Integrated National Medication Error Reporting System (INMERS)

Medication Error Summary Report (May 01 - May 06, 2025)

Generated on: May. 06, 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. 06, 2025	May. 06, 2025	Incorrect prescription (medication order)	male	5.00	5	sample	sample	sample	sample	sample	sample	Generic Medicine: Metformin; Route: Injection into muscle (Intramuscular)

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2	May. 05, 2025	May. 05, 2025	Incorrect prescription (medication order)	female	5.00	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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3	May. 05, 2025	May. 05, 2025	Incorrect transcription on patient chart / record	male	5.00	5	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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4	May. 02, 2025	May. 02, 2025	Incorrect Dispensing	female	5.00	5	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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5	May. 02, 2025	May. 02, 2025	Incorrect Administration - Wrong dose/ dosage	male	3.00	25	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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6	May. 02, 2025	May. 02, 2025	Incorrect Administration - Wrong dose/ dosage	male	3.00	25	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.	**Generic Medicine** / **Route**: Haloperidol / Injection into muscle (Intramuscular)

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7	May. 02, 2025	May. 02, 2025	Incorrect Administration - Wrong dose/ dosage	male	3.00	25	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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8	May. 02, 2025	May. 02, 2025	Others (Other error type)	male	3.00	25	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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9	May. 02, 2025	May. 02, 2025	Incorrect prescription (medication order)	male	8.00	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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10	May. 02, 2025	May. 02, 2025	Incorrect prescription (medication order)	male	5.00	5	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. 01, 2025	May. 05, 2025	Incorrect transcription on patient chart / record	male	49.49	157.69	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