Medication Administration Questionnaire

Fogarty and McKeon (2006)

1. Introduction

This document contains the questions used in the "errors" and "violations" sections of the survey used by Fogarty and McKeon (2006). You are welcome to use these questions in your own research provided that suitable acknowledgement is made to:

Fogarty, G. & McKeon, C. (2006). Patient safety during medication administration: The influence of organisational and individual variables on unsafe work practices and medication errors. *Ergonomics, 45(5-6),* 444-456.

2.Medication Administration Questionnaire – Errors

2.1 Background

This scale was developed with the assistance of subject matter experts. The items were based on the 'five rights', that is, the guidelines traditionally taught to all nurses regarding medication administration: 'the right patient, the right drug, the right dose, the right route, and the right time'. These 'five rights' have been referred to as the ritual that nurses should use to prevent medication errors in nursing.

2.2 Instructions and Questions

To be completed by registered nurses and enrolled nurses with medication endorsement who are currently involved in medication administration.

In this section, we are seeking your support to discover what is happening in the hospital system that is contributing to medication errors. Research indicates that medication errors are common. Research in other complex industries has found that the system in which people wok has an impact on their performance, and when conditions in the organisation are improved, the number of errors decreases.

Your responses will NOT be available to anyone EXCEPT the researchers at the University of Southern Queensland and you are assured that they will be treated as strictly confidential. To ensure anonymity, the results will be reported for the District as a whole and not by individual hospitals or sections within hospitals.

To the best of your knowledge, in the last 12 months, have you ever mistakenly done any of the following when administering a medication?

		Never	Once or Twice	Three or four times	More often
1.	Given the wrong drug	☐	☐	☐	☐
2.	By the wrong route	☐	☐	☐	☐
3.	To the wrong patient	☐	☐	☐	☐
4.	At the wrong time	☐	☐	☐	☐
5.	At the wrong dose	☐	☐	☐	☐
	If you wish, please comment on what you believe may have contributed to the above.				

3. Medication Administration Questionnaire – Noncompliance

3. 1 Background

This scale was designed to capture generic violation behaviours based on nursing competencies and to include only those behaviours directly under the control of the nurse administering the medication. That is, it excludes doctors' behaviours. The scale was developed with the assistance of subject matter experts, that is, nurses with many years of experience in medication administration, and with reference to the procedures required for safe medication administration.

3.2 Instructions and Items

In this section, we want to know if it is necessary for you to "bend the rules" to get your job done. Medication administration involves following guidelines that are in place to maintain quality outcomes. However, because of conditions in the workplace (for example, workload, unavailability of doctors, impractical procedures, etc), it may not always be possible to follow all the rules.

Again, you are assured that your responses will be treated as STRICTLY CONFIDENTIAL, with the results being reported for the District as a whole and not by individual hospitals or sections within hospitals.

Please indicate how often in the past 12 months you have had to bend the rules in the following ways when administering a medication:

		Never	Sometimes	Often	Frequently	Most of the time
1.	Did not verify with a doctor, an order that was illegible, unclear, incomplete, or that seemed inappropriate or unreasonable for the patient.	☐	☐	☐	☐	☐
2.	Did not obtain the proper authority (e.g., order from doctor or signed protocol).	☐	☐	☐	☐	☐
3.	Did not complete appropriate documentation.	☐	☐	☐	☐	☐
4.	Did not verify a verbal/telephone order and its transcription according to hospital policy.	☐	☐	☐	☐	☐
5.	Did not check reference material (e.g., MIMS) when unsure about or unfamiliar with medication.	☐	☐	☐	☐	☐
6.	Did not check for allergies or previous adverse reactions.	☐	☐	☐	☐	☐
7.	Did not monitor the effects of the drug after administration.	☐	☐	☐	☐	☐
8.	Did not record/report side or adverse effects.	☐	☐	☐	☐	☐
9.	Did not check with a doctor before changing the route of administration.	☐	☐	☐	☐	☐
10.	Did not check the patient's identity.	☐	☐	☐	☐	☐
11.	Did not check the patient's chart.	☐	☐	☐	☐	☐
12.	Did not give relevant education and information to the patient (e.g., information sheet and/or clear expectation of procedure, side-effects, etc.)	☐	☐	☐	☐	☐
13.	Did not observe the patient taking the medication.	☐	☐	☐	☐	☐
	If you wish, please comment on what you believe may have contributed to the above					