	Stage at which an error can occur
Patient enters "paperless" world	***eP interface*: Patient admitted from primary care; from another hospital; from theatre/ICU** Patient's current medicines entered into the eP system **Prescribing the medicine (doctors)** Prescriber *assesses clinical need* for medication *Selects patient record* from eP menu *Decides which drug*(s) to prescribe *Picks drug name, strength and formulation* (eg: tablet, liquid, injection....) from menu *Enters dose* to be given (as strength, eg: 500mg or as number of units, eg: "2 tablets") *Enters frequency* (eg: give now; give if needed; give regularly three times a day) May also give instructions for length of treatment; quantity to supply **Supplying the medicine (pharmacy staff)** *Dispensing* of ward stock items and individual patient medication **Administering the medicine (nurses)** Nurse *selects patient record* *Administers and records* regular drugs due at that time Administers and records "when required" medicines Administers and records "once only" drugs **Monitoring the effects (doctors, nurses, pharmacists)** *Make and record* clinical observations *Order and assess* laboratory tests Observe and record drug-related problems Order and assess drug plasma levels ***eP interface*: Patient is discharged home; to another hospital; or moves to theatre or ICU** Prescriber assesses clinical need for medication Prescribes medicines (as above) "to take home" Current medication reported for paper-based prescribing
Patient leaves "paperless" world	