

# 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

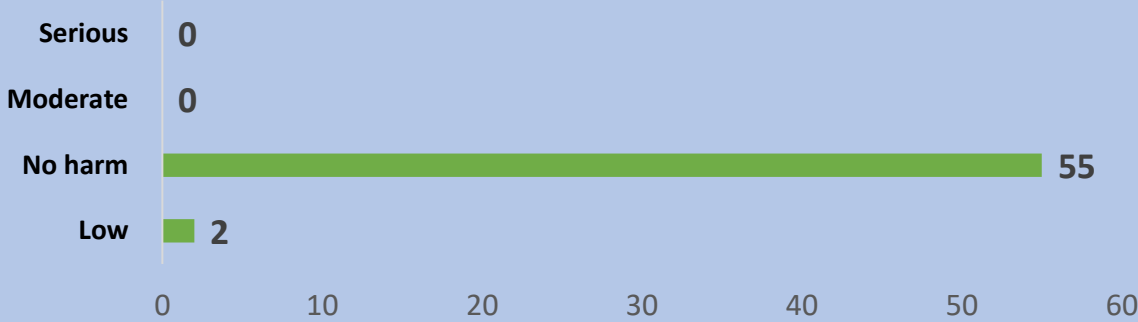
## Recommendations

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

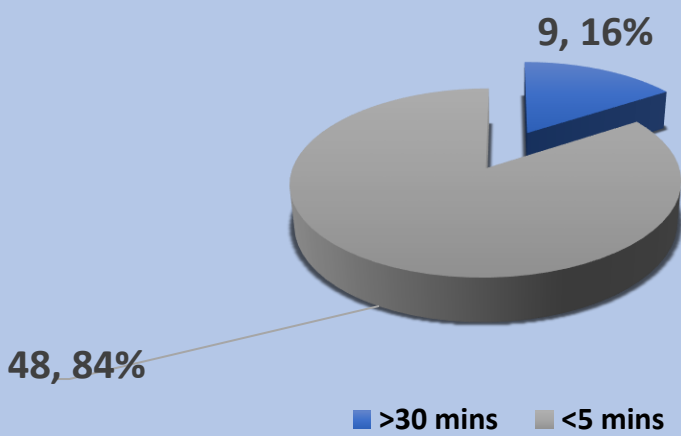
## Potential Future Benefits

- **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

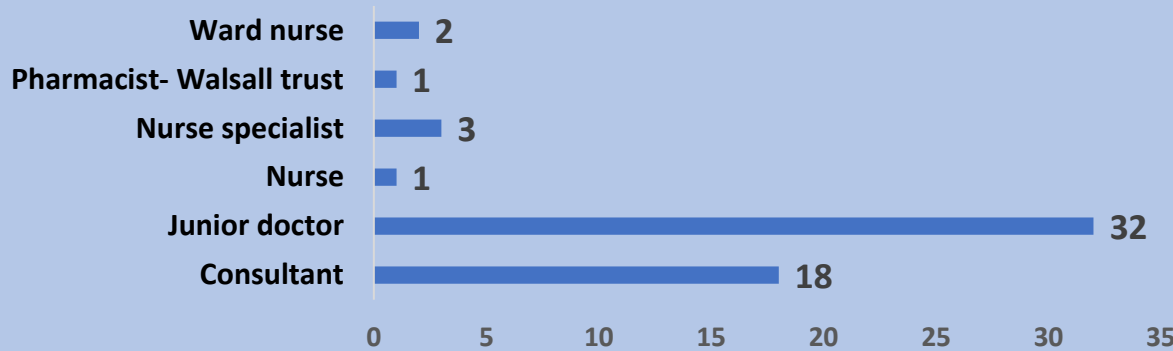
### Level of Harm



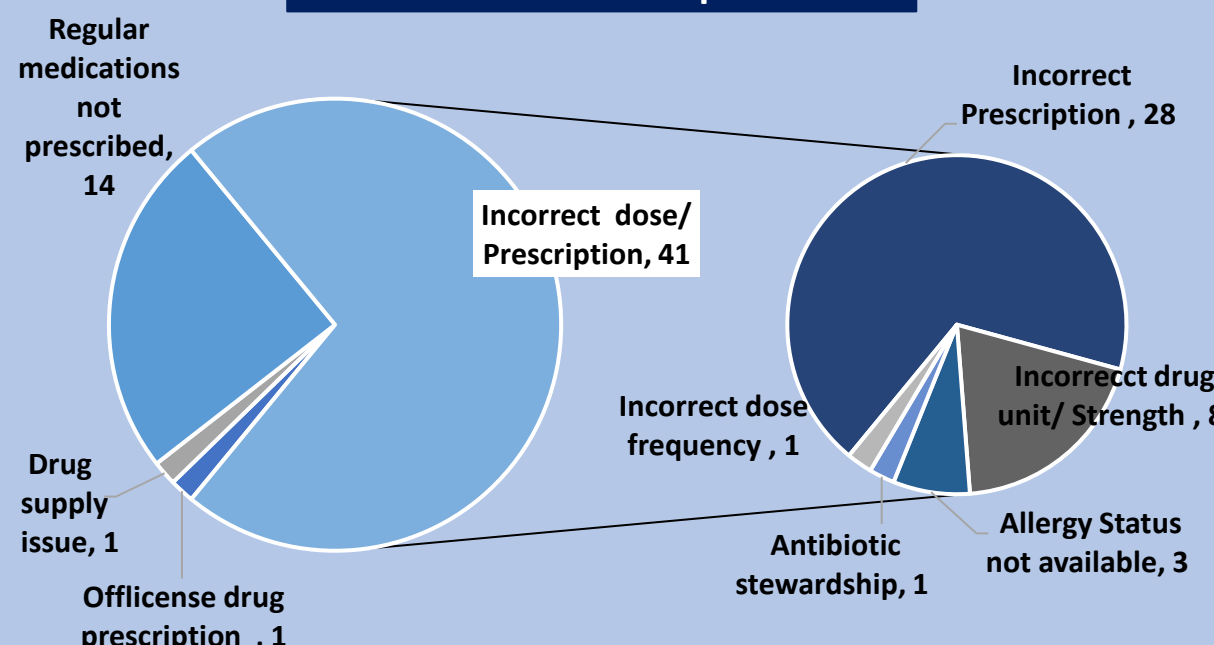
### Time taken to contact Medical team post incident identification



### Escalation Trend post incident



### Distributions of Prescription errors



## Department / Team Name

Paediatric Department – Walsall Manor Hospital

Working in partnership

The Royal Wolverhampton NHS Trust  
 Walsall Healthcare NHS Trust