SBAR – Glucose Tolerance Beverage Administration

Situation: Management has discovered the wrong glucose tolerance beverage dose, commonly called "glucola", was administered to a patient.

Background: A Staff member handed a patient the wrong dose of glucose beverage. As the patient began to drink the glucose beverage, he/she noticed the error and stopped the patient from consuming the glucose beverage.

Assessment: There are 3 doses of glucose tolerance beverages available. The doses are 100 mg, 75 mg and 50 mg. Both the 75 mg and 50 mg beverages are orange and have been reportedly been misidentified in the past.

Recommendation:

1. Label shelves and door in the glucose beverage refrigerator, one for each Glucose dose.
2. Prior to stocking the glucose beverage in the refrigerator, write the glucose mg dose on the cap of each bottle.
3. Segregate the three glucose beverages according to dose on the labeled shelves / door in the refrigerator.
4. In the event the wrong glucose beverage dose is administered to a patient, notify laboratory management immediately.