

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Magy Hernandez

Date: 03-26-2024

DAS Assignment #   1  

Name of the defendant: Omolara Oluwabukola Jowojobi (RN)

License number of the defendant: 876035

Date action was taken against the license: 05-07-2018

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.*

While employed in the Cardiology Unit at Baylor St. Luke's Medical Center, Missouri City, Texas, for about two months, around August 23, 2017, the nurse failed to address the swelling arm of the patient 02251692 post-procedure. The nurse also failed to start a Heparin order for over an hour. This exposed the patient to the possibility of getting a blood clot, putting the patient in unnecessary harm for not providing the proper treatment; this also withheld the patient from getting treatment to prevent other complications. The nurse responded that the patient was assessed between 7:15 and 7:30 a.m., and no swollen arm was present. The nurse became aware of the swollen arm until the doctor made rounds in the morning. After the doctor had completed the rounds, the doctor ordered a venous doppler for the left arm and Heparin. The nurse said the preceptor put another IV on the right arm at 4:52 p.m. The nurse ordered an IV pump at 5:18 p.m. after receiving the order. After 15 minutes of ordering the pump and not having it available, the Respondent informed the preceptor around 6:00 p.m. and again at the end of the shift.

In the same facility around September 26, 2017, while employed as an RN, the Respondent administered an excess frequency and/or dosage of insulin to Patient 03110303 to treat the patient's glucose, although they had previously been treated. The nurse did not view the MAR before administering the medications and ignored error messages popping up on the display of the electronic medical record system. In addition, the Respondent failed to document the physician's verbal order to hold the scheduled night insulin. She also failed to inform the nurse coming in of the physician's order. It is stated that the Respondent's actions were to injure the patient since excess dosage and/or frequency of insulin was administered, which could cause harm from adverse effects. The Respondent's conduct also injures caregivers since they rely on the Respondent's documentation to provide patient care. In response, the nurse stated that the preceptor had administered insulin to the patient. She also admitted it was her duty to review the MAR and ignore the error messages on the display of the electronic medical record

system. The Respondent stated she received the physician's verbal order to hold the evening insulin, documented the order, and verbally notified the nurse coming in.

Finally, these actions of failing to notice swelling, giving medication on time, documenting, giving too much medication, and informing a nurse of vital information, Omolara Oluwabukola Jowojobi had to have a court hearing to address those issues resulting in receiving a warning with stipulations.

- *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.*

Implementing Florence Nightingale's hourly rounds, the nurse would have noticed the swelling in the arm sooner, although she had not seen it from 7:15-7:30 a.m. The Responder could have also delegated to the CNA to let them know if the patient has any abnormal vital signs, complaints of pain, or anything abnormal to the skin. Lastly, if the preceptor did not help her find an IV pump to give the medication on time, she should have let the charge nurse know about the situation.

The Responder should have gone through the 3 medication checks. Doing this, the nurse would have had 3 situations to verify if she should be giving the insulin. The nurse should have also done the seven medication rights at the bedside, and the patient may have stopped the Responder to let them know they had already received the insulin. Another action that could have prevented the nurse from administering the insulin is listening to the error messages on display in the electronic medical record system. Those messages are there to alert nurses, and if the responder had read the messages, they would not have given more insulin. Finally, the Responder should have double-checked that they were in the correct chart, as the nurse could have documented the order in another patient's chart.

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

**Critical Thinking.** A universal competency that was broken was SBAR. When giving report to the oncoming nurse, the Responder failed to inform the nurse of the verbal order given by the doctor to discontinue all evening insulin. Although the Responder states they did inform the nurse, we cannot know that since it was verbal, and there is no documentation. Next, decision-making was also violated when the nurse decided to give the medication, although it had already been given. Assessment related to the patient system was violated when the nurse did not assess the patient's glucose before administering the insulin.

**Documentation.** The Responder did not save all documentation, causing harm to caregivers trusting the documentation in the patient's chart. This was violated when Nurse Omolara Oluwabukola Jowojobi did not document the physician's verbal order.

**Safety and Security (Physical)** Professional interactions were violated when the RN did not do hourly rounds and the patient. Due to failing to complete the hourly rounds, the nurse did not notice the swelling of the arm. Promoting trust and respect was also violated by that action since the patient trusted the caregiver to give them proper care.

- *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 person to have discovered these issues, I would prioritize caring for the patients first to make sure there is nothing critical going on. Then, I would notify the charge nurse of the findings. In this case, for the swelling of the arm, I would contact the doctor to inform them of the patient's state and then notify the caregiver of the patient what I had done. For the patient who received too much insulin, I would prioritize getting a blood glucose level and vital signs, notify the charge nurse, and call the provider. Finally, after both cases, I would ask the caregiver what was going on that made them make those mistakes. I would also report the nurse to the Texas Board, as this could have cost the patient their life.