

Self-Reflection for Medication Error and Near Miss

This should be completed by each staff member involved in the medication error or near miss. This form is designed to allow staff to reflect on what may have led to an error or near miss occurring and what they can do going forward to reduce the risk of this happening again. This form is **not** to assign blame on any person, but to encourage an open and honest conversation about the root causes of medication errors.

This should be completed as part of the "Medication Error and Near Miss reporting form".

Reflective account of incident:

Describe the error, including what happened leading up to the error, the error itself, and what was done following the error being identified (e.g. when and where the error occurred, how the error or near miss was identified, who else was involved).

Describe the context and circumstances around the error, from your view (e.g. what was the environment like, any human factors).

How did you feel before and after the incident?

What have you learnt from the error?

What can be done to prevent a similar error from happening again?

What actions do you plan to take as a result of this incident?

Name: _____ Signature: _____ Date: _____

Line Manager: _____ Signature: _____ Date: _____