MEDICATION ERROR QUALITY REVIEW

QAR #:	Date of Incident:

Name of Reviewer:	FIRST NAME	LAST NAME

Date of Interview:

Employee Interviewed: Choose from list...

Name:

Employee PR Number:

Agency of Interviewed Employee: Choose from list...

Other Agency Involved: Choose from list...

How many years practicing as a Paramedic in Pinellas County?	Choose from list...
How many years practicing as an EMT in Pinellas County?	Choose from list...
How many total years practicing in EMS?	Choose from list...

Version (Year) of MOMs active at time of incident:

Number of Protocol(s) involved (ex. C1 - Medical Cardiac Arrest, CP1 - Adult Airway Management):

EMD Determinant:

Indication for Medication: Choose from list...

Other, please specify:

Name of Medication:

Chief Complaint of Patient (in EPCR):

Number of hours on shift when incident occurred: Choose from list...

Estimated number of calls on current shift:

Estimated number of calls on previous shift:

Did you work an extra shift prior to this shift? ◯ YES ◯ NO

How many hours?

Did you have at least 8 hours of rest time available prior to reporting for this shift/duty period?

◯ YES ◯ NO (other Job, Obligations, Sleep Disruption, etc.)

If less than 8 hours, please explain the situation and how many hours:

How were you feeling at the time of the incident? Choose from list...

Other, please specify:

Time of incident:

Number of medics at patient: Choose from list...

If no medics, how many EMTs?

Where was the medication given? Choose from list...

Whose medication supply was used? (Select all that apply)

- ☐ FD response bag
- ☐ Sunstar response bag
- ☐ FD truck supply (includes ambulance refrigerator box)
- ☐ Sunstar truck supply (includes ambulance refrigerator box)
- ☐ FD controlled substance box
- ☐ Sunstar controlled substance box

FIRST dose (please include units, ex. 5mg or 100 mcg):

First dose route:	Choose from list...
Who drew up the first dose?	Choose from list...
Name of provider and county ID:	
Who administered the first dose?	Choose from list...
Name of provider and county ID:	
Who confirmed the MACC prior to administering the first dose?	Choose from list...
Name of provider and county ID:	

Was a second dose given? ◯ YES ◯ NO

SECOND dose (please include units, ex. 5mg or 100 mcg):

Second dose route:	Choose from list...
Who drew up the second dose?	Choose from list...
Name of provider and county ID:	
Who administered the second dose?	Choose from list...
Name of provider and county ID:	
Who confirmed the MACC prior to administering the second dose?	Choose from list...
Name of provider and county ID:	

Was a third dose given? ◯ YES ◯ NO

THIRD dose (please include units, ex. 5mg or 100 mcg):

Third dose route:	Choose from list...
Who drew up the third dose?	Choose from list...
Name of provider and county ID:	
Who administered the third dose?	Choose from list...
Name of provider and county ID:	
Who confirmed the MACC prior to administering the third dose?	Choose from list...
Name of provider and county ID:	

Explain any issues with the MACC, CRM, and/or document any factor pertaining to the incident:

When was the error realized? Choose from list...

Other, please specify:

What do you feel were some contributing factors for the error?

- ☐ Scene issue/safety
- ☐ Protocol deficiency
- ☐ Fatigue
- ☐ Communication lapse
- ☐ Equipment issue/medication packaging
- ☐ Recent protocol change
- ☐ Medication shortage/medical control directive
- ☐ Complacency
- ☐ Other

If “Other”, please explain:

Investigator opinion of possible cause factors for the error:

- ☐ Scene issue/safety
- ☐ Protocol deficiency
- ☐ Fatigue
- ☐ Communication lapse
- ☐ Equipment issue/medication packaging
- ☐ Recent protocol change
- ☐ Medication shortage/medical control directive
- ☐ Complacency
- ☐ Other

If “Other”, please explain:

Was OLMC contacted during the call? ◯ YES ◯ NO

How was the incident discovered? Choose from list...

Other, please specify:

Just Culture Determinant: Choose from list...

Please explain (error of omission, error of commission, provider attitude, etc.):