Table 2: Contributing Factors in Incident Reporting Form

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| 1. Was essential PATIENT INFORMATION for the administration of this medication missing, not available and /or not accessed? Yes/No   If yes, indicate all the PATIENT INFORMATION that was lacking.   * Age * Weight * Allergies * Diagnosis/medical history * Pregnancy Status * Lab values * Vital Signs * Patient identifiers missing (e.g., armband) * No access to chart  1. Was there a lack of knowledge related to the DRUG involved? Yes/No   If yes, indicate all the DRUG INFORMATION that was lacking.   * Up-to-date drug information not accessible * Up-to-date drug information not referenced * Lack of knowledge related to protocols or order sets * Lack of awareness of special precautions or special monitoring needed with drug * Computer warning of unsafe dose overlooked or ignored * MAR warning/precautions overlooked or ignored * Drug interaction unknown or overlooked  1. Was there a problem with COMMUNICATION between health care providers that contributed to this incident? Yes/No   If yes, indicate all the COMMUNICATION issues involved.   * Abbreviation issue * Communication failure (e.g., physician to nurse or nurse to nurse/student or nurse to pharmacy) * Incomplete medication order * Failure to transmit order to pharmacy * Transcription problem * Confusion with MAR * Documentation error * Failure of pharmacy to dispense med  1. Was there an issue with DRUG NAMES, LABELING and/or PACKAGING? Yes/No   If yes, indicate all the DRUG NAMES, LABELING and/or PACKAGING issues involved.   * Incomplete, confusing, or absent manufacturer or pharmacy drug label * Unlabeled or mislabeled meds or syringes * Confusing drug name (e.g., look-alike or sound-alike) * Lack of unit dose (e.g., need to split tab) * Packaging problem (e.g., cloudy, tab deterioration)  1. Was there an issue related to DRUG STORAGE or DRUG AVAILABILITY? Yes/No   If yes, indicate all the DRUG STORAGE or DRUG AVAILABILITY issues involved.   * Drug storage problem (e.g., several drugs stored together) * Drug available on unit as bulk stock * Nurse required to prepare medication on unit (e.g., reconstitution, dilution) * Drug not available as unit-dose from pharmacy * Drug not delivered from pharmacy * Drug not available in med station  1. Was there an issue related to a DRUG DELIVERY DEVICE? (e.g., infusion pumps, oral or injection syringes) Yes/No   If yes, indicate all the DRUG DELIVERY DEVICE issues involved.   * Device malfunction * Incorrect programming of IV pump * Infusion lines not properly labeled * Infusion line mix-up * Infusion pump not available * Oral or injection syringe problem * IV set up or maintenance  1. Did ENVIRONMENTAL FACTORS or HUMAN LIMITATIONS contribute to this incident? Yes/No   If yes, indicate all the ENVIRONMENTAL FACTORS or HUMAN LIMITATIONS involved.   * Interruption * Distraction * Noise * Inadequate space or lighting * Inadequate staffing * Significant workload * Fatigue  1. Were there issues related to KNOWLEDGE, SKILL, OR ABILITY of *ANY* member of the health care team that contributed to the incident? Yes/No   If yes, indicate all the KNOWLEDGE, SKILL or ABILITY issues involved.   * Lack of medication information * Inexperience/limited experience with medication administration * Lack of skill in administering the specific medication * Did not follow safe medication practices * Did not carry out expected patient assessment or monitoring * Lack of knowledge of medication delivery device * Medication calculation error  1. Did the PATIENT/FAMILY EDUCATION or LACK OF ENGAGEMENT contribute to the incident? Yes/No   If yes, indicate all the PATIENT/FAMILY EDUCATION and/or ENGAGEMENT issues.   * Patient/Family not informed about medication that was being administered * Patient/Family questions not answered * Patient with language barrier * Patient not oriented to time, person, place, or situation OR Cognitively impaired * Low health literacy  1. Were there issues related to following POLICIES or PROCEDURES to reduce the risk of an error? Yes/No   If yes, indicate all POLICY OR PROCEDURE issues.   * Independent double check not done or not done correctly * MAR not taken to bedside * 2-patient identifiers not checked correctly * Documentation not done immediately after administration * Documentation done in wrong place on MAR * Documentation of exact time of med administration not done * 3 checks of medication label not done * Administration of medications to more than 1 patient at a time * Physician/NP original order not checked * Essential patient information not accessed or assessed * Meds left at bedside, at Pyxis or outside room |
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