# MEDICATION DISCREPANCY REPORT

(To be completed by nurse responsible for medication discrepancy or by nurse who discovers the discrepancy)

Healthcare Center

Date | Time of Discrepancy ☐ AM ☐ PM

Name of Nurse | Date of Report

*Check items that are applicable:*

- ☐ 1) Omission (drug ordered but not administered at least once)
- ☐ 2) Unauthorized Drug (drug administered without a physician's order)
- ☐ 3) Wrong Dose
- ☐ 4) Wrong Route of Administration
- ☐ 5) Wrong Dosage Form
- ☐ 6) Wrong Drug
- ☐ 7) Wrong Time
- ☐ 8) Failure to Follow Manufacturer's Specifications and/or Accepted Professional Standards
- ☐ 9) Other: ___

*Answer YES or NO:*

| Question | YES | NO |
|---|---|---|
| 1. Was the order written correctly? | ☐ | ☐ |
| 2. Did you follow the THREE RULES?<br>- LOOK at the medicine as you removed it from the cart?<br>- COMPARE it with the MAR?<br>- LOOK at it as you replaced it in the cart? | ☐ | ☐ |
| 3. Was the order plainly written? | ☐ | ☐ |
| 4. Was the order transcribed onto the MAR properly? | ☐ | ☐ |
| 5. Was the environment and lighting (well lit) conducive to pouring medications? | ☐ | ☐ |
| 6. Did pharmacy provide the correct medication and labeling? | ☐ | ☐ |
| 7. Did pharmacy place proper auxiliary label on prescription? | ☐ | ☐ |
| 8. Was attending physician notified? Date ___ Time ___ | ☐ | ☐ |
| 9. Was family or responsible party notified? Date ___ Time ___ | ☐ | ☐ |

Describe the incident (include medication, dose, route and time administered)

Outcome to resident (provide factual comparison of resident before and after incident)

Corrective action taken

Measures taken to prevent recurrence

Doctor's response

Number of residents to whom you were giving medications: | Signature of Nurse

**SIGNATURES** *(per facility policy)*

| | | | |
|---|---|---|---|
| Signature of DON | Date | Signature of Medical Director | Date |
| Signature of ☐ Consultant Pharmacist ☐ Risk Manager | Date | Signature of Administrator | Date |
| Signature of Attending Physician | Date | | |

| Resident Name | ID # | Room # | Physician |
|---|---|---|---|
| | | | |

**WHITE** - Director of Nursing/Nursing Supervisor **YELLOW** - R.Ph. Consultant

Form # **MP5427** Rev. 10/04

Reorder From: **MED-PASS** The Fine Art of Document Design 800-438-8884

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INH 010201

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