PIONEER MEDICAL CENTER

PMC MEDICATION VARIANCE FOLLOW UP

The variance is to be investigated within seven days of the initiation of the Medication Variance Report.
Attach to Medication Variance Report.

Name of patient_____ **Date Investigation Initiated**_____

* CONTRIBUTING FACTORS

☐ A contributing factor not determined ☐ Poor lighting ☐ Code situation ☐ Staff, inexperienced
☐ Cross coverage ☐ Staffing, alternative hours ☐ No 24-hour pharmacy ☐ Staff, agency / temporary
☐ Patient transfer ☐ Staffing, insufficient ☐ Patient name similar/same ☐ Workload increase
☐ Distractions ☐ Shift change ☐ No access to patient information ☐ Emergency Situation
Other_____

* CAUSE(S) OF ERROR (*Check all that apply*)	EXPLANATION OF ERROR/COMMENTS
☐ Abbreviations	
☐ Brand / generic names look alike	
☐ Brand / generic names sound alike	
☐ Calculation error	
☐ Communication	
☐ Contraindicated, drug allergy	
☐ Contraindicated, drug / drug	
☐ Contraindicated, drug / food	
☐ Contraindicated in disease	
☐ Decimal point	
☐ Diluent wrong	
☐ Dispensing device involved	
☐ Documentation inaccurate / lacking	
☐ Dosage form confusion	
☐ Drug distribution system	
☐ Drug shortage/not available	
☐ Equipment design confusing / inadequate	
☐ Equipment (not pumps) failure / malfunction	
☐ Fax / scanner involved	
☐ Handwriting illegible / unclear	
☐ Incorrect medication activation	
☐ Knowledge deficit	
☐ Label (manufacturer's) design	
☐ Labeling (PMC's)	
☐ Labeling (Coles)	
☐ Leading zero missing	
☐ Measuring device inaccurate / inappropriate	
☐ Monitoring inadequate / lacking	
☐ Non-metric units used	
☐ Packaging / container design	
☐ Patient identification failure	
☐ Performance (human) deficit	
☐ Prefix / suffix misinterpreted	
☐ Procedure / protocol not followed	
☐ Pump, failure / malfunction	
☐ Pump, improper use	
☐ Reference material confusing / inaccurate	
☐ Repackaging by this facility	
☐ Repackaging by another facility	
☐ Similar packaging / labeling	
☐ Storage proximity	
☐ System safeguard(s) inadequate	
☐ Trailing / terminal zero	
☐ Transcription inaccurate / omitted	
☐ Verbal order confusing / incomplete	
☐ Written order confusing / incomplete	
Other:	

LEVEL OF STAFF INFORMATION

*** Level of staff that made the initial error**:

- ☐ Nurse, Registered
- ☐ Physician
- ☐ Nurse practitioner
- ☐ Physician Assistant
- ☐ Pharmacist
- ☐ Pharmacy technician
- ☐ Nurse, LPN / LVN
- ☐ Unit secretary / clerk
- ☐ Nurse, Agency/Travel/RN
- ☐ Nurse, Agency/Travel/LPN
- ☐ Patient/Caregiver
- ☐ ** Other: _____

Level of staff also involved in the error (i.e., perpetuated the error):

- ☐ Nurse, Registered
- ☐ Physician
- ☐ Nurse practitioner
- ☐ Physician Assistant
- ☐ Pharmacist
- ☐ Pharmacy technician
- ☐ Nurse, LPN / LVN
- ☐ Unit secretary / clerk
- ☐ Nurse, Agency/Travel/RN
- ☐ Nurse, Agency/Travel/LPN
- ☐ Patient/Caregiver
- ☐ ** Other: _____

Level of staff or other individual that discovered the error:

- ☐ Nurse, Registered
- ☐ Physician
- ☐ Nurse practitioner
- ☐ Physician Assistant
- ☐ Pharmacist
- ☐ Pharmacy technician
- ☐ Nurse, LPN / LVN
- ☐ Unit secretary / clerk
- ☐ Nurse, Agency/Travel/RN
- ☐ Nurse, Agency/Travel/LPN
- ☐ Patient/Caregiver
- ☐ ** Other: _____

Action taken to avoid future similar error:

- ☐ Communication process enhanced
- ☐ Computer software modified / obtained
- ☐ Education / training provided
- ☐ Environment modified
- ☐ Formulary changed
- ☐ Informed staff who made the initial error
- ☐ Informed staff who was also involved in error
- ☐ Informed patient / caregiver of medication error
- ☐ Informed patient's physician
- ☐ None
- ☐ Policy / procedure changed
- ☐ Policy / procedure instituted
- ☐ Staffing practice / policy modified

Action taken and recommendations to avoid a similar error?

_____

_____

_____

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PRODUCT INFORMATION (* Required Information)

(If the cause of the error is product related (label confusing/incorrect) or a result of a Pharmacy error, attach the container/label associated with the error to the report)

*** Generic name**: _____

*** Brand name**: _____

*** Strength / concentration**: _____

*** Dosage form**: _____

* PATIENT PROFILE INFORMATION

(REUIRED ONLY for Category D or greater)

***Patient age:** _____ days, weeks, months, years (*circle one*)

Patient Gender ☐ Male ☐ Female

***Error result on level of patient care:**

- ☐ No change in level of care
- ☐ A level of care not determined
- ☐ Airway established / patient ventilated
- ☐ Antidote administered
- ☐ Cardiac defibrillation performed
- ☐ CPR administered
- ☐ Drug therapy initiated / changed
- ☐ Laboratory tests performed
- ☐ Vital signs / monitoring initiated / increased
- ☐ Hospitalization, initial performed
- ☐ Hospitalization, prolonged 1-5 days
- ☐ Hospitalization, prolonged 6-10 days
- ☐ Hospitalization, prolonged >10 days
- ☐ Narcotic antagonist administered
- ☐ Observation initiated / increased
- ☐ Oxygen administered
- ☐ Surgery performed
- ☐ Transferred to higher level of care
- ☐ X-ray / MRI / other diagnostic test

☐ Other:_____

Details of error result on level of patient care:

_____

_____

_____

Test/laboratory data, with dates, if relevant to the error:

_____

_____

Other patient history, including pre-existing medical conditions and other concomitant drug therapy, with dates, if relevant to the error:

_____

_____

_____

This document is part of a quality improvement process and is CONFIDENTIAL/PEER REVIEW – Not to be included as part of the patient medical record.

Signature of DON/PCC_____ Date_____

Signature of QI Coordinator_____ Date_____

Other_____ Date_____

Personnel Involved _____ _____ _____

_____ _____ _____