

# WMER

## Prescribing error incident audit - looking beyond the root cause

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# Prescribing Error Incident Audit - Looking Beyond The Root Cause

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## Clinical Practice guideline – Medication Safety Best Practice for effective paediatric ward round

### Aim & Objective

Benchmark the performance with respect to RCPCH guideline:

- Root cause post identification of medication error
- Recommendation & action plan to minimise/eliminate medication error

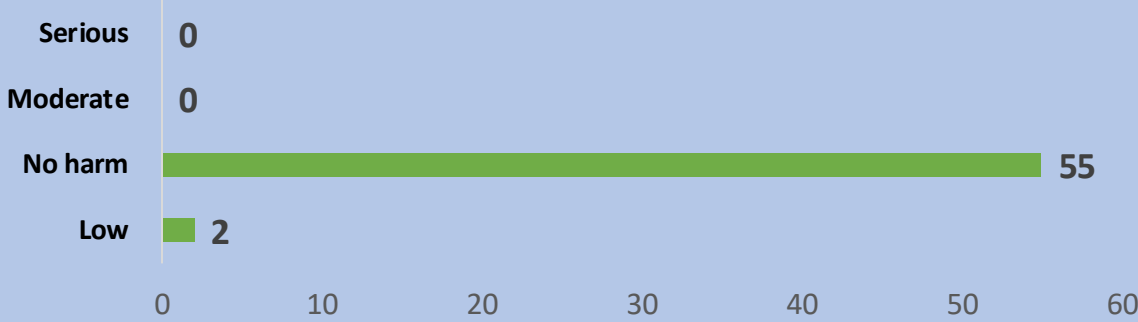
### Recommendations

- Regular medication safety audit to ensure effectiveness
- Introduce online prescriptions
- Introduce AI enabled virtual assistant for verification of online prescription

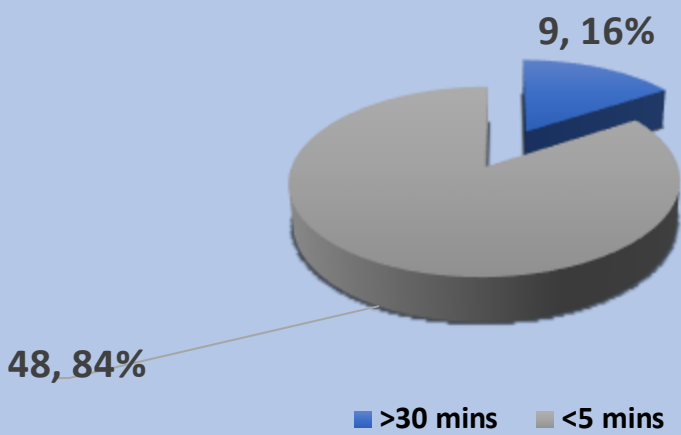
### Potential Future Benefits

- **Direct impact ( Tangible Savings)**
  - ~72% Manual error reduction
  - Potential man-hour saving
- **Indirect impact ( Non-Tangible benefit)**
  - Enhanced patient safety
  - Improved patient satisfaction
  - Better utilisation of skilled workforce

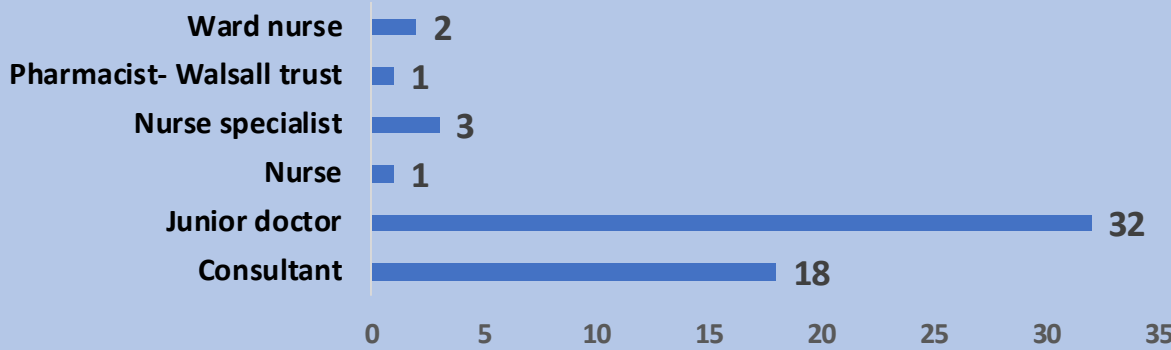
#### Level of Harm



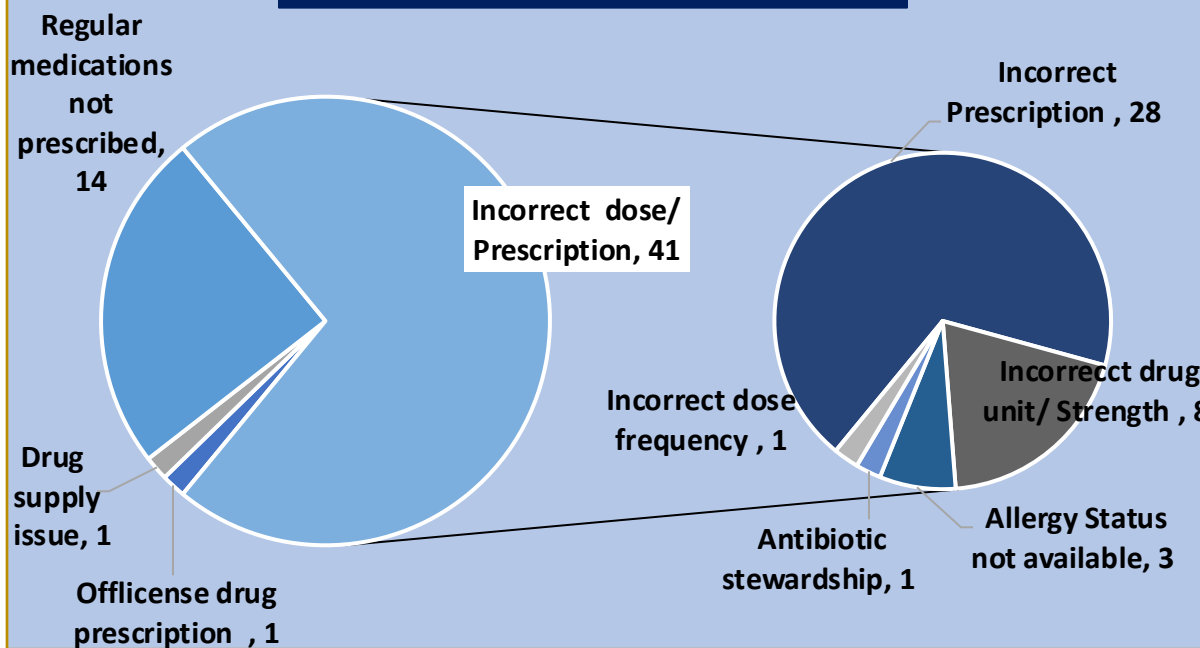
#### Time taken to contact Medical team post incident identification



#### Escalation Trend post incident



#### Distributions of Prescription errors



## Department / Team Name

Paediatric Department – Walsall Manor Hospital

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