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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