PRESCRIPTION ERROR REPORTING FORM

MNTRH Pharmacy Department | Medication Safety Programme

Aligned with PPB Framework (FOM21/MIP/PMS/SOP/001)

CONFIDENTIAL Submission does not constitute an admission of fault. Reporter identity is strictly confidential. Data is used solely to improve medication safety at MNTRH and fulfil PPB pharmacovigilance obligations.

Fields marked * are required. Complete all sections relevant to the event.

SECTION A EVENT DETAILS

Prescription Reference / Sequence No. *	*e.g. RX-2026-001 or pharmacy serial no.*

A1. Date of Error (dd/mm/yyyy) *	A2. Time of Error (24-hr) *	A3. Date of This Report *

A4. Where did the error occur? * *

☐ Main Pharmacy	☐ Outpatient / OPD	☐ Ward / Nursing Station	☐ Specialist Clinic
☐ General Outpatient Clinic	☐ Dental Department	☐ Rehab	☐ Other (specify below)

If other

A5. At which stage of the medication-use process? (Tick all that apply) * *

☐ Prescribing	☐ Transcription / Chart entry	☐ Dispensing / Filling	☐ Labelling
☐ Administration	☐ Counselling / Patient education	☐ Other	

A6. Work environment at time of error (Tick all that apply)

☐ Peak hours / high patient load	☐ Staff shortage	☐ Change of shift / handover	☐ After-hours / night shift
☐ Locum / relief staff involved	☐ System / computer downtime	☐ Normal conditions	☐ Other

SECTION B ERROR CLASSIFICATION

B1. Type of prescription error (Tick all that apply) * *

☐ Wrong drug	☐ Wrong dose / strength	☐ Wrong dosage form
☐ Wrong route	☐ Wrong frequency / interval	☐ Wrong duration
☐ Wrong patient	☐ Drug duplication	☐ Contraindicated drug

☐ Allergy not considered	☐ Drug–drug interaction missed	☐ Illegible / unclear prescription
☐ Missing prescription information	☐ Incorrect calculation	☐ Look-alike / sound-alike (LASA) confusion
☐ Other		

If other / briefly describe error (no patient identifiers)

B2. If a dosing error — dose was:

☐ Overdose (too high)	☐ Underdose (too low)	☐ Unclear / cannot determine	☐ Not applicable

B3. Likely cause(s) of the error (Tick all that apply) * *

☐ Illegible handwriting	☐ Non-standard abbreviations	☐ Inadequate prescriber knowledge
☐ Inadequate pharmacist / dispenser knowledge	☐ Distraction / interruption	☐ Heavy workload / fatigue
☐ LASA drug name or packaging	☐ Incomplete patient record / history	☐ No allergy status documented
☐ No drug interaction check performed	☐ System / software error	☐ Poor stock labelling / arrangement
☐ Communication breakdown	☐ Other	

B4. Outcome — tick the MOST severe applicable category * *

ℹ *NCC MERP harm classification applied.*

Tick	Outcome	Code
☐	Potential error only — did not reach patient	Near Miss
☐	Error reached patient, no harm	Category A
☐	Required additional monitoring, no harm	Category B
☐	Temporary harm, required intervention	Category C
☐	Temporary harm, required hospitalisation	Category D
☐	Permanent harm	Category E
☐	Near-death / life-threatening event	Category F
☐	Contributed to patient death	Category G

Describe outcome / effect on patient (include any interventions, monitoring required)

SECTION C MEDICATION DETAILS

ℹ *Complete both columns if a substitution occurred. If only one drug is involved, complete 'Intended Drug' only.*

Field	Intended Drug	Drug Involved in Error
Generic name (active ingredient)		
Brand / trade name		
Dose & frequency		
Route		
Dosage form		
Duration		

C2. Was this a look-alike / sound-alike (LASA) error?

☐ Yes — look-alike name	☐ Yes — look-alike packaging	☐ Yes — sound-alike name	☐ No

SECTION D PATIENT INFORMATION

ℹ *Do NOT include full name, ID number, or any unique identifier. Initials and age only.*

D1. Patient Initials	D2. Age / Year of Birth	D3. Weight (if known)

D4. Patient category * *

☐ Paediatric (0–17 yrs)	☐ Adult (18–59 yrs)	☐ Elderly (≥ 60 yrs)	☐ Pregnant / Breastfeeding

D5. Gender

☐ Male	☐ Female	☐ Not specified	

D6. Documented allergy / ADR on record? * *

☐ Yes — and it was missed / ignored	☐ Yes — and it was considered
☐ No known allergies on record	☐ Allergy status unknown / not documented

D7. Was the patient on polypharmacy (≥ 5 concurrent medications)? *	☐ Yes	☐ No	☐ Unknown

SECTION E PRESCRIBER & PRESCRIPTION

E1. Prescriber cadre * *

☐ Medical Officer / Intern	☐ Specialist / Consultant	☐ Clinical Officer
☐ Nurse Prescriber	☐ Dentist	☐ Other

E2. Prescription format * *

☐ Handwritten	☐ Electronic / Computer-generated	☐ Verbal / Phone order	☐ Fax / Copy

E3. Legibility (handwritten only)

☐ Clearly legible	☐ Partially legible	☐ Illegible	☐ N/A — electronic

E4. Was the prescription complete (name, date, drug, dose, route, frequency, duration, signature)? * *

☐ Yes — complete	☐ No — items missing (tick below)

E4a. If incomplete, what was missing?

☐ Patient name / ID	☐ Date	☐ Drug name
☐ Dose / strength	☐ Route	☐ Frequency
☐ Duration	☐ Prescriber name / signature	☐ Prescriber contact / stamp
☐ Other		

SECTION F DETECTION & RESOLUTION

F1. How was the error detected? (Tick all that apply) * *

☐ Routine prescription review	☐ Drug interaction alert (system)	☐ Allergy alert (system)
☐ Patient / caregiver query	☐ Clinical discrepancy noted	☐ During ward round
☐ Medication reconciliation	☐ Reported by colleague	☐ Other

F2. Was the error intercepted before reaching the patient? *	☐ Yes	☐ No

F3. Was corrective action taken at the point of detection? *	☐ Yes	☐ No

F4. If yes — pharmacist intervention(s) taken (Tick all that apply)

- ☐ Prescription returned to prescriber
- ☐ Drug changed / substituted
- ☐ Prescription cancelled
- ☐ Prescriber contacted (verbal clarification)
- ☐ Medication administration reversed / stopped
- ☐ Patient referred to prescriber / clinic
- ☐ Dose adjusted / corrected
- ☐ Dosage form changed
- ☐ Patient counselled
- ☐ Dispensing withheld pending clarification
- ☐ Clinical team / nurse notified
- ☐ Other (specify below)

F4a. Additional notes / describe outcome of intervention (if Other above, specify here)

SECTION G REPORTER DETAILS

ℹ *Reporter identity is strictly confidential and will not appear in any public record.*

G1. Reporter Name	G2. Cadre / Designation *	G3. Department / Unit

G4. Date of Report *	G5. Contact / Mobile	G6. Email Address

Once completed, submit to the Pharmacy In-Charge or directly to PPB

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