

Medication Error and Near Miss reporting form

Name of service user		
affected by incident		
-		
DOB		
Date of incident	Time of incident	
Name of staff involved		
Name of person	Date reported	
completing report		
Describe the incident		
	t happened? (To be completed by member of staff involved in th	ne
Why do you think the incider incident)	t happened? (To be completed by member of staff involved in th	ne
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Describe any harm caused to the resident					
What actions were taken to minimise the impact to the service user?					
The second secon					
Date GP/Pharmacist/111 informed? (state who was informed)					
Date of fr harmacisty III mornica: (state who was mornica)					
Advice given from GP/Pharmacist/111					
What actions have you taken to prevent the incident occurring again					

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	What was correct	What was incorrect
Name of medication	Timat was contect	What was meetineed
Dose		
Route		
Formulation of medication		

Route cause analysis competed?	Yes/No/Not required	Date:			
CQC notified?	Yes/No/Not required	Date:			
Safeguarding referral made?	Yes/No/Not required	Date:			
Managers Signature					
Date:					

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