Observational Tool Oral Med Appendix

What is your username?

Staff ID

Patient ID

Medication trolley in the patient room

Velg …

Medication administration

☐ Scanned ID wristband
☐ Wrong room number on the patient medication box
☐ Medication not labeled correctly

Total nummer medications?

Velg …

Total nummer medications?

Dette elementet vises kun dersom alternativet «Other» er valgt i spørsmålet «Total nummer medications?»

How many medications had a barcode?
Includes blisters with printed label, but not packed

Velg …

How many medications had a barcode?

Dette elementet vises kun dersom alternativet «Other» er valgt i spørsmålet «How many medications had a barcode?»
Observational Tool Oral Med Appendix – Vis - Nettskjema

How many were scanned?
Scanned the barcode, not manually confirmed

How many medications were scanned?

- Dette elementet vises kun dersom alternativet «Other» er valgt i spørsmålet «How many were scanned?»

If the patient room number on the medication box was wrong, short explanation?

- Dette elementet vises kun dersom alternativet «Wrong room number on the patient medication box» er valgt i spørsmålet «Medication administration»

Use keywords (patient in the hallway, wrong room number written or patient changed room, etc.)

Medications that were overridden (not scanned but manually confirmed)
Reason for not scanning if verbalized by the staff member and name of the medications

If trolley not in the patient room, why?

- Dette elementet vises kun dersom alternativet «No (workaround)» eller «Other» er valgt i spørsmålet «Medication trolley in the patient room»

Medication/s NOT prepared correctly in the trolley?
Missing medication (not in the medication box).
Medication from another patient placed in the medication box.
Discontinued medications prepared.
Medication not labeled correctly

- [ ] Dette elementet vises kun dersom alternativet «Medication not labeled correctly» er valgt i spørsmålet «Medication administration»

- [ ] Bar Code missing
- [ ] Bar Code placed in the box, not attached
- [ ] Bar Code attached to plastic bag
- [ ] Other

Labelling errors-other

- [ ] Dette elementet vises kun dersom alternativet «Other» er valgt i spørsmålet «Medication not labeled correctly»

Staff observed patient taking the medications?

- [ ] Yes
- [ ] No
- [ ] Other

Technological support

Any technological discrepancies observed?

- [ ] Low battery (laptop)
- [ ] System blockage
- [ ] Log in discrepancies
- [ ] The laptop was not charged during the night
- [ ] The laptop was not functioning optimally
- [ ] Unavailable scanner for the administration (taken by other nurses or can't find)
- [ ] Scanner malfunctioning
- [ ] Other

If system blockage, how occurred/resulted?

- [ ] Dette elementet vises kun dersom alternativet «System blockage» er valgt i spørsmålet «Any technological discrepancies observed?»
If login discrepancy, how occurred/consequences?

Dette elementet vises kun dersom alternativet «Log in discrepancies» er valgt i spørsmålet «Any technological discrepancies observed?»

If low battery on laptop how resolved/consequences?

Dette elementet vises kun dersom alternativet «Low battery (laptop)» er valgt i spørsmålet «Any technological discrepancies observed?»

If laptop not functioning optimally, how resolved/consequences?

Dette elementet vises kun dersom alternativet «The laptop was not functioning optimally» er valgt i spørsmålet «Any technological discrepancies observed?»

Answer question only IF: The patient uses his PRIVATE MEDICATIONS in hospital: write what and if administered during the observation?

*If not administered while observing, still write if this practice occurred.

Further comments

Did you observe any errors, discrepancies in the medication management process?

- Undocumented/Unprescribed medications, labeling errors, system workarounds, information mismatch, wrong dose prepared of the parenteral medication, not thrown away rest of medication
- The nurse was about to give medication to the wrong patient found out of it before it happened (near miss).