

MEDICATION ERROR/CHARTING DISCREPANCY REPORT

1. **COMPLEX ERROR:** An error which resulted from two or more distinct errors of different types.
2. **ERROR OF PRESCRIBING:** An incorrect selection of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, illegible prescriptions or medication orders and instructions for use of a drug product.
3. **ERROR OF DISPENSING:** When the incorrect drug, concentration, drug dose or quantity is formulated and delivered for use to the point of intended use.
4. **ERROR OF ADMINISTRATION:** When there is an incorrect selection and administration of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber.

DATE: _____ BUILDING & UNIT _____

DATE & TIME OF OCCURRENCE: DATE: _____ TIME: _____ AM/PM

STATEMENT OF ERROR/DISCREPANCY: _____

MEDICATION ERROR WAS THOUGHT TO BE DUE TO:

- ' Unavailable client information prior to dispensing or administering drug (lab values, allergies, etc.)
- ' Unavailable drug information (written resources)
- ' Miscommunication of drug orders (similar names, inappropriate abbreviations, illegible handwriting, etc.)
- ' Problems with labeling, packaging
- ' Drug standardization, storage (look-alike containers, etc.)
- ' Drug device use and monitoring (equipment malfunction, etc.)
- ' Environmental stress (distractions, noise during transcription or dispensing, extended shifts, etc.)
- ' Staff knowledge regarding medication
- ' Other: _____

CLIENT'S REACTION TO THE ERROR: (Side effects, adverse reactions, etc)

CLINICAL ACTION TAKEN: _____

PHYSICIAN NOTIFIED: DATE: _____ TIME: _____ am/pm PHYSICIAN: _____

SIGNATURE OF PERSON REPORTING DISCREPANCY: _____

INSTRUCTIONS:

Form to be completed by person making error/discrepancy. If unknown, by person discovering error/discrepancy.	_____ Nursing Supervisor's Signature	_____ Date
	_____ Nurse Executive's Signature	_____ Date

- * Level 1: Client experienced no or minimal adverse consequences & no treatment or intervention other than monitoring was required.
- Level 2: Client experienced short-term, reversible adverse consequences & treatment(s) and/or intervention(s) in addition to monitoring or observation was/were required.
- Level 3: Client experienced life-threatening and/or permanent adverse consequences.

DO NOT FILE IN CLIENT'S RECORD

STAMP PLATE

NURSING REVIEW: _____

* Severity Level: 1 ____ 2 ____ 3 ____ Explain: _____

MEDICAL STAFF REVIEW: _____

* Severity Level: 1 ____ 2 ____ 3 ____ Explain: _____

Physician's Signature Date

Clinical Director's Signature Date

PHARMACY REVIEW: _____

* Severity Level: 1 ____ 2 ____ 3 ____ Explain: _____

Pharmacist's Signature Date

Pharmacy Director's Signature Date

***Coding (Appropriate Discipline)**

Division: CHD ____ DDD ____ FSD ____ PSD ____ Type Error: _____ # Doses: _____

Complex Error: Yes ____ No ____ Severity Level: 1 ____ 2 ____ 3 ____

Corrective Action: _____ (If more than one person, note action for each person & # of doses involved below.)

Responsible Individual(s) (Include # errors per person): _____

Was nurse involved working: agency Yes No; overtime Yes No; PT/Hourly Yes No Was nurse

working more than eight (8) hours? Yes No Was nurse covering more than one (1) unit? Yes No

How many? ____ Where any other staffing issues associated with this error? Yes No If yes, explain: ____

*To be coded by the Nurse Executive, Clinical Director, and/or Pharmacy Director. Depending on error, might require code by one or all three.

**The Clinical Director shall determine severity level in situations of non-concurrence.