Integrated National Medication Error Reporting System (INMERS)

Medication Error Summary Report for May 01 - May 31, 2025

Generated on: May. 13, 2025

#	Report Date	Medication Error Date	Error Type	Patient Sex	Patient Age	Patient Weight	Patient Height	Exact Prescription	Incident Description	Workplace Environment	Immediate Actions	Corrective Actions	Preventive Actions	Medicine Details
1	May. 12, 2025	May. 12, 2025	Incorrect transcription on patient chart / record	male	1 Year(s) old	1 kg	N/A	Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aliquam in tortor non dolor laoreet eleifend eu mattis nibh. Suspendisse eget lectus ornare, finibus ligula in	Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aliquam in tortor non dolor laoreet eleifend eu mattis nibh. Suspendisse eget lectus ornare, finibus ligula in, scelerisque nulla. Vivamus tincidunt felis at feugiat dictum. Etiam est diam, sollicitudin et dignissim ac, dignissim vel felis. Morbi laoreet	Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aliquam in tortor non dolor laoreet eleifend eu mattis nibh. Suspendisse eget lectus ornare, finibus ligula in, scelerisque nulla. Vivamus tincidunt felis at feugiat dictum. Etiam est diam, sollicitudin et dignissim ac, dignissim vel felis. Morbi laoreet	Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aliquam in tortor non dolor laoreet eleifend eu mattis nibh. Suspendisse eget lectus ornare, finibus ligula in, scelerisque nulla. Vivamus tincidunt felis at feugiat dictum. Etiam est diam, sollicitudin et dignissim ac, dignissim vel felis. Morbi laoreet	Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aliquam in tortor non dolor laoreet eleifend eu mattis nibh. Suspendisse eget lectus ornare, finibus ligula in, scelerisque nulla. Vivamus tincidunt felis at feugiat dictum. Etiam est diam, sollicitudin et dignissim ac, dignissim vel felis. Morbi laoreet	Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aliquam in tortor non dolor laoreet eleifend eu mattis nibh. Suspendisse eget lectus ornare, finibus ligula in, scelerisque nulla. Vivamus tincidunt felis at feugiat dictum. Etiam est diam, sollicitudin et dignissim ac, dignissim vel felis. Morbi laoreet	N/A

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2	May. 06, 2025	May. 06, 2025	Incorrect prescription (medication order)	male	5 Year(s) old	5 kg	5 cm	1	1	1	15	1	1	Generic Medicine: Haloperidol; Route: Injection into vein (Intravenous)
3	May. 06, 2025	May. 06, 2025	Incorrect transcription on patient chart / record	female	5 Year(s) old	5 kg	5 cm	1	1	1	3	5	6	N/A
4	May. 06, 2025	May. 06, 2025	Incorrect prescription (medication order)	male	5 Year(s) old	5 kg	5 cm	sample	sample	sample	sample	sample	sample	Generic Medicine: Metformin; Route: Injection into muscle (Intramuscular)

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5	May. 05, 2025	May. 05, 2025	Incorrect prescription (medication order)	female	3 Week(s) old	5 lb	N/A	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Diazepam</td><td>Injection into muscle (Intramuscular)</td></tr><tr><td>Haloperidol</td><td>Injection into muscle (Intramuscular)</td></tr></table>

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6	May. 05, 2025	May. 05, 2025	Incorrect transcription on patient chart / record	male	5 Year(s) old	5 kg	5 cm	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	N/A

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7	May. 02, 2025	May. 02, 2025	Incorrect Dispensing	female	5 Year(s) old	5 kg	5 cm	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Metformin</td><td>Injection into muscle (Intramuscular)</td></tr><tr><td>Haloperidol</td><td>Injection into muscle (Intramuscular)</td></tr></table>

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8	May. 02, 2025	May. 02, 2025	Incorrect Administration - Wrong dose/ dosage	male	8 Day(s) old	3 lb	25 in	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Metformin</td><td>Injection into vein (Intravenous)</td></tr><tr><td>Haloperidol</td><td>Injection into muscle (Intramuscular)</td></tr><tr><td>Ibuprofen</td><td>Oral</td></tr></table>

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9	May. 02, 2025	May. 02, 2025	Incorrect Administration - Wrong dose/ dosage	male	8 Day(s) old	3 lb	25 in	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Haloperidol</td><td>Injection into muscle (Intramuscular)</td></tr></table>

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10	May. 02, 2025	May. 02, 2025	Incorrect Administration - Wrong dose/ dosage	male	8 Day(s) old	3 lb	25 in	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	N/A

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11	May. 02, 2025	May. 02, 2025	Others (Other error type)	male	8 Day(s) old	3 lb	25 in	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	N/A

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12	May. 02, 2025	May. 02, 2025	Incorrect prescription (medication order)	male	7 Week(s) old	8 lb	N/A	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	N/A

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13	May. 02, 2025	May. 02, 2025	Incorrect prescription (medication order)	male	5 Year(s) old	5 kg	5 cm	The doctor prescribed Amoxicillin 500 mg tablets to be taken twice daily for 7 days to treat a bacterial infection.	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.	Before the incident, the workplace was moderately busy, with staff multitasking to handle patient check-ins and medication preparation. During the incident, there was a rush to meet patient schedules, and the storage area was poorly lit and disorganized.After the incident, the staff became aware of the error and immediately stopped further medication administration to other patients, reviewing all prescription records.	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.	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.	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.	N/A

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14	May. 01, 2025	May. 09, 2025	Incorrect transcription on patient chart / record	unknown	71 Year(s) old	80.66 kg	168.17 cm	Auditor aggero vita.	Carmen summopere abduco ustulo tepesco. Considero patior cunctatio utrum carpo aqua conqueror coniecto confido solio. Concedo itaque subiungo cogo torqueo suadeo turbo.	Tersus cupiditate spiritus testimonium animus carus adeptio aro damnatio. Cinis valeo atavus verecundia cognomen subseco.	Repellat adstringo exercitationem aeger claustrum supellex amplexus tollo vinco compono. Vix voluptate tabesco soleo tergo triduana tendo sunt tutamen.	Clibanus ultra via suadeo territo. Perspiciatis vacuus ater xiphias verbum varius cunabula vestrum ullus.	Sulum solutio amaritudo clamo uxor tremo dolore. Commemoro aequitas vulariter crastinus uter acsi territo vulnus tricesimus clementia.	N/A
15	May. 01, 2025	May. 31, 2025	Incorrect Administration - Wrong medication	female	63 Year(s) old	81.77 kg	188.98 cm	Turbo modi abutor spiritus repudiandae acerbitas pectus artificiose.	Spiritus possimus virga varietas canonicus aer confido. Curso suppono adhaero celebrer at magni verbum desipio velit. Decumbo thesaurus coepi.	Vitiosus curriculum conturbo atrox triduana quae. Talio dapifer caste vito advoco repellat cavus commemoro sed.	Ciminatio desolo adduco ventito auctus. Strenuus tres vestrum desparatus callide careo.	Approbo adamo audentia caterva timor. Valens theatrum cedo blanditiis cauda sollers cernuus.	Verus videlicet territo volubilis. Alius terreo quod.	N/A

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16	May. 01, 2025	May. 26, 2025	Incorrect Administration - Wrong dose/ dosage	female	80 Year(s) old	82.41 kg	177.71 cm	Suscipit deporto unde.	Denuncio alioqui quo. Trado cunctatio cado sonitus terror ater socius virtus cotidie. Rerum usque supra iusto aliqua.	Confero sulum tracto dedico delego. Tui ago strenuus considero sordeo verecundia subnecto.	Vapulus video circumvenio vado cervus adnuo. Considero bibo decens curia sollicito vulgus vado.	Adamo tunc comprehendo solutio audio derideo sub quibusdam viriliter tot. Unde stipes stella decimus absconditus eius blandior vulariter ventito.	Corporis vivo sol aiunt eius. Cultellus thesaurus tribuo expedita.	N/A
17	May. 01, 2025	May. 05, 2025	Incorrect transcription on patient chart / record	male	80 Year(s) old	49.49 kg	157.69 cm	Calcar varius subiungo defungo.	Cogito adipisci amaritudo delectus cavus paens votum vulariter. Vesica atque amplexus. Administratio conspergo perferendis solitudo cilicium.	Crapula temeritas sollicito tredecim molestias creber cinis placeat. Infit umerus sed thymum bellum ocer cupiditas arguo tui.	Repellat desparatus abbas vereor ustulo tondeo tracto suffoco addo allatus. Caelum sto volaticus censura.	Aequus decumbo aperte. Amplexus cattus accusamus spiculum cibus subvenio ascisco speculum.	Iusto adfero beatus cubo ducimus damno abbas adsuesco. Aut ait arx blandior conspergo accommodo advoco.	N/A