ROYAL PHARMACEUTICAL SOCIETY

Near Miss Error Log

Week/Month.....

No:	Date	Time of day	Staffing level	Dispensed by (optional)	Checked by (optional)	Name and brand of drug	Type of near miss*	Possible causes (see table 1 in QRG)	Things to consider (see table 1 in QRG)	Action taken	Potential adverse event discussion (tick on completion)
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											

***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E = Out of date product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 1: Near Miss Error Codes

Code	Type of near miss	Possible causes (non-exhaustive)	Things to consider when reviewing (non-exhaustive)
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E	Out of date product	• Out of date products on shelf • Out of date product sent from supplier	• Are you checking the expiry dates of medicines regularly?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 • Are there any more out of date products on the shelf?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 • Dispense 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 pre-scription (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