Preamble

This document provides a standard taxonomy of medication errors to be used in combination with systems analysis in recording and tracking of medication errors. It is not intended to assess blame. The document is not all-inclusive, but can be expanded as new issues arise. The purpose of this taxonomy is to provide a standard language and structure of medication error-related data for use in developing databases analyzing medication error reports.

Guidance is provided to assist in the application of this instrument. Please note that the taxonomy is not designed as a reporting form, but is rather a tool to categorize and analyze reports of medication errors.

It is recommended that health care organizations develop systems and procedures to collect adequate information needed to analyze and report medication errors at the time the error occurs. In most cases, it should not be necessary to conduct retrospective audits to collect the needed information in order to apply this taxonomy.

The effectiveness of the taxonomy, and the resulting analysis of medication error reports, is dependent upon the amount and the quality of the data collected through medication error reports. For optimum application of the taxonomy, include as much information as possible in the instrument. However, if all the information described in the taxonomy is not collected, the information that is available should be categorized as shown in the taxonomy.

Specific Instructions

1. Note that some fields require selection from a defined list of choices and other fields require entry of free text.
2. To use the taxonomy properly, choose the most specific code available. If this level of specificity is not possible, select the code of the parent category.
The purpose of this section is to:

* permit entry of an identification code that allows matching information in the taxonomy with medication error reports
* allow sorting and reporting of medication error reports (e.g., analyze medication error reports by age ranges)

For a report of Category A error (see item #31), this section can be omitted. Otherwise, complete as many of these sections as possible.

10.1 Identification Number or Initials: ___________________
10.2 Age - Date of Birth
10.3 Gender
10.4 Weight [may be omitted unless directly pertinent to the error (e.g., medication overdose in a pediatric patient)].

20 THE EVENT

21 DATE (mmddyyyy)
[Complete as many items as possible in this section]

21.1 Date of event
   21.1.1 Weekend
   21.1.2 Holiday
21.2 Date of Initial Report
21.3 Date of Follow-up Report

22 TIME

22.1 Time of Error (24 hour clock)

23 SETTING (of initial error)

[Select either one category or one subcategory, whichever provides the best known information]

23.1 Adult Day Health Care
23.2 Assisted Living/Board and Care
23.3 Correctional Facility
23.4 Emergency Rescue Unit
23.5 Health Food Store
23.6 Hospice
23.7 Hospital
   23.7.1 Cardiac Step Down
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.7.2</td>
<td>Central Supply</td>
</tr>
<tr>
<td>23.7.3</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>23.7.4</td>
<td>Intensive Care Unit (ICU)</td>
</tr>
<tr>
<td>23.7.4.1</td>
<td>Cardiac ICU</td>
</tr>
<tr>
<td>23.7.4.2</td>
<td>Medical ICU</td>
</tr>
<tr>
<td>23.7.4.3</td>
<td>Neonatal ICU/Step Down (Infant Transitional)</td>
</tr>
<tr>
<td>23.7.4.4</td>
<td>Pediatric ICU</td>
</tr>
<tr>
<td>23.7.4.5</td>
<td>Surgical ICU</td>
</tr>
<tr>
<td>23.7.5</td>
<td>Labor/Delivery</td>
</tr>
<tr>
<td>23.7.6</td>
<td>Long Term Acute Care</td>
</tr>
<tr>
<td>23.7.7</td>
<td>Nursery</td>
</tr>
<tr>
<td>23.7.8</td>
<td>Nursing Unit</td>
</tr>
<tr>
<td>23.7.9</td>
<td>Oncology</td>
</tr>
<tr>
<td>23.7.10</td>
<td>Operating Room</td>
</tr>
<tr>
<td>23.7.11</td>
<td>Outpatient</td>
</tr>
<tr>
<td>23.7.12</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>23.7.13</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>23.7.13.1</td>
<td>Inpatient</td>
</tr>
<tr>
<td>23.7.13.2</td>
<td>Outpatient</td>
</tr>
<tr>
<td>23.7.13.3</td>
<td>Nuclear</td>
</tr>
<tr>
<td>23.7.14</td>
<td>Psychiatric Unit</td>
</tr>
<tr>
<td>23.7.15</td>
<td>Radiology</td>
</tr>
<tr>
<td>23.7.15.1</td>
<td>Nuclear</td>
</tr>
<tr>
<td>23.7.15.2</td>
<td>Special Procedures Area</td>
</tr>
<tr>
<td>23.7.16</td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td>23.7.17</td>
<td>Recovery Room (PACU)</td>
</tr>
<tr>
<td>23.7.18</td>
<td>Sub-acute Care</td>
</tr>
<tr>
<td>23.7.19</td>
<td>Other</td>
</tr>
<tr>
<td>23.8</td>
<td>Home Health Care</td>
</tr>
<tr>
<td>23.9</td>
<td>Mental Health Facility</td>
</tr>
<tr>
<td>23.10</td>
<td>Nursing Facility (Free Standing)</td>
</tr>
<tr>
<td>23.10.1</td>
<td>Skilled</td>
</tr>
<tr>
<td>23.10.2</td>
<td>Intermediate</td>
</tr>
<tr>
<td>23.10.3</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>23.11</td>
<td>Outpatient Facility</td>
</tr>
<tr>
<td>23.11.1</td>
<td>Ambulatory Surgery</td>
</tr>
<tr>
<td>23.11.2</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>23.11.3</td>
<td>Urgent Care Clinic</td>
</tr>
<tr>
<td>23.12</td>
<td>Patient's Home/Work</td>
</tr>
<tr>
<td>23.13</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>23.13.1</td>
<td>Community</td>
</tr>
<tr>
<td>23.13.2</td>
<td>Home Health Care</td>
</tr>
<tr>
<td>23.13.3</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>23.13.4</td>
<td>Mail Service</td>
</tr>
<tr>
<td>23.13.5</td>
<td>Managed Care</td>
</tr>
<tr>
<td>23.13.6</td>
<td>Mental Health</td>
</tr>
</tbody>
</table>
23.13.7 Nuclear
23.14 Prescriber's Office
23.15 School
23.16 Other
23.17 Unknown

24 SETTING (Where Error Perpetuated)

[Select as many settings as are applicable]

24.1 Adult Day Health Care
24.2 Assisted Living/Board and Care
24.3 Correctional Facility
24.4 Emergency Rescue Unit
24.5 Health Food Store
24.6 Hospice
24.7 Hospital
  24.7.1 Cardiac Step Down
  24.7.2 Central Supply
  24.7.3 Emergency Room
  24.7.4 Intensive Care Unit (ICU)
    24.7.4.1 Cardiac ICU
    24.7.4.2 Medical ICU
    24.7.4.3 Neonatal ICU/Step Down (Infant Transitional)
    24.7.4.4 Pediatric ICU
    24.7.4.5 Surgical ICU
  24.7.5 Labor/Delivery
  24.7.6 Long Term Acute Care
  24.7.7 Nursery
  24.7.8 Nursing Unit
  24.7.9 Oncology
  24.7.10 Operating Room
  24.7.11 Outpatient
  24.7.12 Pediatrics
  24.7.13 Pharmacy
    24.7.13.1 Inpatient
    24.7.13.2 Outpatient
    24.7.13.3 Nuclear
  24.7.14 Psychiatric Unit
  24.7.15 Radiology
    24.7.15.1 Nuclear
    24.7.15.2 Special Procedures Area
  24.7.16 Respiratory Therapy
  24.7.17 Recovery Room (PACU)
  24.7.18 Sub-acute Care
24.7.19 Other
24.8 Home Health Care
24.9 Mental Health Facility
24.10 Nursing Facility (Free Standing)
  24.10.1 Skilled
  24.10.2 Intermediate
  24.10.3 Pharmacy
24.11 Outpatient Facility
  24.11.1 Ambulatory Surgery
  24.11.2 Rehabilitation
  24.11.3 Urgent Care Clinic
24.12 Patient's Home/Work
24.13 Pharmacy
  24.13.1 Community
  24.13.2 Home Health Care
  24.13.3 Long Term Care
  24.13.4 Mail Service
  24.13.5 Managed Care
  24.13.6 Mental Health
  24.13.7 Nuclear
24.14 Prescriber's Office
24.15 School
24.16 Other
24.17 Unknown

25 DESCRIPTION OF EVENT
[This is a free text entry field. The user should provide a narrative description of the event, including how the error was perpetuated and discovered. Other relevant information should be included, such as:
  • Laboratory data or tests, including dates
  • Other relevant history, including preexisting medical conditions (e.g., allergies)
  • Concomitant therapy
  • Dates of therapy
  • Indication for use (Diagnosis)
  • Medical intervention(s) following the error
  • Actions taken and recommendation for prevention].
[NCC MERP recommends that medication error information be collected and reported as soon as possible, while the information is still fresh. It is recognized that the eventual patient outcome may change from the time when the medication error initially occurs. For example, the patient may initially require hospitalization due to the error, but eventually die as a result of the error after several weeks of treatment and support in the hospital. If the patient outcome or other variables should change, the medication error information can be updated or corrected at a later time.

In selecting the patient outcome category, select the highest level severity that applies during the course of the event. For example, if a patient suffers a severe anaphylactic reaction (Category H) and requires treatment (Category F) but eventually recovers completely, the event should be coded as Category H (33.4).

Select only one of the medication error categories or subcategories, whichever best fits the error that is being reported.

31 NO ERROR

31.1 Category A
Circumstances or events that have the capacity to cause error

32 ERROR, NO HARM

[Note: Harm is defined as temporary or permanent impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom requiring intervention.]

32.1 Category B
An error occurred but the error did not reach the patient
(An “error of omission” does reach the patient.)

32.2 Category C
An error occurred that reached the patient, but did not cause patient harm
32.2.1 Medication reaches the patient and is administered
32.2.2 Medication reaches the patient but not administered

32.3 Category D
An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm
33 ERROR, HARM

33.1 Category E
An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention

33.2 Category F
An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization

33.3 Category G
An error occurred that may have contributed to or resulted in permanent patient harm

33.4 Category H
An error occurred that required intervention necessary to sustain life

34 ERROR, DEATH

34.1 Category I
An error occurred that may have contributed to or resulted in the patient's death.

50 PRODUCT INFORMATION - #1 [PRODUCT THAT WAS ACTUALLY (OR POTENTIALLY) GIVEN]

[Classify each medication involved in a medication error. Include the intended product for use, as well as the actual product used, if these are different. Select numbers 51-54 to code the product actually or potentially administered. Select numbers 55-59 to code the intended product, if different from the product actually administered or intended].

51 GENERAL
[Select and complete as many items as possible in this section].

51.1 Name of Drug (or other products, if applicable)
  51.1.1 Proprietary (Trade) Name
  51.1.2 Established (Generic) Name
  51.1.3 Compounded Ingredients

51.2 Strength

51.3 Dose, Frequency & Route

51.4 Status
  51.4.1 Prescription
  51.4.2 Over-the-Counter
  51.4.3 Investigational

51.5 Name of Manufacturer
51.6 Name of Labeler or Distributor
52 DOSAGE FORM
[Note: This list is not all inclusive; other dosage forms not listed should be captured under "other". Select one item from this section]

52.1 Tablet
  52.1.1 Extended-release

52.2 Capsule
  52.2.1 Extended-release

52.3 Oral Liquid
  52.3.1 Concentrate

52.4 Injectable

52.5 Cream-Ointment-Gel-Paste

52.6 Aerosol (spray and metered)

52.7 Other

53 PACKAGING - CONTAINER
[Note that these are some examples of packaging frequently involved in errors. The list does not include all packaging configurations available in the marketplace. Select one item from this section]

53.1 Unit Dose

53.2 Multiple Dose Vials (Injectable)

53.3 Single Dose Vials/Ampuls (Injectable)

53.4 Intravenous Solutions (small and large volume parenterals)
  53.4.1 Manufacturer Prepared
  53.4.2 Institution Prepared

53.5 Syringes

53.6 Manufacturer Samples

53.7 Other (Please specify)

54 PHARMACOLOGIC - THERAPEUTIC CLASSIFICATION

The council recommends the use of the pharmacologic-therapeutic classification system defined by either the American Society of Health-Systems Pharmacists (i.e., AHFS code) or the Veterans Administration (i.e., VA codes).
56   GENERAL
[Select and complete as many items as possible in this section].

56.1 Name
56.1.1 Proprietary (Trade) Name
56.1.2 Established (Generic) Name
56.1.3 Compounded Ingredients
56.2 Strength
56.3 Dose, Frequency & Route
56.4 Status
56.4.1 Prescription
56.4.2 Over-the-Counter
56.4.3 Investigational
56.5 Name of Manufacturer
56.6 Name of Labeler or Distributor

57   DOSAGE FORM
[Note: This list is not all inclusive; other dosage forms not listed should be captured under "other". Select one item from this section]

57.1 Tablet
57.1.1 Extended-release
57.2 Capsule
57.2.1 Extended-release
57.3 Oral Liquid
57.3.1 Concentrate
57.4 Injectable
57.5 Cream-Ointment-Gel-Paste
57.6 Aerosol (spray and metered)
57.7 Other

58   PACKAGING - CONTAINER

[Note that these are some examples of packaging frequently involved in errors. The list does not include all packaging configurations available in the marketplace. Select one item from this section].

58.1 Unit Dose
58.2 Multiple Dose Vials (Injectable)
58.3 Single Dose Vials/Ampuls (Injectable)
58.4 Intravenous Solutions (small and large volume parenterals)
58.4.1 Manufacturer Prepared
58.4.2 Institution Prepared
58.5 Syringes
58.6 Manufacturer Samples
58.7 Other (Please specify)

59 PHARMACOLOGIC - THERAPEUTIC CLASSIFICATION

The council recommends the use of the pharmacologic-therapeutic classification system defined by either the American Society of Health-Systems Pharmacists (i.e., AHFS code) or the Veterans Administration (i.e., VA codes).

60 PERSONNEL INVOLVED

61 Initial Error Made by 62 Error Perpetuated by
[Select one item] [Select all that apply]
61.1 Physician 62.1 Physician
61.1.1 Intern 62.1.1 Intern
61.1.2 Resident 62.1.2 Resident
61.1.3 Practicing Physician 62.1.3 Practicing Physician
61.1.4 Other 62.1.4 Other

61.2 Pharmacist 62.2 Pharmacist
61.3 Nurse 62.3 Nurse
61.3.1 Nurse Practitioner/Advanced Practice 62.3.1 Nurse Practitioner/Advanced Practice
61.3.2 Registered Nurse 62.3.2 Registered Nurse
61.3.3 Licensed Practical Nurse 62.3.3 Licensed Practical Nurse
61.3.4 Other 62.3.4 Other

61.4 Physician Assistant 62.4 Physician Assistant
61.5 Dentist 62.5 Dentist
61.6 Veterinarian 62.6 Veterinarian
61.7 Optometrist 62.7 Optometrist
61.8 Support Personnel 62.8 Support Personnel
61.8.1 Pharmacy Technician 62.8.1 Pharmacy Technician
61.8.2 Nurses Aide 62.8.2 Nurses Aide
61.8.3 Medication Aide 62.8.4 Medication Aide
61.8.4 Clerical 62.8.5 Clerical

61.9 Health Professions Student 62.9 Health Professions Student
61.9.1 Medicine 62.9.1 Medicine
61.9.2 Pharmacy 62.9.2 Pharmacy
61.9.3 Nursing 62.9.3 Nursing
61.9.4 Other 62.9.4 Other

61.10 Patient/Caregiver 62.10 Patient/Caregiver
61.11 Other 62.11 Other
61.12 Unknown 62.12 None
63 Error Discovered by
[Select one item]
63.1 Physician
   63.1.1 Intern
   63.1.2 Resident
   63.1.3 Practicing Physician
   63.1.4 Other
63.2 Pharmacist
63.3 Nurse
   63.3.1 Nurse Practitioner/Advanced Practice
   63.3.2 Registered Nurse
   63.3.3 Licensed Practical Nurse
   63.3.4 Other
63.4 Physician Assistant
63.5 Dentist
63.6 Veterinarian
63.7 Optometrist
63.8 Support Personnel
   63.8.1 Pharmacy Technician
   63.8.2 Nurses Aide
   63.8.3 Medication Aide
   63.8.4 Clerical
63.9 Health Professions Student
   63.9.1 Medicine
   63.9.2 Pharmacy
   63.9.3 Nursing
   63.9.4 Other
63.10 Patient/Caregiver
63.11 Other
63.12 Unknown
[Select as many items as are applicable from this section. Note: Category A
errors (where only the capacity for error exists) should not be classified by Type].

70.1 Dose Omission
[The failure to administer an ordered dose to a patient before the next
scheduled dose, if any. This excludes patients who refuse to take a
medication or a decision not to administer.]

70.2 Improper Dose
70.2.1 Resulting in Overdosage
70.2.2 Resulting in Under dosage
70.2.3 Extra Dose

70.3 Wrong Strength/Concentration

70.4 Wrong Drug

70.5 Wrong Dosage Form

70.6 Wrong Technique (includes inappropriate crushing of tablets)

70.7 Wrong Route of Administration

<table>
<thead>
<tr>
<th>Route Given</th>
<th>Route Intended</th>
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</thead>
<tbody>
<tr>
<td>70.7.1</td>
<td>IV</td>
</tr>
<tr>
<td>70.7.2</td>
<td>Intrathecal</td>
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<tr>
<td>70.7.3</td>
<td>IV</td>
</tr>
<tr>
<td>70.7.4</td>
<td>IV</td>
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<tr>
<td>70.7.5</td>
<td>IM</td>
</tr>
<tr>
<td>70.7.6</td>
<td>Other</td>
</tr>
</tbody>
</table>

70.8 Wrong Rate
70.8.1 Too fast
70.8.2 Too slow

70.9 Wrong Duration

70.10 Wrong Time
[Administration outside a predefined time interval from its scheduled
administration time, as defined by each health care facility]

70.11 Wrong Patient

70.12 Monitoring Error (includes Contraindicated Drugs)
70.12.1 Drug-Drug Interaction
70.12.2 Drug-Food/Nutrient Interaction
70.12.3 Documented Allergy
70.12.4 Drug-Disease Interaction
70.12.5 Clinical (e.g., blood glucose, prothrombin, blood pressure,)
70.13 Deteriorated Drug Error (Dispensing drug which has expired)
70.14 Other
[Any medication error that does not fall into one of the above]

80 CAUSES

[Indicate the reported causes of the medication error, as stated by the perspective of the reporter of the incident. Select as many causes as are applicable from each section]

81 COMMUNICATION

81.1 Verbal miscommunication
81.2 Written miscommunication
81.2.1 Illegible handwriting
81.2.2 Abbreviations
81.2.3 Non-metric units of measurement (e.g., apothecary)
81.2.4 Trailing Zero
81.2.5 Leading Zero
81.2.6 Decimal Point
81.2.7 Misread or Didn't Read
81.3 Misinterpretation of the order

83 NAME CONFUSION

83.1 Proprietary (Trade) Name Confusion
83.1.1 Suffix confusion
83.1.2 Prefix confusion
83.1.3 Sound-alike to another trade name
83.1.4 Sound-alike to an established (generic) name
83.1.5 Look-alike to another trade name
83.1.6 Look-alike to an established name
83.1.7 Appears to be misleading
83.1.8 Confusion with Over-the-Counter "Family Trade Names"

83.2 Established (Generic) Name Confusion
83.2.1 Sound-alike to another established name
83.2.2 Sound-alike to a trade name
83.2.3 Look-alike to another established name
83.2.4 Look-alike to a trade name

85 LABELING
85.1 Immediate Container Labels of Product - Manufacturer, Distributor or Repackager

85.1.1 Looks too similar to another manufacturer
85.1.2 Looks too similar within the same company's product line.
85.1.3 Appears to be inaccurate or incomplete
85.1.4 Appears to be misleading or confusing
85.1.5 Distracting Symbols or Logo

85.2 Labels of Dispensed Product - Practitioner

85.2.1 Wrong Directions
85.2.2 Incomplete Directions (including lack of ancillary labels)
85.2.3 Wrong Drug Name
85.2.4 Wrong Drug Strength
85.2.5 Wrong Patient
85.2.6 Other

85.3 Carton Labeling of Product - Manufacturer, Distributor or Repackager

85.3.1 Looks too similar to another manufacturer
85.3.2 Looks too similar within the same company's product line.
85.3.3 Appears to be inaccurate
85.3.4 Appears to be misleading
85.3.5 Distracting Symbols or Logo

85.4 Package Insert

85.4.1 Appears to be inaccurate
85.4.2 Appears to be misleading
85.4.3 Other

85.5 Electronic Reference Material

85.5.1 Inaccurate
85.5.2 Unclear or inconsistent
85.5.3 Omission of data
85.5.4 Outdated
85.5.5 Unavailable

85.6 Printed Reference Material

85.6.1 Inaccurate
85.6.2 Unclear or inconsistent
85.6.3 Omission of data
85.6.4 Unavailable

85.7 Advertising

85.7.1 Error or error potential associated with the commercial advertising of a product.

87 HUMAN FACTORS

87.1 Knowledge Deficit
87.2 Performance Deficit
87.3 Miscalculation of Dosage or Infusion Rate
87.4 Computer Error
  87.4.1 Incorrect selection from a list by computer operator
  87.4.2 Incorrect programming into the database.
  87.4.3 Inadequate screening for allergies, interactions, etc.
87.5 Error in Stocking/Restocking/Cart Filling
87.6 Drug Preparation Error
  87.6.1 Failure to activate delivery system
  87.6.2 Wrong Diluent
  87.6.3 Wrong Amount of Diluent
  87.6.4 Wrong amount of active ingredient added to the final product
  87.6.5 Wrong drug added
87.7 Transcription Error
  87.7.1 Original to Paper/Carbon paper
  87.7.2 Original to Computer
  87.7.3 Original to Facsimile
  87.7.4 Recopying MAR
87.8 Stress (high volume workload, etc.)
87.9 Fatigue/Lack of Sleep
87.10 Confrontational or intimidating behavior
89 PACKAGING/DESIGN
89.1 Inappropriate Packaging or Design
89.2 Dosage Form (Tablet/Capsule) Confusion:
   89.2.1 Confusion due to similarity in color, shape, and/or size to another product.
   89.2.2 Confusion due to similarity in color, shape, and/or size of the same product but different strength.
89.3 Devices
   89.3.1 Malfunction
   89.3.2 Wrong Device Selected (e.g., TB syringe used instead of Insulin syringe)
   89.3.3 Adapters (e.g., Parenteral vs Enteral)
   89.3.4 Automated Distribution/Vending Systems
   89.3.5 Automated Counting Machines
   89.3.6 Automated Compounders
   89.3.7 Oral Measuring Devices (e.g., syringes, cups, spoons)
   89.3.8 Infusion (PCA, Infusion pumps)

90 CONTRIBUTING FACTORS (SYSTEMS RELATED)

[Select as many items as are applicable from this section].

90.1 Lighting
90.2 Noise Level
90.3 Frequent Interruptions and distractions
90.4 Training
90.5 Staffing
90.6 Lack of availability of health care professional
   90.6.1 Medical
   90.6.2 Other Allied Health Care Professional
   90.6.3 Pharmacy
   90.6.4 Nursing
   90.6.5 Other
90.7 Assignment or placement of a health care provider or inexperienced personnel
90.8 System for Covering Patient Care (e.g., floating personnel, agency coverage)
   90.8.1 Medical
   90.8.2 Other Allied Health Care Professional
   90.8.3 Pharmacy
   90.8.4 Nursing
   90.8.5 Other
90.9 Policies and procedures
90.10 Communication systems between health care practitioners
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.11</td>
<td>Patient counseling</td>
</tr>
<tr>
<td>90.12</td>
<td>Floor Stock</td>
</tr>
<tr>
<td>90.13</td>
<td>Pre-printed medication orders</td>
</tr>
<tr>
<td>90.14</td>
<td>Other</td>
</tr>
</tbody>
</table>
Questionnaire
NCC MERP Taxonomy of Medication Errors

Please return to: Secretariat, NCC MERP c/o USP, 12601 Twinbrook Parkway, Rockville, MD 20852

1. Do you have a medication error reporting system?
   - Yes (answer 1a and 1b below)
   - No

   1a. Does the NCC MERP taxonomy include the fields and data elements applicable to this system?
       - Yes
       - No → What is missing?

   1b. Will you consider using or adapting the taxonomy for application within your system?
       - Yes
       - No → Why not?

2. Do you have a medication error database?
   - Yes (answer 2a and 2b below)
   - No

   2a. Does the NCC MERP taxonomy include the fields and data elements applicable to this database?
       - Yes
       - No → What is missing?

   2b. Will you consider using or adapting the taxonomy for application within your database?
       - Yes
       - No → Why not?

3. If you answered “No” to Question 1 or 2 above: Will you consider using the taxonomy to develop your own reporting system and/or database?
   - Yes
   - No → Why not?

4. If you are considering using the taxonomy, may we contact you in the future?
   - No
   - Yes → Please fill in your contact information below.

Your Name and Title:

Facility Name:

Address:

Email: __________________________

Fax Number: _______ -- _______ -- _______

Thank you for supporting the NCC MERP and its work in medication error reporting and prevention.