Integrated National Medication Error Reporting System (INMERS)

Medication Error Summary Report (January 01 - June 30, 2025)

Generated on: May. 09, 2025

#	Report Date	Medication Error Date	Error Type	Patient Sex	Patient Weight	Patient Height	Exact Prescription	Incident Description	Workplace Environment	Immediate Actions	Corrective Actions	Preventive Actions	Medicine Details
1	May. 08, 2025	Apr. 26, 2025	Incorrect Dispensing	female	12.70	N/A	Co-amoxiclav 457mg/5mL, 6mL PO every 12 hours	Patient (12.7kg) was prescribed with Co-amoxiclav 457mg/5mL, 2mL every 8 hours (40mkday). Since this is a 7:1 formulation, POD referred the dose to 40mkday every 12 hours at 1:18 AM of April 26. At 4:47 AM, ROD revised the AOF to 3mL every 12 hours; however, order on pink form was 6mL every 12 hours (40mkdose). POD received the pink form, prescription, and AOF then dispensed 1 bottle of Co-amoxiclav 457mg/5mL suspension. However, POD failed to notice the discrepancy between the doses written on AOF and pink form. AMS POD (morning shift) noticed that PIDS name was not written on AOF (Watch Group of Antibiotic requires PIDS approval). AMS POD went to ward to check if PIDS approved the use of antibiotic.	Moderately busy	Co-amoxiclav was put on hold and later shifted to Amoxicillin 250mg/5mL, 4mL every 8 hours (50mkday).	Drug was put on hold	Double checking with other co-pharmacists	

Generic Medicine	Route
Co-Amoxiclav (amoxicillin + potassium clavulanate)	Oral

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								While reviewing the chart, POD noticed the discrepancy and immediately notified the ROD and NOD since initail was already administered at 9AM of that day. ROD informed PIDS and Gastro service of the incident. PIDS replied that dose ordered was still within the recommended range of 80-90mkday for pneumonia; however, PIDS preferred the use of either Cefuroxime or Amoxicillin for patient's case.					

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2	May. 08, 2025	Apr. 25, 2025	Incorrect Dispensing	male	20.30	N/A	Piperacillin tazobactam 2030 mg IV q 6 h	On April 26, AMS POD noticed that ordered dose of Piperacillin tazobactam was different from Pharmacy's record. Based on physician's order, patient was prescribed with Piperacillin Tazobactam 2030mg IV q 6 h. However on Pharmacy's record, patient was prescribed with 1030mg IV q 6 h. AMS POD checked the medication sheet to ensure that dose transcribed was 2030mg IV q 6 h and not 1030mg IV q 6 h. As the dose prescribed in pink form corresponds to the dose on medication sheet, AMS POD counterchecked whether doses dispensed by Pharmacy was the same to dose ordered by ROD. Unfortunately, the dispensed doses for patient was labelled as Piperacillin tazobactam	Moderately busy	The succeeding doses were corrected starting on 3PM dose. New prescription was also forwarded to Pharmacy.	Drug was revised to appropriate prescribed dose	Double checking with other co-pharmacist	**Generic Medicine**: Piperacillin + Tazobactam (as sodium salt) **Route**: Injection into vein (Intravenous)

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								1030mg instead of 2030mg. POD confiscated the dose intended for 3PM dose. NOD was also informed of the incident. Patient received a total of 3 insufficient doses of Piperacillin Tazobactam on April 25 9PM and April 26 3AM and 9AM. PIDS was also informed of the incident Upon investigating this incident, on April 25 around 2PM, Night POD received the order (Piperacillin Tazobactam 2030mg IV q 6 h) for patient as an outpatient order since patient was not admitted. POD dispensed 4 vials to patient's watcher. At around 2:30 PM, ER NOD called Pharmacy if it was possible for POD to compound the dose even if watcher already bought 4 vials of antibiotic. POD replied that they could compound the antibiotic					

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								and to return the purchased antibiotic to avoid another charge of antibiotic. The POD informed the NOD to send the pink form, AOF, and prescription. Around 2:40 am, the pink form was sent to the pharmacy indicating the dose of 2030 mg IV every 6 hours. The POD on duty made 3 label stickers for the 2030 mg dose and compounded the doses. After 10 minutes, the antibiotic was prepared but wasn't released because AOF and prescription were still not sent to the pharmacy. After follow-up calls, AOF and prescription were finally sent to the pharmacy. POD attached the prescription to the IV card and didn't verify the prescription since POD already verified it when the pink form was sent; however, POD didn't notice the					

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								incorrect dose of antibiotic in the prescription. Around 6:00 am, POD compounded the pending fluids beforeencoding the antibiotics started during their duty. After that the IV AMS arrived at the pharmacy and offered that they could manage to encode the to-start antibiotics since Night POD still had another work to accomplish.					

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3	May. 08, 2025	Apr. 24, 2025	Incorrect Dispensing	female	3.04	N/A	Paracetamol 300mg IV q 4 h for fever	Patient (3 mos old, 2.9kg) was prescribed with Paracetamol 300mg IV q 4 h for fever on April 24. Order was sent to Pharmacy and POD dispensed 5 ampules of Paracetamol. Around 1AM, ROD revised the dose to 37mg IV q 4 h for 24 hours. When NOD carried out the order, they noticed the large difference between ongoing and previous doses. NOD reported the incorrect dose to ROD, who also reported the incident to Consultant and referred the patient to Toxicology. Paracetamol 12.5mkdose every 4 hours RTC for 24 hours was continued while awaiting feedback from toxicology. Patient was noted with increasing trends of serum ALT and serum AST. Fortunately after 3 days, ALT and AST	Moderately busy	Patient's liver function was monitored and Paracetamol was discontinued. Patient was also prescribed with N-acetylcysteine as antidote.	Antidote was given	Double checking with other co-pharmacists	**Generic Medicine** / **Route**: Paracetamol / Injection into vein (Intravenous)

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								were decreasing. This is also a prescribing and administration error.					

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4	May. 08, 2025	Apr. 18, 2025	Incorrect Dispensing	male	21.80	N/A	Ciprofloxacin 500mg tab, 1 tab divided into 5 papers, give 1 paper q 12 h (40mkday)	On April 23, AMS POD noticed that weight used for patient was inconsistent for the two antibiotics prescribed to patient. For Azithromycin PO on April 12, weight used was 21.8 kg while for Ciprofloxacin PO on April 18, weight used was 4.8 kg. Due to the difference in weights, AMS POD asked NOD to reweigh the patient to confirm the correct weight. It was confirmed that the correct weight was 21.8kg. AMS POD asked NOD to refer the Ciprofloxacin dose for recomputation and to inform the ROD that previous doses administered to the patient were below the recommended dosing. Patient was prescribed Ciprofloxacin 500mg tablet, divide 1 tablet into 5 papers (100mg/paper), give 1 paper every 12 hours	Moderately busy	Dose was revised to Ciprofloxacin 500mg tab, divide 7 tablets into 8 papers (437.5mg/paper), give 1 paper every 12 hours (40mkday).	Dose was revised to recommended mkday	Double checking the curret weight used in antibiotics	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Ciprofloxacin</td><td>Oral</td></tr></table>

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								(40mkday) based on 4.8kg on April 18. However, if based on correct weight of 21.8kg, ordered dose was only at 4.5mkdose or 9mkday. A total of 10 doses were given to patient since the evening of April 18 until the morning of April 23. PIDS was also informed regarding the incident. This is also a prescribing and administration error.					

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5	May. 08, 2025	Apr. 05, 2025	Incorrect Dispensing	male	2.40	N/A	Loperamide 2mg/tab, 3mg per paper, give 1 paper every 6 hours	Patient was initially prescribed with Loperamide 1mkDAY using Loperamide 5mg/5mL syrup for high output ileostomy. However, this preparation is not available in Philippine market so prescription was revised to papertabs. Unfortunately, dose prescribed was at 1mkDOSE (2.5mg/paper, 1 paper every 6 hours). POD also referred to round off the order to 3mg/paper. Revision was received by Night POD who also referred the dose, however, ROD insisted that dosing was based on ileostomy guidelines. POD did not ask for a copy of the reference and prepared the doses as prescribed. Loperamide was started at 3AM on April 6 and 10 doses were administered as of	Moderately busy	Loperamide was temporarily put on hold and revised to 0.5mkday every 8 hours on April 9. In addition, NOD was advised to monitor patient for delayed reaction and to immediately notify doctors if any reaction occurs.	Dose was revised to recommended mkday	Double checking with other co-pharmacists	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Loperamide (as hydrochloride)</td><td>Oral</td></tr></table>

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								discovery of error. Ostomy output decreased with no noticeable difference in consistency. Doctors and NODs were immediately informed and POD searched for ileostomy guidelines. Recommended is at 0.4-0.8mkday (maximum 8mg per day). Incident was only discovered upon informing ROD of another incident involving another patient. ROD replied that dose prescribed for another patient was based on order for this patient. This is also a prescribing and administration error.					

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6	May. 08, 2025	Apr. 06, 2025	Near-miss	female	15.50	N/A	Pyrazinamide 250mg/5mL, 9.5mL orally once a day (30mkday)	On April 6 at 12:36PM, Pharmacy received order and AOF to start Ceftriaxone, Clindamycin, and anti-TB meds (Isoniazid 200mg/5mL, Rifampicin 200mg/5mL, Ethambutol 300mg tablet, Pyrazinamide 250mg/5mL). Ward was advised to register patient to TB-DOTS upon the following day (Monday) and to reorder Ethambutol to 400mg tablet. AOF was returned to ward for correction of stock dose and order. Around 2PM, Pharmacy received the corrected AOF, however, no pink form was forwarded. POD called the ward to ask for the pink form and NOD insisted that resident wanted the anti-TB meds to be immediately started. POD prepared the KidzKit III Forte (Isoniazid 200mg/5mL, Rifampicin 200mg/5mL,	Moderately busy	NOD immediately notified the resident to revise the order. NOD notified Pharmacy about incident at 10:30AM.	The drug has been revised to the stock dose available at the pharmacy	Counter checking with other co-pharmacist	N/A

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								Pyrazinamide 500mg/5mL) and was not able to check the previously sent pink form. Order for revised order of Ethambutol was forwarded at 8PM. On April 7, anti-TB meds were started. At 9AM while preparing doses, NOD noticed that Pyrazinamide stock was 500mg/5mL. Order on chart was 250mg/5mL.					

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7	May. 08, 2025	Apr. 02, 2025	Incorrect Dispensing	female	70.00	N/A	Piperacillin tazobactam 4.5g IV q 6 h	At around 3PM of April 3, PM POD was asked about the 3PM dose of Piperacillin Tazobactam of the patioent. Upon checking the profile, patient was prescribed Piperacillin Tazobactam 4.5g IV q 6 h. Recommended dosing is 4g per dose only (Piperacillin-based). Upon asking how the antibiotic was administered, NOD relayed that they diluted 1 vial of Piperacillin Tazobactam equivalent to 4 grams and another vial to get the equivalent of 500mg. Available stock dose is Piperacillin Tazobactam 4g/500mg vial. Dosing must be based on Piperacillin content only. 4.5g of Piperacillin Tazobactam was given to the patient on 9PM of April 2, 3AM and 9AM of April 3. This is also a prescribing and administration error.	Moderately busy	POD relayed that only 1 vial will be given for the 3PM dose and a revised order was needed for the succeeding doses.	The dose was revised to maximum recommended dosage	Double checking with other co-pharmacist	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Piperacillin + Tazobactam (as sodium salt)</td><td>Injection into vein (Intravenous)</td></tr></table>

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8	May. 08, 2025	Apr. 01, 2025	Incorrect Dispensing	female	3.70	N/A	Hydrocortisone 36mg IV q 6 h (10mkday)	Upon ward rounds on April 2 at around 4PM, Clinical POD noted that there was a revision order of Hydrocortisone last April 1 at 9 PM. Upon checking the previous orders, POD noticed that admitting order to PICU was Hydrocortisone 63mg IV q 6 h (10mkday). Patient weighed 2.5kg and upon recomputation, ordered dose was at 25mkdose. Patient was given 63mg per dose for 3 doses (3AM, 9AM, 3PM). Dose should be 6.3mg IV q 6 h (10mkday, 2.5kg) only. This is also a prescribing and administration error. Upon monitoring, patient had no hyperglycemic or hypertensive episodes.	Moderately busy	Since drug was a corticosteriod, Hydrocortisone can't be discontinued abruptly. Continuous monitoring was ordered for patient due to possible ADR.	Incident was referred to FOD and Consultant.	Double checking with other co-pharmacists	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Hydrocortisone</td><td>Injection into vein (Intravenous)</td></tr></table>

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9	May. 07, 2025	Mar. 28, 2025	Incorrect Dispensing	male	1.00	N/A	Gentamicin 5mg IV q 48 h	On March 25, patient was prescribed with Gentamicin 5mg IV q 48 h. First dose was given at 2PM of March 25 then second dose on March 27 12NN. However on March 27, POD dispensed 1 ampule upon ward rounds when next dose should be on March 29. NOD failed to check the schedule so 1 dose was administered on 12NN of March 28. Another dose was also given on March 29. Incident was discovered by Clinical POD and reported to the Head Nurse, ROD, and FOD.	Heavy workload and time pressure	Patient was monitored for adverse reactions.	Double checking correct due dates	Double checking with the NOD the correct due date of medicines	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Gentamicin (as sulfate)</td><td>Injection into vein (Intravenous)</td></tr></table>

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10	May. 07, 2025	Mar. 21, 2025	Incorrect Dispensing	male	28.20	N/A	Aqueous Penicillin G 4 000 000 units IV q 6 h	On March 20, patient was prescribed Aqueous Penicillin G 2 820 000 units IV q 6 h (28.2kg; 100 000 units/kg/dose), however, no AOF was forwarded to pharmacy. Around 12:30 AM of March 21, ROD revised the dose to Penicillin G (Aqueous) 6 000 000 units IV q 6 h with side noted of 'max dose: 24 000 000 units/24hours'. POD referred that maximum units per dose was 4 million units only, hence, ROD revised the order to 4 million units IV q 6 h. First dose was dispensed at 2:40 AM. At around 8AM, AMS POD noticed the discrepancy and referred the dose to ROD. Two doses (3AM and 9AM) were already administered to patient. POD failed to check the desired dose based on patient's weight.	Busy with non stop in-coming doctor's orders	Dose was revised back to 100 000 units/kg/dose equivalent to 2 820 000 units IV q 6 h. Senior ROD also made a verbal order that 3PM dose must not be given.	Dose was revised to desired dose based on patients weight	Double checking with other co-pharmacists	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Penicillin G Crystalline (benyzylpenicillin) (as sodium salt)</td><td>Injection into vein (Intravenous)</td></tr></table>

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11	May. 07, 2025	Mar. 18, 2025	Incorrect Dispensing	female	2.79	N/A	Furosemide 7.8mL + D5W 12.2mL to make 20mL IV at 0.2mL/hour (BW: 3.1kg; 2mkday)	On March 18, patient was prescribed Furosemide IV drip 7.8mL + D5W 12.2mL to make total volume of 20mL at a rate of 0.2mL/hour. Desired dose for patient was 2mkday (Birth weight: 3.1kg). However, dose prescribed was at 6mkday which was 3 times more than desired dose. This is also a prescribing and administration error.	Moderately busy	Discrepancy was noticed by Clinical POD and referral was made. Dose was revised to Furosemide IV drip 2.5mL + 17.5mL D5W to make 20mL at a rate of 0.2mL/hr (2mkday).	Drug was revised with the correct prescribed dose	Double checking with other co-pharmacists	**Generic Medicine** / **Route** Furosemide / Injection into vein (Intravenous)

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12	May. 07, 2025	Mar. 17, 2025	Near-miss	female	28.00	N/A	Lactulose 3.3g/5mL, 10mL PO BID	On March 17 at around 9AM, POD received a request for Lactulose of patient. POD checked the patient's profile to check if patient already had an order of Lactulose. Afterwards, POD dispensed the medicine to the NA. At around 9:30 AM, POD received a phone call from NOD informing that they received Aluminum Magnesium hydroxide suspension instead of Lactulose suspension. POD realized that she must have switched the medication from an order from another ward.	The unit was busy with in coming doctor's orders	Drug was returned and replaced by POD.	Drug was replaced with the correct prescribed medication by the POD.	Double checking with other co-pharmacists	N/A

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13	May. 07, 2025	Mar. 17, 2025	Incorrect Dispensing	female	14.00	N/A	Cotrimoxazole 480mg/5mL, 1.3mL PO every 8 hours (4 mkday)	On March 17 at 9:45AM, Inpatient POD received an order of Cotrimoxazole 400mg/80mg/5mL, give 1.3mL PO q 6 h for UTI (20mkday). POD called NOD to verify the weight of patient to check if the order was correct. NOD confirmed that patient's weight is 15.7kg. POD checked the order in which the POD confirmed that dose was at 4mkday only. POD referred the dose to 8-12mkday q 12 h based on Lexicomp. Around 10:30AM, POD received the revised AOF and order of the medication. POD inquired with the ward if FOD was still at the ward to confirm if dose was revised to 1.3mL PO q 8 h which was previously q 6 h. After confirming the dose, POD dispensed the medication. Only 1 dose of 1.3mL was	Moderately busy	AMS POD referred the dosing to PIDS to base the computation on TMP component. AMS POD also referred the dose to Neuro FOD. Dose was revised to Cotrimoxazole 400mg/80mg/5mL, give 6.5mL PO q 8 h.	Dosing for Cotrimoxazole was computed based on Trimethoprim (TMP) component	Double checking with other co-pharmacist	**Generic Medicine** / **Route**: Cotrimoxazole (sulfamethoxazole + trimethoprim) / Oral

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								administered to the patient. Around 2PM, AMS POD noticed the discrepancy in the Cotrimoxazole order. Dosing for Cotrimoxazole should be computed based on Trimethoprim (TMP) component; however, dose was based on Sulfamethoxazole (SMX) component. Inpatient POD also failed to notice that intended dosing of FOD for patient is 20mkday divided q 6 - 8 h.					

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14	May. 07, 2025	Mar. 12, 2025	Incorrect Dispensing	female	10.00	N/A	Levetiracetam 200mg IV as loading dose then Levetiracetam 100mg IV + 10mL sterile water every 12 hours	On March 12, POD received an order of Levetiracetam 200mg IV as loading dose then Levetiracetam 100mg IV + 10mL sterile water every 12 hours. POD dispensed 1 vial of Levetiracetam IV; however POD failed to ask another POD to countercheck the order of the medication. On March 13, the POD assigned on checking all the medicines to be delivered noticed that the diluent used for Levetiracetam IV was sterile water for injection. Recommended diluents according to package insert are: NSS, Lactated Ringer's Solution, and Dextrose 5% Water only. Unfortunately, the vial at the ward was already administered to the patient. This is also a prescribing, administration and	The unit was busy	Order was revised by ROD and patient was observed for any adverse reactions.	Double checking appropriate diluents in references	Double checking with other co-pharmacists	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Levetiracetam</td><td>Injection into vein (Intravenous)</td></tr></table>

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								medication preparation error.					

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15	May. 07, 2025	Feb. 28, 2025	Near-miss	male	0.47	N/A	TPN total volume of 40mL	On February 28 at around 8:30PM, NOD reported thru Viber about the insufficient volume of TPN of patient. Based on the photos forwarded, it was seen that only approximately 34mL of TPN was aspirated contrary to the desired 40mL total volume of TPN. POD informed the TPN POD about the incident.	Moderately busy	TPN POD compounded another TPN for the patient. TPN POD asked another POD to countercheck the newly prepared TPN and it was observed to be approximately 34mL only. However, there was still some fluid left on the bottle and TPN POD was asked to aspirate the remaining fluid. After aspirating all the contents of the bottle, the resulting volume increased to approximately 40mL. The newly prepared TPN was dispensed to ward as replacement from previously compounded and dispensed TPN.	Aspirating all the contents of the bottle	Double checking prepared medication	N/A

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16	May. 07, 2025	Feb. 24, 2025	Near-miss	female	59.00	N/A	Ipratropium + Salbutamol	On February 23, a patient was prescribed Nicardipine and Ipratropium + Salbutamol. However, Budesonide neb was dispensed instead of Ipratropium + Salbutamol. Incident was discovered the next day since the medicines will be shipped to the province.	The unit was moderately busy	Correct drug was dispensed and delivered by the POD.	Correct drug was replaced	Double checking with other co-pharmacists	N/A

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17	May. 07, 2025	Feb. 15, 2025	Incorrect Dispensing	male	8.60	N/A	Potassium 8mEqs + equal amount diluent to run for 1 hour	On February 15 at 6:20AM, ROD ordered Potassium chloride 8mEqs + equal amount of diluent to run for 1 hour to correct the patient's serum potassium to normal levels. Order was carried out by NOD at 7AM. Central line concentration for potassium chloride infusion has a maximum rate of 1mEq/kg/hour which is appropriate for the patient while the maximum concentration should be 150-200mEqs/L, with some case reports up to 400mEqs/L. The final concentration of prescribed medication ordered by ROD is 1mEq/mL or 1000mEqs/L.	The unit was moderately busy	Clinical POD noticed the discrepancy and referred the dose for revision.	The dose was revised with the appropriate concentration intended	Double checking with other co-pharmacists	**Generic Medicine** / **Route**: Potassium Chloride / Injection into vein (Intravenous)

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18	May. 07, 2025	Feb. 04, 2025	Incorrect Dispensing	female	2.70	N/A	Cotrimoxazole 480mg/5mL, 0.2mL PO every 8 hours (5 mkdose)	On February 7, Clinical POD checked the revision orders of patient's medication due to change in weight of patient. Patient's weight was changed from 1.97 kg to 2.4kg. On the Cotrimoxazole order, ROD computed the dose based on both sulfamethoxazole (400mg) and trimethoprim (80mg) instead of trimethoprim (80mg) only as stated by dose guidelines. Revised dose was Cotrimoxazole 480mg/5mL, 0.8mL every 8 hours. Upon reviewing the previous doses given, Clinical POD noticed that patient was given Cotrimoxazole 480mg/5mL, 0.2mL every 8 hours (5mkday) since February 4. However, on February 4, doctor's notes stated that dose must be computed as 5mkdose every 8 hours due to	The unit was moderately busy	Incorrect doses for the previous days were referred to PICU resident and fellow as well as PIDS fellow.	Dose was revised with correct mkdose desired	Double checking with other co-pharmacists	<table><tr><th>Generic Medicine</th><th>Route</th></tr><tr><td>Cotrimoxazole (sulfamethoxazole + trimethoprim)</td><td>Oral</td></tr></table>

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								decreased renal function. Cotrimoxazole was prescribed to be given for 14 days which was until February 7 at 9AM. Cotrimoxazole was extended for 3-4 more days. This is also a prescribing and administration error.					

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19	May. 07, 2025	Feb. 05, 2025	Near-miss	female	36.00	N/A	Budesonie + Formoterol 160mcg/4.5mcg MDI Rapihaler, 1 puff BID	Patient was ordered with Budesonide + Formoterol 160mcg/4.5mcg MDI, 1 puff bid around 6:45 AM of February 5. The pharmacist on-duty asked to reorder the pink form since the doctor did not indicate the dosage form/preparation, if rapihaler or turbuhaler form. At 10:45 AM, the revised pink form was forwarded to Pharmacy. The pharmacist on-duty mistakenly dispensed Budesonide+Formoterol MDI Rapihaler 80mcg/4.5mcg. The patient was discharged at 11:20AM of February 6. The error was discovered around 5:00 PM of the same day when pharmacy made an inventory of the stocks. Pharmacy immediately contacted the guardian and informed her of the wrong dispensing.	The unit was moderately busy	Pharmacy replaced the drug with the correct dosage strength.	Pharmacist replaced the drug with the correct prescribed medication	Double checking with other co-pharmacist	N/A

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20	May. 07, 2025	Jan. 27, 2025	Incorrect Preparation - Compounding errors	male	48.80	N/A	Colistin 2 440 000 IU IV q 8 h	Patient had standing order of Colistin 2 440 000 IU IV every 8 hours which was started on January 23 at 10PM. Each dose must be labeled as Colistin 40 000 IU/mL, 2 440 000 IU (1 vial + 11mL) based on the available stock of 2M IU Colistin. The file used in preparing the sticker labels had a discrepancy so the formulated label stated 2 400 000 IU (2 vials + 11mL) which was based on the previous available stock of 1M Colistin. However, from January 24 until January 27 (2PM), the PODs were able to manually correct the labels. Unfortunately, on January 27, the PODs failed to correct the label for the 10PM dose of January 27 and 6AM dose of January 28. Incident was discovered on January 28 by NOD. This is also a	The unit was moderately busy	2PM dose was put on hold by PIDS.	The file used for formulating the labels was corrected	Counter checking between pharmacists	**Generic Medicine** / **Route** Colistin / Injection into vein (Intravenous)

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								dispensing and administration error.					
21	May. 07, 2025	Jan. 22, 2025	Near-miss	male	25.00	N/A	Cetirizine 5mg/5ml syrup, give 5mL BID	Around 11:50AM, mother of patient Lawrence Labrinto called Pharmacy to inform that the drops form of Cetirizine (2.5mg/mL) was dispensed to her instead of the syrup form (5mg/5mL). She sent thru viber pictures of both the prescription and the Cetirizine 2.5mg/mL drops that was issued to her.	long waiting line at outpatient service	Watcher said she will go back to Pharmacy to have the medicine replaced.	Medicine was replaced with the correct medicine based on prescription.	Double-checking with another pharmacist.	N/A