SECTION 1 — STUDENT ACTIVITY

ACTIVITY 5: MEDICATION SAFETY

Vancomycin Troughs, Acetaminophen Totals, and the Orders Nobody Wrote

SCENARIO FRAMING

It's the morning of your second day precepting with Mary. M.C. (Mike Crabby) has been on the unit overnight, and a lot has happened since you left yesterday: a Vancomycin dose got held, a trough has been pending for hours, and the night shift handed off to Mary at 0700 with that result still outstanding.

Mary wants to walk through the medication record with you before the next pass — not because anything is necessarily wrong, but because this is exactly the kind of thread a nurse has to track across a shift change. “A hold isn't a decision you make once and forget,” she says. “It's a decision you keep making until the dose is either given or cancelled. Let's see where this one actually stands.”

You'll be using the Notes, Medications, Orders, and I&O panels for this activity — the story is scattered across all four, which is the point. Nothing here is going to be flagged or highlighted for you. If something looks off, that's because you noticed it, not because the chart told you to.

Estimated time: 25–40 minutes.

PART 1: THE VANCOMYCIN TROUGH — WHAT ACTUALLY HAPPENED OVERNIGHT

Instructions

- Open the M.C. PAWS chart (link provided in Canvas)
- Navigate to the Notes panel and locate the nursing notes timestamped between 0330 and 0820 on 02/15
- Cross-reference what you find against the Medications panel (Vancomycin row) and the Orders panel (Order #9 and the Vancomycin Trough Contingency order)
- Answer the questions below based only on what the chart documents — not what you assume must have happened

Q1. Why the 0400 Dose Didn't Go In

Vancomycin dose 2 was scheduled for 0400. It wasn't given. According to the chart, why not?

[Text answer box]

Q2. Was the Hold the Right Call?

Based on what you know about Vancomycin and what the chart documents, was holding the 0400 dose the correct decision? Explain your reasoning.

[Text answer box — 2–3 sentences]

Q3. Did Anyone Drop the Ball?

Review every note timestamped between 0330 and 0820. Was the trough actively followed up on during that window, or did it just sit? Be specific about who did what, and when — use actual timestamps from the chart in your answer.

[Text answer box — list the timestamps and who acted at each one]

Q4. Explaining It to the Patient

M.C. asks you, “What exactly is a trough, and why does it matter if you're late on my antibiotic?” In your own words — the way you'd actually say it to a patient, not a textbook definition — how do you answer him?

[Text answer box]

Q5. True or False

If you call the pharmacy to ask what color blood collection tube is needed for a Vancomycin trough, they will be able to tell you.

[True / False — with one sentence explaining why]

Q6. Timing Check — Was the Schedule Right?

Dose 1 was given at 1600 on 02/14. Vancomycin in this order is scheduled Q12H.

1. Was 0400 the correct scheduled time for dose 2? Show your math.
2. Was the trough drawn at the correct time relative to that dose? What's the rule, and did night shift follow it?
3. Once dose 2 is finally given, what time will the next dose (dose 3) be due?

[Text answer box]

Q7. Before You Give It

The trough result is going to come back eventually. Walk through what needs to happen, in order, between the moment that result is released and the moment dose 2 is actually administered.

[Text answer box — list the steps in order]

PART 2: THE REST OF THE MEDICATION LIST

Instructions

Mary isn't only worried about the Vancomycin. Before the next med pass, she wants you to look at the rest of M.C.'s active medications with the same eye for detail.

Q1. Acetaminophen — What's Actually Ordered

What is the ordered dose, route, and frequency for M.C.'s Tylenol (acetaminophen)? What is the documented 24-hour maximum in this chart?

[Text answer box]

Q2. Acetaminophen — Doing the Math

If Tylenol had been given exactly as ordered, every time it was due, since admission — how many doses would that be over a 24-hour period, and what would the total milligram amount be? Is that within the documented maximum?

[Text answer box — show your calculation]

Q3. The Part That's Not in That Math

M.C. mentioned to a previous nurse that he'd been taking NyQuil at home before admission. Why does that matter to the calculation you just did in Q2? Does it matter that NyQuil isn't the same brand as the Tylenol he's getting here?

[Text answer box]

Q4. Omeprazole (Prilosec)

What indication(s) are listed in the chart for M.C.'s Omeprazole? He has a documented history of GERD — but is that the reason he's getting this medication right now, during this admission? Explain.

[Text answer box]

Q5. Metformin

M.C. takes Metformin at home for Type 2 Diabetes. Check his current Medications panel — is he receiving it now? If not, look it up: why might Metformin be held during a hospital admission like this one?

[Text answer box — you may use a drug reference]

Q6. The Sliding Scale

M.C. is on an insulin sliding scale in addition to his scheduled Lantus. In your own words, what does “sliding scale” mean? Using the actual scale documented in the chart, give one example: pick a blood glucose value and show what dose it would result in.

[Text answer box]

Q7. Spot the Documentation Hazard

One of the Joint Commission's official “Do Not Use” abbreviations shows up more than once in this chart — in places where someone was writing quickly. Find at least one example and explain what's wrong with it and what should be written instead.

[Text answer box — quote where you found it]

PART 3: THE FLUID THAT'S RUNNING WITH NO ORDER

Instructions

Before you go back in to see M.C., Mary has one more thing she wants you to check — something she calls “the oldest trick in the book.”

[Scene: Nurses' station. Mary pulls up the I&O panel next to the Medications and Orders panels on the workstation screen.]

MARY: “Take a look at his fluids. He's got D5½NS running at 75 an hour — it's right there in the I&O and I mentioned it in my note from yesterday afternoon. Now go find me the order for it.”

[You search the Orders panel. You search the Medications panel. There is no order for this IV fluid anywhere in the chart.]

MARY: “This happens more than you'd think. Patient comes up from the ED or out of recovery, the provider says ‘start some fluids’ at the bedside, somebody hangs the bag — and then the actual order

never makes it into the chart. The fluid's been infusing and being documented in I&O all shift. Nobody questioned it because it's just… there."

Q1. What Did You Find?

Where in the chart can you see evidence that this IV fluid is actually running? Where did you look for the order, and what did you find (or not find)?

[Text answer box]

Q2. What Do You Do About It?

Put the following actions in the order a nurse should actually take them, from the moment you realize a fluid is infusing with no matching order:

- [Drag-and-drop / dropdown sequencing item — see Canvas build notes for exact step list and order]

Q3. Reflection — Why Report It?

Even though the patient is stable and nothing has gone wrong yet, why does a gap like this need to be reported rather than just quietly fixed?

[Text answer box — 2–3 sentences]