

PATIENT CARE VARIANCE REPORT

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CONFIDENTIAL

Addressograph

I. GENERAL INFORMATION

A) Name of Person Completing Report: _____ C) Time/Shift of Occurrence: _____
 Title: _____ D) Location of Occurrence: _____
 Phone: _____ E) Name of Person(s) Involved: _____
 B) Date of Occurrence: _____

II. OCCURRENCE TYPE

A) INJURY Treated Untreated
 Abrasion
 Bite
 Bruise
 Burn
 Contusion
 Laceration
 Needle Stick
 Sprain
 Strain
 Other (specify) _____

B) HIGH RISK EVENT
 Alleged Sexual Activity
 AWOL
 Code Blue
 Elopement
 Elopement Attempt
 ** Med. Emergency
 Physical Assault
 ** Seizure Activity
 ** Sexual Aggression
 ** Suicide Attempt
 Other (specify) _____

D) MISCELLANEOUS
 AMA/Discharge
 Refusing Discharge
 Refusal of Treatment
 Other (specify) _____

Caused from...

Environmental (specify) _____

Patient-on-Patient

Patient-on-Staff

Recreational (specify) _____

Accidental Injury

Intentional (Self-Inflicted) Injury

C) PERSONAL BELONGINGS DAMAGE/LOSS

Money

Clothes

Wallet

Other (specify) _____

** Specify below in Section III

III. BRIEF DESCRIPTION (Please Print)

IV. IMMEDIATE ACTION

No Action Indicated

Transfer to BTGH/LBJ (circle one)

Family Notified

Plan of Care Revised (specify below) _____

Education/Training

Corrective Action (Employee)

Policy Change Identified

Equipment Removed/Repaired

Administrator On-Call Notified

Administrative Alert Completed

Physician Visit

Other (specify) _____

MD Notified (Name) _____ Date _____ Time _____

MD Implementations/Recommendations: _____

Nursing Supervisor Notified: _____ Date _____ Time _____

Signature of Reporter: _____ Date _____ Time _____ Last 4 of SS# _____

V. INTEGRATED OCCURRENCE STRATEGY

A. Proactive Implementations (to be completed by Unit/Department as appropriate)

1) Patient/Family Education/Meeting: _____

2) Consultation with Treatment Team: _____

Titration Medications: _____

Re-Assess MTP: _____

3) Recommendation (Special Observation and/or Precautions):

Fall Precaution _____ Suicide Precaution _____ 1:1 _____

4) Other: _____

5) Dept: _____ Person Referred to: _____ Date: _____

Action: _____

Signature: _____

Signature of Implementer: _____ Date _____ Time _____ Last 4 of SS# _____

B. Risk Manager Review and Evaluation

Date Occurrence Report received: _____ Time Occurrence Report received: _____

1) Corrective Actions: _____

2) Implementation Plans _____

3) Risk/Quality Issues: _____

4) Recommendations:

Refer for further follow-up: _____

Refer to changes to Policy & Procedures: _____

Refer to Practice Patterns: _____

Refer to Staffing Patterns: _____

Other: _____

Signature of Departmental Manager _____ Date _____ Time _____

Signature of Director of Nursing _____ Date _____ Time _____

Signature of Risk Manager _____ Date _____ Time _____