1. I do not think there was an error within the process that contributed to making this incident. I think we were all so focused on the patient being dehydrated, and making sure that he had his medications that we were working too fast and got ahead of ourselves. Regarding the normal saline, when I looked at the MAR, I misread the order and did not see that it was a flush, so I hung the bag of fluids without an order. With the Acetaminophen, I underdosed the patient because even though I calculated the correct dose of 7mL, I only gave one of the syringes which contained 2mL, and forgot to give the other syringe containing 5mL. Finally, when giving the Ondansetron, the patient was overdosed because I did my medication math incorrectly. Rather than giving the correct dose of 2.3mL, I forgot to divide the 4.5mg by 2mg which would have got the correct dose of 2.3mL. Instead of this I gave 9mg, which is equal to 4.5mL.
2. The medication that was given without an order was the infusion of normal saline at 71mL/hour. It would have been important to monitor the patient for potential complications such as fluid overload leading to edema and HTN, electrolyte imbalances specifically regarding potassium which could cause potential cardiac issues. Another complication this could have caused is kidney strain because the kidneys would have had to work harder to get rid of that excess fluid that was going into the body.
3. I think the biggest thing that I am going to do to prevent this event from happening in the future is double check all of the orders and medications I am giving, as well as my math that I do. I am glad that I made these mistakes during simulation and not on a real patient where I have the opportunity to reflect on my mistakes and correct them so they do not happen again. I also want to make sure I slow down and read everything before administering the medication because I understand that someone's life could be on the line.
4. **S** – The patient was given a fluid infusion of normal saline at a rate of 71mL/hour that was not ordered, as well as underdosed on Acetaminophen which should have been 7mL, but only 2mL were given, and finally, the patient was overdosed on the Ondansetron that was ordered because 4.5mL was given rather than the correct dose of 2.3mL.
   B – An 8-year-old patient came in to the ER with his mom because he had been vomiting quite a bit and had not been able to keep anything down.
   A - During the initial assessment the patient was complaining of abdominal pain of a 4 on the FACE scale, and his temperature was 102.5 degrees. His urine was a dark yellow, and he had pink and moist mucous membranes. Pt had not vomited since coming to the hospital. He did not show any signs and symptoms of complications from the incorrect doses of meds given as well as the unordered fluids.
   R – Continue to monitor the patient for signs of complications regarding the unordered fluids given, underdosing of Acetaminophen, and overdosing of Ondansetron, such as fluid overload, edema, headaches, and dizziness. Educate mom about these signs and symptoms as well, and continue POC to help with his vomiting and diarrhea.