

Incident Report Writing in Hospital

Header Information

Date: February 12, 2025

Time: 3:15 PM

Location: Emergency Department, City General Hospital

Reported by: Lisa Thompson, RN, Emergency Department

Description of the Incident

At approximately 3:00 PM, a medication error occurred in the Emergency Department of City General Hospital. The incident involved the accidental administration of a higher dosage of Morphine to patient Jane Doe, who was admitted for severe abdominal pain. The prescribed dosage was 2 mg IV, but the patient received 5 mg IV due to a miscommunication between the nursing staff during a shift change.

Parties Involved

- **Jane Doe:** Patient, recipient of the incorrect medication dosage.
- **Nancy Clark:** RN, administered the medication.
- **Robert Wells:** RN, responsible for overseeing the medication handover.
- **Dr. Emily Stanton:** Attending Physician, prescribed the correct dosage.

Actions Taken

Upon realization of the error, the following steps were immediately taken:

- The patient was monitored closely for any adverse effects from the overdose.
- Vital signs were checked every 5 minutes, and oxygen saturation was continuously monitored.

- Dr. Emily Stanton was notified, and additional medication to counteract the effects of Morphine was administered.
- A detailed review of the patient's medical chart and medication administration record was conducted to understand the error's origin.
- The patient and her family were informed about the incident, and apologies were extended.

Recommendations for Future Prevention

1. **Enhanced Communication Protocols:** Implement standardized communication protocols during shift changes, specifically regarding patient care and medication details.
2. **Regular Training on Medication Safety:** Mandatory training sessions for all medical staff on safe medication administration practices and error prevention.
3. **Double-Checking Mechanism:** Introduce a mandatory double-check system for all medication dosages administered in critical care areas.
4. **Use of Medication Administration Technology:** Increase the use of barcode scanning for medication administration to ensure the correct patient, drug, dosage, and time.
5. **Audit and Feedback:** Regular audits of medication administration practices and feedback sessions with staff to reinforce adherence to safety protocols.

Attachments

- **Patient Monitoring Records:** Documenting the patient's vital signs and condition post-incident.
- **Staff Statements:** Written accounts from Nancy Clark and Robert Wells detailing their roles and perspectives on how the incident occurred.
- **Medication Administration Record Review:** Analysis of the medication administration process and identification of the failure point.

- **Incident Review Meeting Minutes:** Notes from the meeting held with the hospital safety committee to discuss the incident and preventive measures.