Meitra Hospital

INCIDENT MANAGEMENT REPORT

SHOWING DATA FROM 2025-08-27 TO 2025-09-26

INC- 8

Incident Details	**Incident Short Name:** Food & Beverages **Incident:** Food & Beverages related issues **Incident Description:** A concern was raised regarding food and beverage services, where the quality, handling, or delivery of meals did not meet hospital standards. This created dissatisfaction and potential risk to patient comfort and care experience. **What went wrong:** tandard protocols for food preparation, storage, or service were not consistently followed. Gaps in communication between the dietary team and service staff contributed to the issue, leading to errors in quality or timeliness of delivery. **Immediate action taken:** The affected meals were immediately corrected/replaced, and the patient(s) were assured. The dietary and service staff were counseled to follow prescribed standards and cross-check processes before meal delivery. The Food & Beverages team reviewed the workflow to identify gaps.
Incident Reported By	TEST EFEEDOR (9009) 9159612117
Incident Occured On	18 Sep, 2025 - 4:34 PM
Incident Reported On	26 Sep, 2025 - 3:37 PM
Incident Reported In	**Floor/ Ward:** 2208 B- Main Building - 3rd Floor **Site:** HO Day care
Assigned Risk	**Medium** (Medium Impact × Medium Likelihood)
Assigned Priority	P2-High
Assigned Category	Unassigned

Patient Details	JNEETH (66666)
Assigned Team Leader	Megha
Assigned Process Monitor	Pintu
Closed On	4:16 pm, 26-09-25
Turn Around Time	39 mins.
Incident Timeline & History	**Assigned** **Date & Time:** 26 Sep, 2025 - 3:45 PM **Action :** Incident Assigned to Megha (Nursing head) (Team Leader) **Process Monitor :** Pintu (Nursing staff) **Assigned by :** Vignesh **Comment:** Assgined for testing **Investigator comment** **Date & Time:** 26 Sep, 2025 - 3:50 PM **Action :** Commented by Pintu () **Notes :** The incident reflects a deviation from established food and beverage service protocols, resulting in compromised quality and patient dissatisfaction. The issue appears to stem from inadequate adherence to preparation, storage, and delivery standards, along with gaps in communication between dietary and service staff. While immediate corrective steps were taken, this highlights the need for stricter monitoring, regular staff training, and systematic checks to ensure compliance with dietary service standards. Ongoing audits and feedback mechanisms will be essential to prevent recurrence. **Described** **Date & Time:** 26 Sep, 2025 - 3:58 PM **Action :** Incident Explained by Megha () **Root Cause Analysis (RCA)** **Tool Applied :** 5WHY • **WHY 1:** Because the meals delivered did not meet hospital standards/prescribed requirements. • **WHY 2:** Because dietary service staff did not properly cross-check meal orders with prescribed standards.

- **WHY 3:** Because there was a communication gap between the dietary team and the food service staff.
- **WHY 4:** Because there was no standardized verification process or monitoring system in place.
- **WHY 5:** Because existing oversight practices were insufficient, and accountability for food quality/service was not strictly enforced.

Corrective Action : Because dietary service staff did not properly cross-check meal orders with prescribed standards.
Preventive Action : Because there was a communication gap between the dietary team and the food service staff.
Lesson Learned : Because the meals delivered did not meet hospital standards/prescribed requirements.

Re-assigned

Date & Time: 26 Sep, 2025 - 4:03 PM
Action : Incident Re-assigned to Suhail (Nursing staff)
Process Monitor :
Re-assigned by : Vignesh
Comment: Reassigned for testing

Described

Date & Time: 26 Sep, 2025 - 4:14 PM
Action : Incident Explained by Suhail ()
Root Cause Analysis (RCA)
Tool Applied : 5W2H

What happened?

Meals provided to patients did not meet the prescribed dietary requirements/standards.

Why did it happen?

Communication gaps and lack of cross-verification between the dietary team and service staff, leading to delivery errors.

Where did it happen?

In the hospital food & beverage service workflow (kitchen, dietary planning, and meal delivery areas).

When did it happen?

During routine patient meal service.

Who was involved?

Dietary service staff, food preparation team, and service/delivery staff.

How did it happen?

Failure to follow standard meal verification protocols, inadequate monitoring, and over-reliance on verbal instructions.

How much/How many (impact/cost)?

Patient dissatisfaction and potential compromise of patient care experience, with risk to dietary compliance in clinical cases.

Corrective Action : Failure in communication and lack of a robust verification/monitoring process within the food & beverages service workflow, leading to delivery of meals that did not align with prescribed requirements.

Preventive Action : Because dietary service staff did not properly cross-check meal orders with prescribed standards.

Lesson Learned : Because the meals delivered did not meet hospital standards/prescribed requirements.

Closed

Date & Time: 26 Sep, 2025 - 4:16 PM

Action : Incident Closed by Vignesh ()

Closure Verification Remark : Verification has confirmed that corrective and preventive actions have been implemented. Communication between the dietary and service staff has been standardized, mandatory cross-checks of meal orders against prescribed diets are being followed, and periodic audits show compliance. No further deviations have been observed. The incident is considered closed with continuous monitoring in place.

INC- 1

Incident Details	**Incident Short Name:** Medication Errors **Incident:** Dispensing error **Incident Description:** test **What went wrong:** **Immediate action taken:**

Incident Reported By	TEST (123) 6767676767
Incident Occured On	18 Sep, 2025 - 8:33 PM
Incident Reported On	25 Sep, 2025 - 8:33 PM
Incident Reported In	**Floor/ Ward:** Others **Site:** Others
Assigned Risk	**High** (High Impact × Medium Likelihood)
Assigned Priority	P2-High
Assigned Category	Adverse
Patient Details	
Assigned Team Leader	Fathima
Assigned Process Monitor	Bhavyasree
Closed On	10:21 pm, 25-09-25
Turn Around Time	1 hrs, 48 mins.
Incident Timeline & History	**Assigned** **Date & Time:** 25 Sep, 2025 - 10:12 PM **Action :** Incident Assigned to Fathima (Nursing In-charge) (Team Leader) **Process Monitor :** Bhavyasree (Nursing Superintendent) **Assigned by :** Kamal Thiyagarajan **Comment:** test **Described** **Date & Time:** 25 Sep, 2025 - 10:15 PM **Action :** Incident Explained by Kamal Thiyagarajan () **Root Cause Analysis (RCA)** **Tool Applied :** 5WHY • **WHY 1:** the Incident in detail with

- **WHY 2:** v the Incident in detail with
- **WHY 3:** the Incident in detail with
- **WHY 4:** the Incident in detail with
- **WHY 5:** the Incident in detail with

Corrective Action : Corrective Actions, Preventive
Preventive Action : Corrective Actions, Preventive
Lesson Learned : Corrective Actions, Preventive

Closed

Date & Time: 25 Sep, 2025 - 10:21 PM
Action : Incident Closed by Kamal Thiyagarajan ()
Closure Verification Remark : test remark