Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Katelyn Bowman Date:08/21/2024 DAS Assignment # 2

Name of the defendant: Mariatu S. Hendricks License number of the defendant: 1013384

Date action was taken against the license: 09/12/2023

Type of action taken against the license: Reprimand 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.*

  Around September 2022 Mariatu S. Hendricks committed several medication administration errors that lead her to have her license reprimanded with stipulations. Mariau did not complete the 7 rights of medication administration which ultimately lead to her medication error. Mariau had a medication order to administer hydromorphone 1 mg bolus through a pump. She failed to confirm the right amount, right route, never scanned the medication once in the pt room and administered 30mg/30 ml by IV push. She then proceeded to not complete the right documentation and recorded that she administered 1 mg bolus through a pump. No assessments were completed after the med error, and the provider was not notified. The patient could have experienced fatal consequences from the above actions that were all preventable. The patient was later transferred to the ICU for further care.
  When the med error came to light Mariau admitted to another incident where many med errors occurred. The charge nurse on shift walked into a patient's room under Mariau's care. She handed a syringe of medication to Mariau and informed her that it was for her patient in the next room. The patient was in visible pain when Mariau entered the room. The syringe of unknown medication did not have a barcode to scan, but Mariau began to administer the medication anyway. Partially through the medication administration, she decided to stop and verify that she had the correct medication. She did not proceed any further from that point and documented that the IV line was bad. The patient was transferred to ICU for further care.
  In this instance Mariau did not verify the right patient, right medication, right route, right dose, right time, right reason or right documentation.

- *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 measures that should have been completed to avoid the medication errors should have been her 3 checks and the 7 rights of medication.

Mariau could have avoided administering the wrong route and dose of the hydromorphone in the first error if she had verified this with her 3 checks. One against the providers orders, one against the EMAR and the last check at the bedside. The third check at the bedside was never completed due to Mariau failing to scan the medication before administering. From there Mariau should have stayed with her patient, notified her charge nurse immediately and monitored vital signs closely. The right documentation of the medication error and all actions taken should have been completed correctly.

In the second medication error Mariau had several instances that were incorrect. To begin, the charge nurse should have never taken medication for a patient next door into another patient's room. The person administering the medication should have been the one to prepare the medication in the med room. The medication was stated to not have a barcode to scan, and the label was placed over the medication name. Before entering the patient's room Mariau should have gone back to verify what medication she was given, or prepared another syringe of the medication that she knew was correct. Failing to do so, Mariau entered the room and began administering the unknown medication. The right patient, right time, right reason, right dose, right route, right medication, were not completed. All of which would have helped prevent this medication error and harm to the patient.

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

Safety and Security: Mariau did not complete her 7 rights of medication in several instances, which ultimately led to medication errors.
Communication: Mariau did not provide any patient teaching before administering the medications.
Critical Thinking: Mariau left her patient after committing medication errors. She did not assess or monitor her patient for adverse effects.
Documentation: Mariau never scanned the medications at bedside when medication errors occurred. She also falsely documented after medication errors occurred.
Human Caring: She did not treat her patient with respect when carelessly administering medications without verification.
Professional Role: The charge nurse handed Mariau medication in a patient's room for the patient next door. This was not appropriate interactions with the patient or staff.

- *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 nurse that discovered these medication errors were happening, I would have reported it to the charge nurse and all physicians of the patients immediately. I would have made sure the patients that received the med error were being monitored closely and transferred to ICU immediately if needed. I would have asked Mariau what happened and if I thought the med errors were made on purpose I would have asked that the remainder of the patients under her care be placed under the care of another nurse.