ASSESS - ERR™

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)? ☐ Yes ☐ No

Drug sample(s)? ☐ Yes ☐ No

Drug(s) packaged in unit dose/unit of use? ☐ Yes ☐ No

Drug(s) dispensed from pharmacy? ☐ Yes ☐ No

Error within 24 hours of admission, transfer, or after discharge? ☐ Yes ☐ No

Did the error reach the patient? ☐ Yes ☐ No

Source of IV solution: ☐ Manufacturer premixed solution ☐ Pharmacy IV admixture ☐ Nursing IV admixture

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

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 (outdated/absent references, inadequate computer screening, inaccessible pharmacist, uncontrolled drug formulary, etc.)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