Near Miss Error Log

Week/Month

<table>
<thead>
<tr>
<th>No:</th>
<th>Date</th>
<th>Time of day</th>
<th>Staffing level</th>
<th>Dispensed by (optional)</th>
<th>Checked by (optional)</th>
<th>Name and brand of drug</th>
<th>Type of near miss*</th>
<th>Possible causes (see table 1 in QRG)</th>
<th>Things to consider (see table 1 in QRG)</th>
<th>Action taken</th>
<th>Potential adverse event discussion (tick on completion)</th>
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*Type of near miss (see also Table 1)

D = Wrong product
E = Out of date product
F = Wrong form
L = Wrong label
M = Missing product
N = Wrong patient name
P = Misread prescription
Q = Wrong quantity
S = Wrong strength
MCA = MCA involved

Time of day (examples)

M = Morning
L = Lunch
A = Afternoon
E = Evening

Staffing level (record number of staff)

E.g.
Number of pharmacists = N x P
Number of pre-registration pharmacists = N x PR
Number of technicians = N x T
Number of dispensers = N x D
Number of healthcare assistants = N x H
<table>
<thead>
<tr>
<th>Code</th>
<th>Type of near miss</th>
<th>Possible causes (non-exhaustive)</th>
<th>Things to consider when reviewing (non-exhaustive)</th>
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</table>
| D    | Wrong product    | • Product put away at wrong location  
      • Product selected incorrectly  
      • Products mixed on dispensing bench  
      • Misread prescription (Rx)  
      • Similar packaging  
      • Additional product | • Do the packs look similar? Should you separate?  
      • Who puts away the products? Training issues?  
      • More than one Rx being dispensed at a time?  
      • See also ‘misread Rx’  
      • Do you dispense from the Rx & not the labels?  
      • Wrong product ordered or delivered by wholesaler?  
      • Has the wrong product been placed in another bag? |
| E    | Out of date product | • Out of date products on shelf  
      • Out of date product sent from supplier | • Are you checking the expiry dates of medicines regularly?  
      • Does stock rotation occur?  
      • Are you checking the expiry date when you pick the medicine off the shelf and carry out the final check?  
      • Do the short dated products have a warning/alert sticker on them?  
      • Are there any more out of date products on the shelf?  
      • Do you check expiry dates of products when receiving them from the wholesaler? |
| F    | Wrong formulation | • Inadequate prescription detail  
      • Product selected incorrectly  
      • Misread Rx | • See also ‘misread Rx”  
      • Is everyone familiar with all formulations?  
      • Do the different formulations have similar packaging? Should they be stored separately? |
| L    | Wrong/ transposed/ Omitted label | • Incorrect transfer of information from the Rx  
      • Misread Rx  
      • Labelling in batches  
      • Incorrect label stuck on the wrong product  
      • Products mixed on dispensing bench | • Errors likely when label selected from repeats on PMR  
      • Are products dispensed and labelled one at a time?  
      • Is the dispensing bench clear of clutter and tidy? |
| M    | Missing item | • Products mixed up on dispensing bench  
      • Fridge line / CD / Owing  
      • Misread Rx  
      • Product not dispensed in a Multi-compartment compliance aid (MCA), dispensed separately  
      • Has the product been ordered or out of stock? | • Has the missing product been placed in another bag?  
      • Consider use of dispensing basket  
      • Warning label informing of fridge / CD line / owing outstanding  
      • Disperse and label one product at a time  
      • Item missed out when preparing for delivery/collection |
| N    | Wrong patient name | • Incomplete Rx reception process  
      • Previous patient selected from PMR  
      • Identical patient names  
      • Wrong patient selected from PMR  
      • Misread Rx  
      • Full name not provided on prescription | • Staff training issues?  
      • Distractions?  
      • Warning for all staff that two patients have the same name  
      • Enough detail on PMR to deal with similar names?  
      • See also ‘misread Rx’ |
| P    | Misread prescription (Rx) | • Inadequate / ambiguous details  
      • Hand-written prescription  
      • Poorly performed Rx evaluation process | • Training issue?  
      • Visual impairment?  
      • Was professional evaluation performed? |
| Q    | Wrong quantity | • Incorrect transfer of information from Rx  
      • Misread Rx or calculation error  
      • Counting error during dispensing | • Have you selected label from PMR or Rx?  
      • Can someone else check your calculation?  
      • If using a counting machine is it regularly calibrated and checked for accuracy?  
      • Several pack sizes available |
| S    | Wrong strength | • Product put away at wrong location  
      • Product selected incorrectly  
      • Products mixed on dispensing bench  
      • Misread Rx | • Do the packs look similar? Should you separate?  
      • Who puts away the goods? Training issue?  
      • Are packs placed on shelf with contents identity visible?  
      • Have you read the Rx correctly? Dispense from the Rx not the label |
| MCA/ MDS | Multi-compartment compliance aid/ Monitored Dosage System | • Product in wrong compartment  
      • Missing/omitted product  
      • Product unsuitable for inclusion in MCA | • Is there a SOP in place for dispensing into MCA  
      • Is a visual description available for each product  
      • Distractions  
      • Using manufacturers info on drug stability  
      • using RPS MCA guidance  
      • UKMi Medicines Compliance Aid Database |

Table 1: Near Miss Error Codes

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