Study Product Administration Activity

Scenario 2: Incorrect Dose

A new research nurse, Gift, retrieves study drug from the pharmacy, and checks the label, which is labeled correctly. The nurse administers the study drug to the study subject (PID 845102). As the nurse connects the IV, the nurse notices that the IV is filled with 250 ml instead of 300 ml. It is too late; the administration of the study drug has already begun.

The nurse is new and fearful to contact the pharmacist about discrepancies that have been noticed during routine drug check prior to dosing the participant: Drug label includes – Time, Drug, PID and is missing the Total Volume, Dosage, and Expiration Time. The PI is well respected and very busy and does not like to be bothered by details of the day. The nurse is scared to report the error to the PI or the pharmacy.

The next day another participant comes to the clinic for the same study. When the nurse retrieves the study drug from the pharmacy, again it is a 250 ml volume instead of a 300 ml volume. The nurse suspects the pharmacy may be preparing the wrong dose on multiple occasions. The nurse wonders how many other nurses have administered the incorrect dose of study product. The nurse decides to ask a fellow nurse if they have noticed an incorrect doses amount being given from the pharmacy.

Questions to Ponder

Scenario 2: Incorrect Dose

What should you do if you notice an error?

Who should you communicate to about the error?

How should you report the error?

What can be done at your site to encourage a culture of quick and honest error reporting?