

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Marcela Guevara

Date: 08-22-24

DAS Assignment # 1

Advisor: Karvas

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: Suspend/Probate

- *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 became a licensed registered nurse in the State of Texas on January 12, 2017. At the time she got a job at Longview Regional Medical Center in Longview, Texas. Jami Warner was employed there for nine months until she encountered actions that led to her suspension. On April 5, 2018, Jami Warner failed to reevaluate the medication dose order and administered to the patient the wrong dose of 1,440 mg of Cardizem instead of 60 mg. During the incident, Jami Warner removed sixteen tablets from the Pyxis, crushed them, and reconstituted in 120 mL of solution. She felt like it was a strange dose to have but continued her administration without getting clarification from the charge nurse or other nursing staff or re-reading the orders. This action caused the patient to get injured leading to respiratory failure and hypotension. After the situation occurred, the charge nurse then discovered the dose was only supposed to be 5 mL of medication, but it was too late. By failing to clarify the right dose of medication, not looking at all orders, and not getting clarification from other personnel led to the patient to be placed on life support and then succumbed to the medication error several days later.

- *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.*

Multiple opportunities could've avoided this situation. The most important of all is always double checking your order and the dosage of each medication. The nurse should have done the three checks which include looking at the orders, verifying order in pyxis, and scanning the medication at beside to verify the correct medication and dose is being administered. Next would be if the nurse feels like the medication is wrong and isn't confident about what she is giving always ask for another nurse for confirmation. Last would be contacting the pharmacy about the abnormal order that was given. If the order isn't right for you as a nurse, then you shouldn't give them medication and contact them immediately because this can put the patient at risk.

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

Safety and Security, communication, critical thinking and documentation are the universal competencies that were violated.

Safety and Security: The nurse violated the dosage and documentation on the 7 rights. She gave the wrong amount and telling the patient the wrong amount they were going to get administered that caused a fatal reaction.

Communication: The nurse lacked communication. She didn't talk to another registered nurse or call the pharmacy about the abnormal medication order that the patient was given. With this, the patient was placed into respiratory failure and hypotension which could've been avoided if the nurse communicated.

Critical thinking: The nurse should've used critical thinking skills when she was pulling the medication and preparing it. The nurse stated "It was strange" when she was pulling sixteen tablets out of the pyxis. In this moment the nurse should've made the decision to not give the medication if she felt it was wrong and should've called the pharmacy.

Documentation: The nurse's documentation was inaccurate when she charted the medication administration in the right dosage and got the dosage the patient needed. This was also violated in the 7 rights when medication was being administered at bedside.

- *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 this event, I would contact the medical provider STAT and inform the charge nurse of the medication error immediately. I would place the patient on oxygen and call the respiratory team or a rapid response. While I wait for help, I'll stay with the patient and do hourly vital signs. I would monitor oxygen saturation continuously. After stabilizing the patient, I would ask the nurse what she did wrong and then report it to the nurse manager so a proper report could be filed with the State Board of Nursing because this incident put the patient's safety at risk.