## **Integrated National Medication Error Reporting System (INMERS)**

Medication Error Report

Reported on: May. 01, 2025

Patient Details	
Patient Sex	male
Patient Age	1 Year(s)
Patient Weight	1 (kg)
Patient Height	5 (cm)
	Medication Error Details
Medication Report Date	2025-05-01
Medication error Type	Incorrect Dispensing
Exact Prescription	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.
Incident Description	During administration, the nurse mistakenly gave the patient 500 mg of Ibuprofen instead of the prescribed Amoxicillin 500 mg due to a labeling error in the medication storage area.
Workplace Environment	During administration, the nurse mistakenly gave the patient 500 mg of Ibuprofen instead of the prescribed Amoxicillin 500 mg due to a labeling error in the medication storage area.
Patient Condition	Before: The patient was experiencing mild symptoms of bacterial infection, including a sore throat and mild fever. During: After receiving the incorrect medication (Ibuprofen), the patient reported dizziness and stomach upset. After: The patient's bacterial infection persisted, requiring additional medical intervention.
Immediate Actions	The nurse immediately informed the attending physician, documented the error in the patient record, and monitored the patient for adverse reactions to Ibuprofen. The correct medication was then administered promptly.

Corrective Actions	The storage area for medications was reorganized to ensure clear labeling of all drugs. Staff received additional training on medication verification processes to prevent future errors.
Preventive Actions	Introduced a barcode scanning system to verify medications before administration, ensuring the correct match between prescription and drug.  Conducted regular audits of medication storage and administration procedures.