Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Anayeli Deleon Date: 01/26/2024 DAS Assignment # __2__

Name of the defendant: Jami Warner License number of the defendant: 913835

Date action was taken against the license: 10/25/2018

Type of action taken against the license: Suspended/Probation

- 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.

Jami Warner worked at Longview Medical Center in Longview, Texas for 9 months. On April 5, 2018, Warner failed to verify the medication order of a patient. Warner had an order to administer 60mg of Cardizem. The Rrespondent took out 16 tablets of the medication from the Pyxis and crushed it to be mixed with a solution. Once the medication was mixed with the solution, it produced 120mL, which was equivalent to 1,440mg. The Respondent did not read the additional instructions that were given regarding the medication. Those additional instructions were “only administer 5mL of the 120mL solution.” Once the entire 120mL of medication were administered to the patient, she began to experience low blood pressure and a low oxygen saturation. The patient was then placed on life support and was deceased days later after she was taken off life support.

- 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.

The nurse did everything she could to protect the patient from the medication, except the most important part of nursing, advocating for the patient and using her nursing judgment before administering her medication. The Respondent stated that she thought it was strange to take 16 tablets out of the Pyxis, so she went into the patients chart to verify if the medication order was correct. Once she noticed that the medication had been previously given to the patient, she went ahead and administered the medication. What the Respondent could have done was trust her intuition and check with he charge nurse or pharmacy if she had any questions about the dosage.

- Identify ALL universal competencies were violated and explain how.

-Safety and security was violated because she did not follow the 7 Rights of Medication Administration. The 7 Rights were not completed when she did not accurately identify the dosage.

-Critical Thinking was violated because of the decision making that led to the medication error. The Respondent had doubts about the dosage, yet still administered the medication despite the fact that she was confused with the grand amount of tablets needed to mix the solution.

-Professional Role was violated because she did not use the equipment or Human Resources efficiently. The equipment she could have used was the eMAR and the other Human Resources she could have used were her charge nurse or the pharmacist.

- 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.

An action that a prudent nurse would take upon being the first to discover the event would be to, first help save the patient and lastly educate the nurse. If I was the prudent nurse who discovered the mistake, I would help the nurse stabilize her patient. I would also have helped the nurse speak to pharmacy and the physicians to see if there was any medication that could decrease the adverse effects such as her blood pressure and oxygen saturations dropping. Once the patient was stabilized, I would help the nurse go in to the chart to review the order and help her understand where she went wrong. Although I know the nurse is the last source of verification before administering the medication, the pharmacist could also take fault by how the medication instructions were written. The note of only administering 5mL out of the 120mL should have been in bold or there could have been a better way of mixing the medication with a less amount of tablets.