Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Meagan Olive Date: May 4, 2021 DAS Assignment # __1__1-4)

Name of the defendant: Holly Jane Hartman License number of the defendant: 774613

Date action was taken against the license: 1/23/2014

Type of action taken against the license: Voluntary Surrender

Use the space below to describe the events which led to action taken against the license. If multiple charges were in play, be sure and cite them, e.g., drug diversion, HIPAA violation, abandonment, forfeiture on student loans, etc.

- On or about May 21, 2011 through May 24, 2011, while employed with Baylor University Medical Center, Dallas, Texas Respondent withdrew Morphine Sulfate, Roxanol, from the Omnicell Medication Dispensing System for Patient Medical Record Number 60180654, but failed to follow the policy and procedure for wastage of any of the unused portions of the medication. Respondent misappropriated Morphine Sulfate, Roxanol 100mg, or failed to take precautions to prevent the misappropriation An audit of the medication indicated that 100mg of the medication Respondent withdrew was unaccounted for. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.

- On or about August 26, 2011 through August 30, 2011, while employed with Baylor University Medical Center, Dallas, Texas Respondent withdrew Hydrocodone 5/325 from the Omnicell Medication Dispensing System for Patient Medical Record Number 60267918, but falsely documented the administration of the Hydrocodone in the patient s Medication Administration Records (MAR), in that the patient denied receiving any medication. Additionally, the patient and her husband both confirmed she did not complain of pain and no medication was administered. Respondent's conduct resulted in an inaccurate record which was likely to deceive other care givers who needed complete information on which to base their case. Respondent withdrew Lorazepam, Hydrocodone, and Zolpidem from the Omnicell Medication Dispensing System for Patient Medical Record Number 60282867, but falsely documented the administration of the medication in the patient's Medication Administration Record (MAR), in that the patient and his wife both confirmed he had not received any narcotics and had no complaints of pain.

- Respondent denies and states that she followed proper documentation and wastage policies, while trying to provide quality patient care. The medications she administered were given for the **reason** prescribed. The patients were confused and hallucinating because of chemotherapy toxicity. The error

was in the documentation of time of discharge. It was busy night and she did not document the medication she administered or the discharge time until after the patient left. She takes complete responsibility for the errors in documentation.

- The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.

Use the space below to provide a description of measures you think could have prevented any action being taken against the license and/or would have prevented harm to the patient, if harm occurred.

- First off, this was a completely avoidable incident on the nurse's part. From reading over the court documents, it looks like not only was she falsifying medication documentation, but also completely forgetting the **REASON** to administer the medication in the first place. Holly gave narcotics to patients without even assessing their pain, or pinpointing the **REASON** to administer the medication, resulting in the patients hallucinating and confused from over administration of narcotics, which ultimately could've even resulted in death.

- The terrible thing about this situation is that by the looks of it, it was intentional. Holly stated that it was a busy night and didn't even get around to documenting till the discharge was complete and the patient had left, which is an issue all in itself. There is absolutely no reason or explanation you can give for not documenting directly after administering, and even assessing your patients pain before touching them with any kind of medication.

- This situation was pure ignorance that was lucky enough not to result in patient death.

Use the space below to describe what action you think a prudent nurse would take as the first to person to discover the event described, in other words, you are the one who discovers the patient has been harmed by the nurse or you have discovered the impairment or criminal activity cited in the disciplinary action.

- As you can tell above, I made it a point to bold and capitalize **REASON** throughout my assignment.

  This could've been avoided if Holly had known her **reason** for every step she was taking and missing throughout her administration process.

- If I was ever to witness this, my first action would be to report the actions that have/haven't been taken by the nurse in question and go directly to my charge nurse with any information.

- Overall, the patient is our first and highest priority and should always be looked at as a family or someone that we care dearly for, treating them and giving them the care that we would not only want, but be expecting our family members to be getting in a healthcare setting.