# Medicines Discrepancy Report Form

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IMPORTANT INFORMATION**  This form is to be used to report a medicines discrepancy as per MP0103/19 - see Policy and Guidelines for information on when a report is required and when to complete this form. All sections are mandatory: complete all fields in full. After completing each Part, email to the Department of Health **AND** your relevant Health Service Provider (HSP).  **PART 1:** An initial review of every discrepancy is required. *If the medicine is located, no report is required*. If the medicine cannot be located, then Part 1 of this form is to be completed and submitted within 24 hours.  **PART 2:** On receipt of Part 1, the HSP is to assign an officer to undertake a preliminary inquiry. On conclusion of the inquiry, Part 2 of this form is to be completed.  This form is a fillable word document. It is designed to be filled in electronically. Once complete it should be saved and emailed. | | | | | | | | | | | | | | | | | | | | | |
| **PART 1 –** Initial Review | | | | | | | | | | | | | | | | | | | | | |
| **Location** | | | | | | | | | | | | | | | | | | | | | |
| **Health Service:** | | | | | | **Hospital / Site:** | | | | | | | | **Ward / Unit:** | | | | | | | |
| **Time identified** | | | | | | | | | | | | | | | | | | | | | |
| **Date:** | | | | | | | | | | | **Time:** | | | | | | | | | | |
| **Medicine(s) involved** | | | | | | | | | | | | | | | | | | | | | |
|  | **Drug Name:** | | | **Dose Form:** | | | | | **Strength:** | | | | | | | | **Type:** | **Discrepancy quantity:** | | | |
| **1** |  | | |  | | | | |  | | | | | | | |  |  | | |  |
| **2** |  | | |  | | | | |  | | | | | | | |  |  | | |  |
| **3** |  | | |  | | | | |  | | | | | | | |  |  | | |  |
| **Initial review** | | | | | | | | | | | | | | | | | | | | | |
|  | **Action performed:** | | | | | | **Details:** | | | | | | | | | **Result:** | | | | | |
| **1** | recount stock | | | | | |  | | | | | | | | |  | | | | | |
| **2** | rule out counting / transcription / clinical error | | | | | |  | | | | | | | | |  | | | | | |
| **3** | re - balance register | | | | | |  | | | | | | | | |  | | | | | |
| **4** | search safe and surrounding area | | | | | |  | | | | | | | | |  | | | | | |
| **5** | other: | | | | | |  | | | | | | | | |  | | | | | |
| **Person making Part 1 report** | | | | | | | | | | | | | | | | | | | | | |
| **Person 1** | | **First name:** | | | **Surname:** | | | | | **Position:** | | | **HE number:** | | | | | | **Date:** | | |
| **Person 2 (witness)** | | **First name:** | | | **Surname:** | | | | | **Position:** | | | **HE number:** | | | | | | **Date:** | | |
| **Complete Part 1, save and then email to** | | | | | | | | | | | | | | | | | | | | | |
| **Health Service** | | | | | | | | **AND** | | | | **Department of Health** | | | | | | | | | |
| **Click here to select email** | | | | | | | | **medicine.discrepancies@health.wa.gov.au** | | | | | | | | | |
| **HSP Use Only** | | | | | | | | | | | | | | | | | | | | | |
| **CMS ID Number:** | | | **Inquiry assigned to:** | | | | | | | | | | | | **Date:** | | | | | **Time:** | |
| **Notes:** | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PART 2 –** Preliminary Inquiry | | | | | | | | | | | | | | | | Continue on from Part 1 | | | | |
| **Preliminary Inquiry** | | | | | | | | | | | | | | | | | | | | |
|  | **Action performed:** | | | | | **Details:** | | | | | | | | | **Result:** | | | | | |
| **1** | repeat initial review | | | | |  | | | | | | | | |  | | | | | |
| **2** | audit register / record keeping | | | | |  | | | | | | | | |  | | | | | |
| **3** | interview staff / patient / other | | | | |  | | | | | | | | |  | | | | | |
| **4** | review CCTV | | | | |  | | | | | | | | |  | | | | | |
| **5** | reconcile charts / usage | | | | |  | | | | | | | | |  | | | | | |
| **6** | review storage conditions / security | | | | |  | | | | | | | | |  | | | | | |
| **7** | other: | | | | |  | | | | | | | | |  | | | | | |
| **Persons consulted / notified** | | | | | | | | | | | | | | | | | | | | |
|  | | | **Name:** | | | | **Position:** | | | | | **Date:** | | | | | | **Comments:** | | |
| Pharmacy | | |  | | | |  | | | | |  | | | | | |  | | |
| Security | | |  | | | |  | | | | |  | | | | | |  | | |
| Nurse Manager | | |  | | | |  | | | | |  | | | | | |  | | |
| Police notified | | |  | | | |  | | | | |  | | | | | |  | | |
| Other | | |  | | | |  | | | | |  | | | | | |  | | |
| **Outcome** | | | | | | | | | | | | | | | | | | | | |
| **No loss** | | | Stock located Missing entry/transfer error Calculation error Clinical error (dose/drug) Damaged stock Other | | | | | | | | | | | | | | | | | |
| **Loss confirmed** | | |  | | | | | | | | | | | | | | | | | |
| **Probable cause of discrepancy** | | | | | | | | | | | | | | | | | | | | |
|  | | | | **Details** | | | | | | **Comment** | | | | | | | **Action / referral** | | | |
| Failure to adhere to policy | | | |  | | | | | |  | | | | | | |  | | | |
| Suspected theft/misconduct | | | |  | | | | | |  | | | | | | |  | | | |
| Other | | | |  | | | | | |  | | | | | | |  | | | |
| **Recommendation:** | | | | | | | | | | | | | | | | | | | | |
| **Supporting documents (attach when e-mailing form)** | | | | | | | | | | | | | | | | | | | | |
|  | **Name:** | | | | | **Type:** | | | | | | | | | **Comment:** | | | | | |
| **1** |  | | | | |  | | | | | | | | |  | | | | | |
| **2** |  | | | | |  | | | | | | | | |  | | | | | |
| **3** |  | | | | |  | | | | | | | | |  | | | | | |
| **Person making Part 2 report** | | | | | | | | | | | | | | | | | | | | |
| **Person** | | **First name:** | | | **Surname:** | | | | **Position:** | | | | **HE number:** | | | | | | **Date:** | |
| **Complete Part 2, save and then e-mail to** | | | | | | | | | | | | | | | | | | | | |
| **Health Service** | | | | | | | | **AND** | | | **Department of Health** | | | | | | | | | |
| **Click here to select email** | | | | | | | | **medicine.discrepancies@health.wa.gov.au** | | | | | | | | | |
| **HSP Use Only** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | **Details:** | | | | | | | | | **Date:** | | | | | | **Time:** |
| Assessment of potential misconduct | | | | |  | | | | | | | | |  | | | | | |  |
| Referral required | | | | |  | | | | | | | | |  | | | | | |  |
| Misconduct notification | | | | |  | | | | | | | | |  | | | | | |  |
| **Notes:** | | | | | | | | | | | | | | | | | | | | |