Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Samantha Kendall Date: 2/3/23 DAS Assignment # 3 (1-4)

Name of the defendant: Lindsay Barnett License number of the defendant: 821623

Date action was taken against the license: 06/16/2015

Type of action taken against the license: Warning with Stipulations

Use the space below to describe the events which led to the action(s) 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.

Lindsay had multiple events that lead to the action of her license being put on a warning and being forced to do remedial education. The first event that occurred was when the nurse didn't read the order appropriately for a type and screen before doing a blood transfusion. The nurse also didn't give any of the blood transfusions or follow the appropriate duration that was written for the patient by the physician in order to get better. The nurse also didn't clarify medications that weren't compatible with each other for the patient's body system and was giving drugs that were acting against each other to not be beneficial for the patient's blood pressure. The nurse had a medication error that allowed her to give more of a medication dose, Mannitol, than was prescribed and put the patient at a serious safety risk. The nurse stated at the end of her disposition that she thought that she gave the right medication but documented the wrong dose amount in the computer instead. The nurse overall had a lot of medication errors that led to the patient's safety being put in jeopardy for further harm.

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.

I believe that the three checks of the medication would have been able to help prevent these actions from happening. The majority of the patient's harm came from not fully looking at the order that the patient was prescribed or even scanning the medication at the bedside. The three checks of looking at the order, to the medication room when grabbing medications, and then at the bedside by scanning all of them could have prevented Lindsay from giving too much of a dose, the wrong medication, or missing medications that were supposed to be given. Tagging on to this, I believe the seven rights of medication administration weren't fully followed either when the wrong dose was given to a patient. These are important fundamental steps that we are taught in nursing school to help keep a patient safe. Lindsay had been a nurse for over two years when she was caught for the first incident that occurred with the transfusion incident. I believe that Lindsay would have benefitted from having a mentorship within the unit or even more classes that were part of her training to be a nurse on time management during orientation. I think that she seemed to struggle with taking the time to go through all of the parts of medication administration and that it would have really helped her to have more education- which is why the Board of Nursing required her to continue even more education after these events to help.

Identify which universal competencies were violated and explain how.

Safety and Security (Physical): The nurse violated this by not following the seven rights of medication administration. Lindsay didn't follow the right reason, dose, drug, or even documentation in a lot of these errors that were documented against her. When she gave more of the drug than was prescribed, she was not making sure that it was the right dose for the patient to take safely. She didn't give the transfusion over the right time or even at all which could have been followed with using the seven rights of medication. She also gave medications that were working against each other to lower and increase the blood pressure at the same time, which violates making sure we are giving medications for the right reason to a patient.

Standard Precautions: The nurse didn't use standard precautions when she didn't follow the standard of medication preparation. The nurse didn't fully prepare the correct dose of certain medications, type and screen the patient before a blood transfusion, or follow all of the precautions to ensure patient safety. Multiple medications that shouldn't have been given or too much of a dose was given occurred by the nurse, Lindsay Barnett.

Critical Thinking: Lindsay didn't fully use appropriate decision making when not giving medications that should have been or doing a type and screen before a blood transfusion. She didn't seem to prioritize her tasks if she wasn't able to give medications that were on her list to give. She also didn't use any intervention to question any of the orders that weren't necessary or didn't make sense to her prior to giving the medication. I think the decision making skills within critical thinking weren't fully followed as well due to some of the errors that occurred she is being cited for on the record.

Documentation: The nurse stated that she felt that she documented the wrong dose of medication given to the patient as her defense. Documentation should be accurate and on time after giving a medication to help continue to ensure patient safety.

Professional Role: The nurse didn't use any type of human resources or even supplies that could have helped her in order to not have any of these medication errors that occurred. She could have time managed and used the people around her to help get caught up or ask a question if she was unsure of what else she could do to help her patient.

Use the space below to describe what action you think a prudent nurse would take as the first 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.

I believe the prudent nurse who discovered the medication errors by the nurse would first do an assessment of vitals on the patient. If the patient hasn't been getting crucial medication or was given too much, getting the patient stable would be the main priority to me as a nurse. After this, I would talk with the nurse to see what was going on and get the whole picture of what I couldn't see. I would make sure that the physician was called if the nurse did something that was pertinent for a doctor to know to help treat the patient better. I would also make sure that there was an incident report or some form of a report given to a leader on the unit such as a charge nurse so we can help prevent this for the future. I think the nurse needed to use these resources and I would also want to communicate with her to see if there is any other support that you can give in the meantime to help things be better for the patient and the rest of your shift.