Near Miss Case Study

A regular customer arrived to collect her repeat prescriptions which had been ordered through an app several days previously. This customer was a pharmacist who used to work at the pharmacy and was well known to the staff by her first name. The shop assistant greeted her by name and went to collect the medications which were in a small basket. Seeing the assistant apparently struggling to find them, the customer also mentioned her surname. The assistant located a basket and placed the two OTC items that the customer had requested on top of the medications. On enquiry, the customer was advised that signing for the prescriptions was not occurring because of COVID safety precautions. The customer took the basket to the cash register for payment. As the items were taken from the basket, she noticed a medication which she had not been prescribed, together with two that she took regularly. The transaction was halted while the customer checked all the medications, and discovered a different patient's name on all labels. She returned the medications to the dispensary and collected her own.

Why did this happen – and how could it have been avoided?

Essentially the error occurred because of multiple points of process failure

- the shop assistant knew the customer's first name but did not know the surname
- the customer provided her surname but the assistant seemed not to hear it clearly, which was a failure of communication (two-way)
- the customer's first name was an uncommon one, and coincidentally, another patient with the same first name and first letter of the surname also had medications waiting to be collected
- the dispensed medications were covered up in the basket by requested OTC items
- due to COVID safety precautions, the repeat forms were not required to be signed by the customer and were not in the basket, so name and address details were not checked

Why was the error picked up before the customer left the pharmacy?

The pharmacy had enough checking steps so that the error ***could*** be detected at the final check – the cash register. However, the customer was also very familiar with the medications she was expecting to see in the basket and was observing them as they were taken out of the basket at the register. A less observant customer, or one who was distracted by interacting with the staff member at the register, may not have picked up the error until she returned home.

What could or should have been done differently?

Given the fact that a number of the checkpoints failed, and particularly considering the precautions being observed during COVID, processes in the pharmacy should probably have been adjusted to account for the extra risk of error

- additional measures to ensure accurate identification of customers when collecting their medications – verbally checking the name of the customer against the name on the label, including a printed address label in the basket if the prescription forms are removed before the customer collects

- involvement of the pharmacist in the transaction
- showing the customer the items which were in the basket, and asking a question such as "*Are these all you are collecting today?*" which encourages the customer to look at the items

What are the key learnings from this near miss?

The pharmacist in charge at the time of the incident was understandably somewhat shaken by the error. Fortunately, no harm was done, and the customer left the pharmacy with the correct medications. However, the fact the error occurred gave all the pharmacists a good opportunity to reflect on the reasons behind the error, and to make changes which would significantly reduce the risk of a recurrence.

Some of the key learnings from this experience are that:

- you should never rely on your own memory of a patient's identity, particularly when you normally only use the first name
- you should not skip critical points of checking; in this case the customer was a pharmacist so all the staff knew she was familiar with her medications and did not require counselling on how to use them, thus the pharmacist on duty did not engage in the transaction and the wrong surname was not detected
- when processes are changed, you should make a risk assessment of the modified process and introduce new checking steps if necessary to ensure the integrity of that process
- coincidences DO occur, such as two customers with unusual first names and same surname initial collecting medications on the same day

The customer returned to the pharmacy the following month to collect the next supply of her medications and was pleased to see that the process was much improved and the risk of error significantly reduced.