Assignment

CASE STUDY

Preventing Medication Errors

During your busy clinical day as a student nurse, the staff nurse assigned to your patient comes to you and says, "Would you like to give this injection? We have a 'now' order for Sandostatin (octreotide) 200 mcg subcutaneously. I've already drawn it up; 200 mcg equals 2 mL. It needs to be given as soon as possible, so I drew it up to save time." She hands you a syringe that has 2 mL of a clear fluid in it and the patient's medication administration record (MAR).

1. **Should you give this medication "now," as ordered? Why or why not?**

   You decide to check the order that is handwritten on the MAR with the order written on the chart. The physician wrote, "Octreotide, 200 mcg now, subcutaneously, then 100 mcg every 8 hours as needed." Before you have a chance to find your instructor, the nurse returns and says, "Your instructor probably won't let you give the injection unless you can show the medication ampules. Here are the ampules I used to draw up the octreotide. Be quick—your patient needs it now!" You take the order, the MAR, the two ampules, and the syringe to your instructor. Together you read the order and then check the ampules. Each ampule is marked "Sandostatin (octreotide) 500 mcg/mL."

1. **If the nurse drew up 2 mL from these two ampules, how much octreotide is in the syringe? How does this amount compare with the amount on the order?** The nurse is astonished when you point out that the ampules read "500 mcg/ mL." She goes into the automated medication dispenser and sees two identical boxes of Sandostatin next to each other in the refrigerated section. One box is labeled "100 mcg/mL," and the other box is labeled "500 mcg/mL." She then realizes that she chose ampules of the wrong strength of drug and drew up an incorrect dose.
2. **What would have happened if you had given the injection?**
3. **What needs to be done at this point? What contributed to this potential medication error, and how can it be prevented in the future?**