

Medication Error and Near Miss Reporting Form

This form should be completed by the care home for any medication error or near miss identified by the home. This should be completed regardless of where the medication error or near miss occurred, for example if staff identify that an incorrect medication is delivered to the care home, a report should still be completed.

If a staff member from the home is involved in the medication error or near miss, then any staff member involved should also complete the "Self-Reflection for Medication Error and Near Miss" form.

Name of service user affected by incident:	
Date of birth:	
Date and time of incident:	

Name of person completing report:	
Name(s) of staff member(s) involved:	
External organisation(s) involved, and how they were involved (e.g. GP, pharmacist, district nurse):	

Describe the error or near miss that occurred: <i>Include as much information as possible, including any events leading up to the incident.</i>	
---	--

Why do you think the incident happened? <i>To be completed with the member(s) of staff involved in the incident. The "Self-Reflection for Medication Error and Near Miss" form should be completed by the staff member(s) involved to support in answering this question.</i>	
---	--

What immediate actions were taken following the incident? <i>Include actions taken to minimise the impact to the service user, and who was spoken to following the incident (e.g. the resident, their family, any healthcare or social care professionals).</i>	
---	--

Was a GP / Pharmacist / NHS 111 contacted?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, state who was contacted:	
What advice was given?	
Describe any harm caused to the resident:	
What actions have been / will be taken to prevent the incident from occurring again?	

Medication involved	What was correct?	What was incorrect?
Name of medication:		
Dose:		
Route:		
Formulation:		

Root cause analysis completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required	Date:
CQC Notified?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required	Date:
Safeguarding referral made?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required	Date:

Manager's Signature:	
Date:	

Please keep a copy of any other relevant documentation (e.g. drug chart, root cause analysis, referral forms) with this Reporting Form.

NHS Kent and Medway - Integrated Care Team	Approval date: October 2025	Version: 2.0	Review date: October 2028
	Status: Approved	Page 2	

