

# FRMCSN SIM Med Errors Reflection Questions

By Melisa Fahey

Provide in-depth, thorough answers to the following questions by 11/14/2025 at 0800.

1. The error in the process that could have contributed to this incident of giving too low of the dose of acetaminophen (130 mg) rectally is because we were all so worried about if the dose was too high, I personally thought if it was lower that's good. Another thing that we all believe may have played a part is that the Vitals went more towards normal, so we thought, "Oh good, we must've done the correct dose." The temperature went down; the child's pain level went down. So not one of us thought anything of it. I believe we were all overcalculating multiple times because we did not want to do this remediation again. But again, definitely a learning experience hoping to never repeat!
2. The potential complications that could've occurred are the child's fever not going down (which it did) and he could have potentially had a seizure. The patient's pain level would have continued to go up (which is never good for a patient).
3. The follow-up care that I would have been provided to the patient related the medication error would have been monitoring the patient's vital signs, administering an additional dose of acetaminophen that would have equaled the accurate dose that we were supposed to have administered at the original time we dosed the patient, assessed the patient's pain level to see if it had come down to relieve the patient of his pain or gone up because of too low of a dose.
4. How I would prevent this event from happening again is to understand that not giving enough medication is just as bad as giving too much medication. I would clarify the dose with another nurse, letting that nurse recheck my figuring to ensure proper dosing and relief for the patient.
5. **S - Situation**  
8-year-old male, 30 kg, admitted to PICU for fever and vomiting. He

received 130 mg acetaminophen rectally, which is below the recommended dose for his weight.

### **B - Background**

Presented with persistent fever and vomiting. Standard acetaminophen dosing for his weight is 10–15 mg/kg (300–450 mg per dose). The lower dose was given out of concern for overdosing. After administration, his temperature and pain level decreased, and vital signs normalized, so the dosing error was not immediately recognized.

### **A - Assessment**

Fever and pain improved, but the dose was subtherapeutic.

Risks: persistent fever, inadequate pain control, and potential for seizure if fever persists.

No immediate adverse effects noted, but he remains at risk for complications due to insufficient antipyretic and analgesic coverage.

### **R - Recommendation**

Continue to monitor vital signs and pain level closely.

Administer an additional dose of acetaminophen to reach the correct total dose (300–450 mg rectally), per provider order.

Double-check all medication calculations with another nurse before administration.

Remind staff that underdosing can be as harmful as overdosing; clarify dosing if uncertain.