Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Josie Brimberry Date: 8/22/2024 DAS Assignment # 1

Name of the defendant: Megan Leigh Dutton License number of the defendant: 886457

Date action was taken against the license: 8/13/2019

Type of action taken against the license: Revoked

- *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.*

  Megan Dutton accumulated multiple charges while hired as a professional Registered Nurse working in several clinical settings. Her ignorant actions included: Incorrectly documenting Vasopressin administration and verification, failing to be cognitively and physically responsible for patients, falsely documenting medication that the patient did not receive, falsely withdrawing medication without administration documentation, falsely withdrawing excessive amounts of Hydrocodone and Fentanyl not corresponding with the physicians orders, incorrectly following the facility's policy for wasting medication, excessive administration of Morphine and Hydrocodone outside physician orders, and incorrectly withdrawal of excess medication. These actions unjustly affect the patient casing further harm, the healthcare team prohibiting best performance and excellence, and skew documentation falsifying the medical records.

  Megan Dutton falsely documented the administration of Vasopressin. At 0146, medical record data was entered showing the Vasopressin medication was administered at 2200 and verified at 2300 and 0000 and 0150. However, the PCU pump recorded the medication start time at 0142 and the rate 1mU/kg/hr when the documented order was 0.5mU/kg/hr. Medication administration must be documented at the bedside for accurate information and patient safety. Failing to administer the correct rate of a medication other than the physicians prescribed order can result in complications and potential further injury to patient and inaccurate data for continuing patient care.

  Additionally, three months later from the original offence, Megan Dutton showed signs of physical and cognitive impairment while at the clinical setting. Behavior included: slurred speech, slow moments, and unsteady balance. She stated that she would oversee another nurse's patients during a brief leave to the break room, however Meagan Dutton proceeded to leave the unit for an extended period of time. Megan Dutton actions place strain on the health care team and other members of the staff on the unit, potential harm for the patients, and inability to soundly make best care decisions for patients.

Later, Megan Dutton failed to account for a medication administration of Fentanyl for a patient in their medical record. The reported medication concluded that the medication bag was empty when a witness confirmed the waste should have left 42mL. This inappropriate misconduct defrauds the cost of medication form the patient and resulted in unaccounted medication.

During the time frame of 4/9/2018-5/1/2018, Megan Dutton falsely withdrew Fentanyl, Hydrocodone, and Midazolam from the medication dispensary for multiple patients and failed to accurately document the administration of the medications. These multiple offensives likely cause harm to the patients because there is lacking information of the quantity of medication a patient received, this could result in ineffective medication doses, overdoses of medication and further complications for the patients.

During that time, she accumulated 12 milligrams of Morphine, 900 milliliters of Fentanyl, 3 tablets of Hydrocodone and 1 milligram of Midazolam of unaccounted and defrauded medication costing the facility and patient money and potential harm.

Megan Dutton also was also charged with incorrectly withdrawal of mediation, administration documentation, and accurate documentation. She withdrew and documented administration of Hydrocodone and Fentanyl double the amount of the physician's orders and an hour sooner. The recorded administration was consistently every 3 hours when the physicians orders were clearly written as PRN Q4H. This occurred for two days in a row. The documentation of the waste was recorded as none, and several patient comments of pain level were not recorded. These actions cause likely harm such as complications of the medication and increased pain to the patient.

The next day, Megan Dutton withdrew Fentanyl and Morphine and failed to follow the facility's policy for wasting the narcotics. The unused medication was unaccounted for and puts herself, the patient, the pharmacy, and the healthcare team at risk for harm of inaccurate medication administration and preparation.

In conclusion, Megan Dutton increased the likelihood of harming multiple patients charged in her care. She falsely documented and administered medication, not cooperating to facility's policies. Her conduct was unprofessional and unethical.

- *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.*

  Megan Dutton could have taken several measures to prevent discrepancies. She could have prevented harm of patients and provided error-free information for the physicians and patient's health care team by accurately recording medication administration. She should have taken measures to immediately record medication administration times and correct rates. She should adhere to the physicians' orders for medication and triple check the amount of medication to administer. She should aways preform wastage procedures as her faculty's regulations. She should always provide detail in her documentation.

  Communication is important when not acquiring the cognitive or physical demeanor to actively care and preform nursing responsibilities.

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

  The universal competencies that Megan Dutton violated included: safety and security, standard precaution, documentation, human caring, and professional role.

Safety and Security were violated because Megan Dutton failed to properly document medication administration. She did not complete documentation at bedside for accurate and effective results. She did not accurately document the right time, right dose, or right reason for the patient and violated the patient's 7 medication administration rights.

Standard Precaution was violated because Megan Dutton incorrectly wasted medication. She did not adhere to the clinical's policy which resulted in unaccounted for medication that is most likely assumed for personal use. She defrauded of the facility and patient.

Documentation was violated because Megan Dutton incorrectly documented medication on multiple occasions. She did not accurately record medications and failed to document completely by leaving portions of the record blank and only recording "none".

Human caring was violated because Megan Dutton likely harmed her patients by overdosing the patient administering amounts of medication exceeding the physician orders.

Professional Role was violated because Megan Dutton was charged with being unfit to effectively preform her responsibility as a nurse and a professional care giver. She was most likely under the influence, but regardless was not present on her unit for an excess amount of time. She was unable to make judgment calls and recognize patient needs.

- *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.*

  As a nurse who has discovered the events of Megan Dutton's conduct, I would report her actions first to the charge nurse and follow the chain of command to identify and resolve the concerns. I would suggest to the physician that labs should be ordered to confirm the amount of medication the patients have actually received for accurate medication administration care. I would report my concerns to the charge nurse of the unfit behavior that Megan Dutton showed while on the job. I would suggest a witness for the wasting of medication and following the facility's regulations.