose/unit of use?                        | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No  |
| Drug(s) dispensed from pharmacy?                                  | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No  |
| Error within 24 hours of admission, transfer, or after discharge? | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No  |
| Did the error reach the patient?                                  | <input type="checkbox"/> Yes                            | <input type="checkbox"/> No  |
| Source of IV solution:  | <input type="checkbox"/> Manufacturer premixed solution | <input type="checkbox"/> Pharmacy IV admixture <input type="checkbox"/> Nursing IV admixture |

Brief description of the event: (what, when, and why) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Possible causes	Y/N	Comments
<b>Critical patient information missing?</b> (age, weight, allergies, VS, lab values, pregnancy, patient identity, location, renal/liver impairment, diagnoses, etc.)		
<b>Critical drug information missing?</b> (outdated/absent references, inadequate computer screening, inaccessible pharmacist, uncontrolled drug formulary, etc.)		
<b>Miscommunication of drug order?</b> (illegible, ambiguous, incomplete, misheard, or misunderstood orders, intimidation/faulty interaction, etc.)		
<b>Drug name, label, packaging problem?</b> (look/sound-alike names, look-alike packaging, unclear/absent labeling, faulty drug identification, etc.)		
<b>Drug storage or delivery problem?</b> (slow turn around time, inaccurate delivery, doses missing or expired, multiple concentrations, placed in wrong bin, etc.)		
<b>Drug delivery device problem?</b> (poor device design, misprogramming, free-flow, mixed up lines, IV administration of oral syringe contents, etc.)		
<b>Environmental, staffing, or workflow problems?</b> (lighting, noise, clutter, interruptions, staffing deficiencies, workload, inefficient workflow, employee safety, etc.)		
<b>Lack of staff education?</b> (competency validation, new or unfamiliar drugs/devices, orientation process, feedback about errors/prevention, etc.)		
<b>Patient education problem?</b> (lack of information, noncompliance, not encouraged to ask questions, lack of investigating patient inquiries, etc.)		
<b>Lack of quality control or independent check systems?</b> (equipment quality control checks, independent checks for high alert drugs/high risk patient population drugs etc.)		

Did the patient require any of the following actions after the error that you would not have done if the event had not occurred?  
 Testing  Additional observation  Gave antidote  Care escalated (transferred, etc.)  Additional LOS  Other \_\_\_\_\_

Patient outcome: \_\_\_\_\_