Medication Error and Near Miss reporting form

NHS Kent and Medway

Name of service user affected by incident			
DOB			
Date of incident		**Time of incident**	
Name of staff involved			
Name of person completing report		**Date reported**	
Describe the incident			
Why do you think the incident happened? (To be completed by member of staff involved in the incident)			
Were there any health care professionals involved? (GP, pharmacist, district nurse) How?			

Approved By: IMOC
Approval Date: July 2023
Renew Date: July 2025

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Describe any harm caused to the resident
What actions were taken to minimise the impact to the service user?

Date GP/Pharmacist/111 informed? (state who was informed)	

Advice given from GP/Pharmacist/111
What actions have you taken to prevent the incident occurring again

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Medication involved in the incident		
	What was correct	**What was incorrect**
Name of medication		
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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