

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 I in QRG)	Things to consider (see table I 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 I)

D = Wrong product	N = Wrong patient name
E = Out of date product	P = Misread prescription
F = Wrong form	Q = Wrong quantity
L = Wrong label	S = Wrong strength
M = Missing product	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	<ul style="list-style-type: none"> Product put away at wrong location Product selected incorrectly Products mixed on dispensing bench Misread prescription (Rx) Similar packaging Additional product 	<ul style="list-style-type: none"> 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E	Out of date product	<ul style="list-style-type: none"> Out of date products on shelf Out of date product sent from supplier 	<ul style="list-style-type: none"> 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 Are there any more out of date products on the shelf?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	<ul style="list-style-type: none"> Inadequate prescription detail Product selected incorrectly Misread Rx 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Incorrect transfer of information from the Rx Misread Rx Labelling in batches Incorrect label stuck on the wrong product Products mixed on dispensing bench 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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? 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Inadequate / ambiguous details Hand-written prescription Poorly performed Rx evaluation process 	<ul style="list-style-type: none"> Training issue? Visual impairment? Was professional evaluation performed?
Q	Wrong quantity	<ul style="list-style-type: none"> Incorrect transfer of information from Rx Misread Rx or calculation error Counting error during dispensing 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Product put away at wrong location Product selected incorrectly Products mixed on dispensing bench Misread Rx 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Product in wrong compartment Missing/omitted product Product unsuitable for inclusion in MCA 	<ul style="list-style-type: none"> 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