

Medication errors and error chains involving high-alert medications in a paediatric hospital setting: a qualitative analysis of self-reported medication safety incidents.

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Understanding how and when [medication errors](#) occur is necessary to implement medication management safety strategies. This study determined that most [self-reported](#) high-alert medication errors in a children's hospital were associated with administration and prescribing. One-quarter of incidents included two to four errors, and wrong dose or omission were the most common. Systemic defenses are required to reduce wrong dose, omission, and [documentation](#) errors.