

Standard Operating Procedure for Preventing errors and Recording near Misses

Purpose:

To ensure patient safety and optimise customer satisfaction.

To ensure that errors and near misses are dealt with appropriately.

Scope:

This SOP covers all errors and near misses that occur in the pharmacy.

Responsibility:

It is the responsibility of all staff to minimise errors that occur in the pharmacy.

**Standard
Operating
Procedure**

Standard Operating Procedure for Preventing errors and Recording near Misses

Responsibility: Pharmacist [P], Technician [T], Assistant [A].

Process Steps	Key Points	
<p>1. Identification of an error.</p> <p>Errors usually present themselves in two forms: Either a past error (move to step 2) or a potential error (move to step 3).</p>	<p>Errors are inevitable. No pharmacist, technician or dispenser can say that they are 100% accurate. The difference comes when how the error is dealt with.</p> <p>It should be treated as open as possible and no shame or guilt passed.</p>	<p>[P] [T] [A]</p>
<p>2. Recording a past error.</p> <p>In this case an error has been identified and needs to be dealt with appropriately. Obtain as much information as possible about what had happened.</p>	<p>If the error is deemed severe, meaning it comes under one of the points stated by the RPSGB as warranting a referral to the Investigating Committee (see supplement sheet) it must be referred to the appropriate higher authority.</p>	<p>[P] [T]</p>
<p>3. Recording a near miss.</p> <p>Near misses should be recorded using a near miss form this can be obtained from the RPSGB website.</p>	<p>The reason for the near miss should be considered and actions taken as to avoid the problem in the future.</p>	<p>[P] [T]</p>
<p>4. Actions under taken to avoid errors.</p> <p>In all cases of error, actions should be undertaken as to avoid future errors not just of the specific kind which occurred, but all types of error</p>	<p>These actions may include and not exclusively training issues, distractions, considering the use of baskets and extra accuracy stamps, stock checking, disability, double checking, final checking...</p>	<p>[P] [T]</p>
<p>5. Review of actions taken.</p> <p>Once actions have been implemented a review should be conducted to ascertain whether there has been a reduction in errors.</p>	<p>If errors have not been reduced then another investigation will be necessary and the process from step 4 will need to be repeated.</p>	<p>[P] [T]</p>
<p>6. Vigilance.</p> <p>It is one of the most important jobs of a pharmacist to protect patients from errors occurring.</p>	<p>Even if errors do not occur in the pharmacy adequate error protecting mechanisms as discussed above should still be implemented.</p>	<p>[P] [T]</p>

Single dispensing errors are not likely to be referred to the Investigating Committee unless one or more of the following statements are true:

There is potential for, or evidence that, the dispensing error caused moderate or severe harm or death.

There is evidence that the dispensing error was a deliberate attempt to cause harm to patients or the public.

There is evidence of ill health or substance abuse by the pharmacist.

There is evidence that the individual departed from agreed safe protocols or standards operating procedures and in doing so took an unacceptable risk.

There are no systems to record errors in the pharmacy (this should result in the Superintendent/Pharmacy owner being referred).

There has been a failure to make an error log (if aware of the error).

There are no systems to learn from errors in the pharmacy (this should result in the Superintendent/Pharmacy owner being referred).

No attempt has been made to learn from the specific error.

The Society's Inspector has previously given advice that would have prevented the error if it had been implemented.

There has been an attempt to cover up the alleged dispensing error or there is relevant history within the last 3 years.

There has been a failure to co-operate with an investigation carried out by the Society's Inspector or other investigatory body.

There is evidence of other misconduct that would form the basis of a complaint.

Failure to apologise/provide an explanation to the patient/representative

Additional notes:

Known risks:

Review procedure:

This SOP is dynamic, and should be constantly updated when and where necessary. The above box can be filled concerning new staff, adverse incidents or any new circumstance which arise after the publication of this first version. If no errors, incidences or RPSGB recommendations occur a review will be carried out every six months starting from the creation date. This review will update the SOP content and format with the goal to enable reduction of error within the pharmacy.*

I have signed to say that I have read and understood the instructions overleaf.

Name	Signature	Date

If there are any further enquiries or problems that arise during carrying out this SOP consult the pharmacist on duty.

Creation Date*:

Review Date:

Version:

Accountable Signature: