What went wrong? Record the facts e.g.
- Types of near misses: 4xD, 3xF (4 x wrong product, 3 x wrong form)
- Time of day: 3xA, 2xE (3 x afternoon, 2 x evening)
- Staffing levels: 1xP, 2xD (1 x pharmacist, 2 x dispensers)
- Identify trends/patterns e.g. most near miss errors are labelling errors in the morning
- Pick up trends on new medicines, changes in packaging, new starters

Why did the near miss error happen, what were the causes/contributing factors e.g. PEOPLE/ENVIRONMENT/EDUCATION AND TRAINING/EQUIPMENT
- Very busy, staff member has called in sick, new staff member, phone ringing is distracting, pharmacy is untidy, expiry date checking of medicines incomplete.
- See table 1 on the near miss error log (NMEL) for other possible causes.

Action plan to address ‘WHY’ the error occurred and to prevent future errors. Identify possible solutions e.g.
- What needs to STOP/CHANGE/IMPROVE/NEW IDEAS
- Team to generate ideas for improvements, then develop an action plan using SMART objectives e.g. Adjust shift patterns, re-visit SOPs, provide staff training, schedule expiry date checking of medicines. See table 1 on the NMEL for things to consider.

To review action plan at the beginning of next review. To ‘check in’ on ideas from proposed action plan.

Was the action plan carried out to completion? What was the outcome? Were the actions a success? If so, continue with changes. If not successful, reconsider and revise action plan in the next review.

Ask for feedback from all staff including locums.

At the start of each review, consider the action plan from the previous review. Was it a success? If not, reconsider and revise the action plan in the next review.

To review to be a continuous, cyclical process to promote continuous learning and improvement implementation.

Staff can sign and date to demonstrate team participation.

Pharmacist can sign and date this ‘review of action plan’ to demonstrate this has been completed, before beginning the next near miss error review.

Completed logs can be stored for future reference.

All pharmacy staff to be part of/briefed on the review.

All staff have an opportunity to learn from near miss errors and generate ideas on how to prevent future errors.

Pharmacist can sign and date this ‘review of action plan’ to demonstrate this has been completed, before beginning the next near miss error review.

Top tips for using the Near Miss Error Improvement Tool

Downloaded from www.rpharms.com/nearmiss

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