

DO NOT COPY

**NOT PART
OF CHART**

CONFIDENTIAL VARIANCE REPORT

The information contained herein is **PRIVILEGED** and **CONFIDENTIAL**.
Complete and forward to **Risk Management - Slot 728**



Patient Name: _____	Visitor Name: _____
Medical Record #: _____	Home Address: _____
Date of Birth: _____	City, State Zip: _____ Phone: _____

Date of Variance	Time	Location of Variance (Room #, Department, etc.)	Other Department Involved	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Status <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Visitor
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I. Falls (Check all that apply) Witnessed Unwitnessed

1 <input type="checkbox"/> Ambulating	8 <input type="checkbox"/> From Table
2 <input type="checkbox"/> From Bed	9 <input type="checkbox"/> From Wheelchair
<input type="checkbox"/> Bed in low Position	10 <input type="checkbox"/> Shower/Tub
<input type="checkbox"/> Bedrails up	11 <input type="checkbox"/> Call Light Not Available
3 <input type="checkbox"/> From Chair	12 <input type="checkbox"/> Call Light On
4 <input type="checkbox"/> From Commode	13 <input type="checkbox"/> Call Light Within Reach
5 <input type="checkbox"/> From Equipment	14 <input type="checkbox"/> Floor Wet or Slippery
6 <input type="checkbox"/> From Stretcher	15 <input type="checkbox"/> Sitter in Room
7 <input type="checkbox"/> Other _____	

Risk factors identified prior to fall Yes No

Medications last 24 hours:

1 <input type="checkbox"/> Sedative	3 <input type="checkbox"/> Narcotic
2 <input type="checkbox"/> Laxative/Diuretic	4 <input type="checkbox"/> PCA/Epidural
5 <input type="checkbox"/> Other _____	

Mental Status Before Variance:

1 <input type="checkbox"/> Alert	2 <input type="checkbox"/> Confused	3 <input type="checkbox"/> Sedated	4 <input type="checkbox"/> Asleep
5 <input type="checkbox"/> Non-compliant		6 <input type="checkbox"/> Other _____	

VI. Medication Error/Problem

1 <input type="checkbox"/> Medication/IV Solution	2 <input type="checkbox"/> Blood	3 <input type="checkbox"/> IV Contrast
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Process involved:

1 <input type="checkbox"/> Administration	4 <input type="checkbox"/> Monitoring
2 <input type="checkbox"/> Dispensing	5 <input type="checkbox"/> Transcription
3 <input type="checkbox"/> Prescribing	

Route of drug:

1 <input type="checkbox"/> Oral	3 <input type="checkbox"/> Intramuscular
2 <input type="checkbox"/> Intravenous	4 <input type="checkbox"/> PCA
5 <input type="checkbox"/> Other _____	

Type of event

1 <input type="checkbox"/> Wrong patient	7 <input type="checkbox"/> Wrong time	13 <input type="checkbox"/> Pyxis filled incorrectly
2 <input type="checkbox"/> Wrong dose	8 <input type="checkbox"/> Delay > 1hr	14 <input type="checkbox"/> Adverse Drug Reaction
3 <input type="checkbox"/> Wrong rate	9 <input type="checkbox"/> Dose omitted	
4 <input type="checkbox"/> Wrong medication	10 <input type="checkbox"/> Duplication/extra dose	Name of Medication _____
5 <input type="checkbox"/> Wrong route	11 <input type="checkbox"/> Extravasation/Infiltration _____	
6 <input type="checkbox"/> Wrong quantity	12 <input type="checkbox"/> Inappropriate med/dose	# of Doses involved _____
15 <input type="checkbox"/> Other _____		

VII. Chart/Order Related

1 <input type="checkbox"/> Wrong pt	4 <input type="checkbox"/> Computer input error
2 <input type="checkbox"/> Missed orders	5 <input type="checkbox"/> Computer system error
3 <input type="checkbox"/> Incorrect order	
6 <input type="checkbox"/> Other _____	

II. Treatment/Procedure Related

1 <input type="checkbox"/> Wrong pt	7 <input type="checkbox"/> Treatment missed	
2 <input type="checkbox"/> Wrong treatment/procedure	8 <input type="checkbox"/> Error performing test	
3 <input type="checkbox"/> Procedure delayed	9 <input type="checkbox"/> Error reporting results	
4 <input type="checkbox"/> Procedure cancelled	10 <input type="checkbox"/> Lost lab specimen	
5 <input type="checkbox"/> Reaction to procedure	11 <input type="checkbox"/> Mislabeled Specimen	
6 <input type="checkbox"/> Treatment delayed	12 <input type="checkbox"/> Other _____	

VIII. Miscellaneous

1 <input type="checkbox"/> Pt. NPO/food served	6 <input type="checkbox"/> Fight among pts/visitors
2 <input type="checkbox"/> Self-extubation	7 <input type="checkbox"/> Rape of patient
3 <input type="checkbox"/> Left AMA	8 <input type="checkbox"/> Unexpected transfer to critical care
4 <input type="checkbox"/> Self-inflicted injury	9 <input type="checkbox"/> Abduction of Infant
5 <input type="checkbox"/> Found unresponsive	10 <input type="checkbox"/> Other _____

III. Surgery/Anesthesia/ L & D

Non-Emergency Case Emergency Case

1 <input type="checkbox"/> Unsterile situation	10 <input type="checkbox"/> Surgery on Wrong pt	
2 <input type="checkbox"/> Instrument count incorrect	11 <input type="checkbox"/> Skin problem: Burn	
3 <input type="checkbox"/> Sponge count incorrect	12 <input type="checkbox"/> Skin problem: Pressure-related	
4 <input type="checkbox"/> Sharps count incorrect	13 <input type="checkbox"/> Maternal Death	
5 <input type="checkbox"/> Unplanned return to OR	14 <input type="checkbox"/> Wrong body part removed	
6 <input type="checkbox"/> Anesthesia variance	15 <input type="checkbox"/> Injury to adjacent organ	
7 <input type="checkbox"/> Incorrect Surgical Site	8 <input type="checkbox"/> Cancelled surgery due to prep/equip. prob.	
9 <input type="checkbox"/> Consent incomplete/incorrect/not done		
16 <input type="checkbox"/> Other _____		

IX. Outcome No injury Monitoring required Further txmt required

1 <input type="checkbox"/> Fainted	9 <input type="checkbox"/> Puncture
2 <input type="checkbox"/> Bruise/Contusion	10 <input type="checkbox"/> Laceration
3 <input type="checkbox"/> Swelling	11 <input type="checkbox"/> Skin tear
4 <input type="checkbox"/> Hematoma	12 <input type="checkbox"/> Object in Eye
5 <input type="checkbox"/> Dislocation	13 <input type="checkbox"/> Burn-chemical
6 <input type="checkbox"/> Sprain/Strain	14 <input type="checkbox"/> Burn-thermal
7 <input type="checkbox"/> Fracture	15 <input type="checkbox"/> Respiratory Depression
8 <input type="checkbox"/> Abrasions	16 <input type="checkbox"/> Death
17 <input type="checkbox"/> Other _____	

IV. Equipment Related (Fill out SMDA form on back if applicable)

1 <input type="checkbox"/> Failed	3 <input type="checkbox"/> Broken	5 <input type="checkbox"/> Wrong equipment
2 <input type="checkbox"/> Not available	4 <input type="checkbox"/> Improper set-up	6 <input type="checkbox"/> Pt. struck by equip.

Packaging saved: Yes No NA 7 Other _____

Immediate Action Taken:

V. Physician Notification

Physician Notified _____

Date _____ Time _____ NA

Notified by _____ Title _____

Seen by Dr. _____

Date _____ Time _____ NA

Additional comments/Follow-up

Report completed by: (please print) _____ Phone: _____

Name: _____ Title: _____