

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Hannah Holland

Date: 03/25/2024

DAS Assignment #   1  

Name of the defendant: Ijeoma Alilonu

License number of the defendant: 903319

Date action was taken against the license: 11/12/2019

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.*

Ijeoma Alilonu had multiple instances where she displayed unprofessional actions that could lead to harm of a patient or others. All of these actions led to disciplinary action to be taken against her. These unprofessional and potentially harmful actions include: Failing to perform Independent Double Check when administering chemotherapy, leaving a chemotherapy bag leaking on the counter and down onto the floor, bypassing safety alerts and administering 120mg of Lovenox instead of the ordered 40mg of Lovenox, failed to accurately assess and/or document a patient's pressure injuries, withdrew Morphine without having a second nurse witness her waste the unused product, infused incompatible fluids through a central venous catheter causing it to crystalize, and administered a Magnesium infusion to a patient without an order. These instances lead to inaccurate medical records and created an unsafe environment for the patients and peers of this nurse. All of these actions led to a disciplinary action.

The failure to perform Independent Double Check when administering chemotherapy was a crucial step that this nurse failed to complete. Nurse Ijeoma Alilonu removed the chemotherapy from the plastic cover and removed the cap on the blue port, before she realized that the chemotherapy was ordered for a different patient. Luckily, the nurse realized that the chemotherapy was for a different patient before administering it. Had she administered chemotherapy to the patient that wasn't prescribed it, she could have caused unnecessary harm to the patient due to her negligence. She then left the chemotherapy on the counter in the medication room and allowed it to spill onto the counter and onto the floor. This put not only her, but her colleagues at risk for harm.

When nurse Ijeoma Alilonu was dispensing her medications and viewing the Pyxis orders, she did not realize that the order was written as an either/or dose based on platelet count. This led her to give both doses of Lovenox, which ended up being 120mg. The prescribed dose in this case was 40mg of Lovenox, so she gave the patient 80 more mg than ordered. She had ample time to realize her mistake before administering the

medication and even bypassed the safety alerts of the Bar Code Scanning System. This conduct put the patient at risk of medical harm and was likely to harm the patient from excessive bleeding.

Next, nurse Ijeoma Alilonu failed to accurately assess and/or document the pressure injuries of a patient. She stated that she documented three pressure ulcers as stage II, however the wound care team noted that two of the pressure ulcers were unstageable and one of them was a stage III. This conduct could cause harm to the patient based on an inaccurate assessment of the pressure ulcer, as well as creating an inaccurate medical record, which is a false record.

When nurse Ijeoma Alilonu was withdrawing Morphine from the medication dispensing system, she failed to follow policies and procedures. She did not have a second nurse witness the wastage of the unused Morphine, which puts her in violation of the Controlled Substances Act. She states that there was not a nurse available to witness her waste the unused portion and that she wasted it into the sink. This breach of policy could deceive the hospital pharmacy.

Nurse Ijeoma Alilonu also infused incompatible fluids through a central venous catheter line, causing the line to become crystalized. Tissue plasminogen activator was then required to clear the line. She failed to verify compatibility herself and relied on a previous shift nurse, resulting in the line crystalizing. Ijeoma's mistake put the patient at risk of harm from occlusion of the CVC and side effects of tissue plasminogen activator, including hemorrhage.

Lastly, nurse Ijeoma Alilonu failed to verify if a patient had a Magnesium level ordered that day, or if the resulted value indicated need for a Magnesium infusion. She administered the Magnesium infusion without an order, which put the patient at risk for complications of magnesium toxicity.

In conclusion, nurse Ijeoma Alilonu was negligent when verifying patients and medication orders and not following proper policies which resulted in risks to patients and peers.

- *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.*

There are various measures that could have prevented the actions being taken against the license, and that could've prevented putting the patient in harms way.

When administering the chemotherapy, nurse Ijeoma Alilonu should have checked which patient the chemotherapy was prescribed for before removing it from its plastic cover and removing the cap on the blue port. This would have prevented her from mistaking it for a different patient and would have prevented it from spilling onto the counter and floors in the medication room. She also should have disposed of the bag or put it away properly to ensure no spilling or leakage would occur.

Nurse Ijeoma Alilonu should have completely read the order to avoid any discrepancies when administering her patient Lovenox. The order was an either/or dose based on platelet count, which she did not catch before administering both doses of Lovenox. The Bar Code Scanning System was producing safety alerts, which should have caught her mistake. She should have thoroughly read these safety warnings, and this could have prevented the wrong dose being administered, which could have caused excessive bleeding in the patient.

In the situation where nurse Ijeoma Alilonu failed to accurately assess and document a patients pressure wounds, she could have avoided this false medical record by following the protocols on documenting wound descriptions. The RNs inaccurate description could have caused the patient further harm if the injuries had not been caught by the wound care team.

In order to prevent breaking hospital wastage protocol, the RN should have found a nurse to witness her wastage of unused Morphine. If no one was available, she should have waited for someone to become

available or asked another nurse to take a minute to witness her wastage. This could have prevented action against her license.

When the RN infused incompatible fluids through a single central venous catheter, she put the patient at risk. She should have personally checked compatibility to avoid crystallization of the line. It would have prevented putting the patient at risk for hemorrhage.

When administering a Magnesium infusion, the nurse failed to verify if the patient had a Magnesium level ordered that day, and if the value fell within range for needing an infusion. She should have checked the orders to prevent giving the patient an infusion without a prescription. This could have led to magnesium toxicity, and the nurse could have avoided that by taking the proper precautions.

- *Identify ALL universal competencies were violated and explain how.*

**Safety and security** was violated when the RN administered the wrong dose of Lovenox to a patient, thus violating the 7 medication rights for administration. She almost gave the chemotherapy to the wrong patient, which would have violated the 7 rights of medication administration as well. She further violated the 7 rights by administering incompatible fluids through a central venous catheter line, which was the wrong route because it crystalized. She also administered a Magnesium infusion without an order, which violates the 7 rights "reason".

**Standard precaution** was violated when the nurse left a chemotherapy bag leaking onto the counter and floor in the medication room. This created an unsafe environment for the nurse and her peers.

**Communication** was violated when the RN did not communicate with agency protocols and wasted Morphine without having another nurse present as a witness.

**Critical thinking** was violated when the RN gave incompatible fluids through a central venous catheter, which violates the decision making aspect of critical thinking. She also violated critical thinking by failing to assess a patients pressure injuries accurately.

**Documentation** was violated when the nurse falsely documented three pressure ulcers on a patient.

**Professional role** was violated when the nurse failed to maintain a clean working environment by leaving the chemotherapy bag on the counter where it then leaked onto the counter and floors of the medication room.

- *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.*

If I were the first person to discover these events, I would report my findings to the charge nurse and all other appropriate personnel. I would ensure each patients needs were met and no harm was done. I would properly dispose of the leaking chemotherapy bag, and run labs on the patient who received the wrong dose of Lovenox, the patient whose central venous catheter line was crystalized, and the patient who received the Magnesium infusion and make sure that they are reacting positively. I would then review the situations with Ijeoma Alilonu and try to figure out what I can do to help.