Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: *Amanda Miller* Date: *August 30, 2024* DAS Assignment # *2*

Name of the defendant: *Lumpkins, Pamela Dawn* License number of the defendant: *RN 845645*

Date action was taken against the license: *December 8th, 2020*

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.*

My case is a two-part case against an RN by the name of Pamela Lumpkins who received her Associate Degree in Nursing from Galveston College, Galveston Texas in 2013.

Lumpkins' first incident was December 18th, 2018 when she was employed in an Emergency Room. Lumpkins was caring for a patient who arrived for an unknown reason when she drew multiple vials of blood. Lumpkins drew the blood, labeled the tubes with the correct patient labels using two patient identifiers, and then left them on the counter. The patient went on to receive a blood transfusion in the ICU, suffered a blood transfusion reaction, and died. The documents suggest multiple contributing factors to the error such as a coworker leaving blood from a previous patient in the room, fault of environmental services for not clearing the blood out of the room during cleaning between patients, and the lab failing to recognize the blood tube being labeled with two different patient labels. When interviewed regarding the incident Lumpkins reported when she entered the patient room to draw the blood it was a "very chaotic scene". She described multiple family members present, personal belongings "strewn about the counter", and multiple providers evaluating the patient. Lumpkins said she labeled the vials correctly and when she put them on the counter, she did not know that blood from a previous patient had been left in the room and must have gotten mixed in "amid the clutter and confusion". Lumpkins claimed the blood tube was sent to the lab labeled with stickers for both patients, and the lab failed by not recognizing the double-labeled specimen.

The second incident occurred approximately three months later, and Lumpkins was still working in the Emergency Room. This time, she was responsible for administering IV fluids incorrectly to her patient. She administered 5% Dextrose and 0.45% Sodium Chloride with 20 mEq Potassium Chloride (D5W 0.45% NaCl 1L KCL 20 mEq) without using an IV pump. When she was interviewed regarding this medication error, she responded that the Emergency Room was short-staffed, and responsible for up to five patients each. Lumpkins does not believe she was the nurse who hung the medication for the patient.

As of August 30th, 2024, Pamela Lumpkin's license status is current, multistate.

- *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.*

In the case of the mishandled blood tube, I believe it was completely unacceptable and preventable. As nurses, we are ultimately responsible for the care and well-being of our patients. A patient died because someone did not thoroughly make sure that their patient was in a clean and safe environment. Yes, multiple people failed this patient in the chain of events leading up to the patient's death but at the end of the day, Lumpkins should have done better. She should have ensured that the patient's room was clean and free of anything that may have been left behind from the previous patient. After she drew the blood from the patient, she should have never put it down. She should have labeled it and sent it to the lab for testing immediately. By doing so, she could have easily prevented such a careless error leading to the death of an unknowing patient.

In response to the medication error, she should have been more diligent in her care. Despite who hung the IV medication for administration, it was her patient, and she should have ensured it was done correctly. Every time she entered the room she should have assessed her patient, including the medications being administered. Administering continuous IV medications is always safer with a pump. Being short-staffed and having multiple patients to care for is not an excuse for sub-par nursing. Every patient deserves the best.

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

The Universal Competencies I believe were violated are *Safety and Security (both Physical and Emotional), Standard Precaution, Critical Thinking,* and *Professional Role*.

Safety and Security (Physical): Although Lumpkins claimed she drew the blood tubes and correctly labeled the patient specimen using two patient identifiers, she failed to confirm when she sent the blood to the lab. She could have easily noticed that the blood tube was double labeled before sending it off, which could have saved the life of her patient.

Safety and Security (Emotional): Lumpkins failed to promote trust and respect for the patient and their family the moment she left the blood tubes on the counter. Lumpkins was trusted to do right by her patient and her carelessness aided in the death of her patient.

Standard Precaution: Lumpkins failed to 'dispose of contaminated materials'. Should failed to provide a clean and safe environment for her patient. By failing to identify the previous patient's blood specimen was left behind, it was mixed in with the current patient she was caring for. This resulted in incorrect testing of a specimen and the unnecessary death of a patient.

Critical Thinking: Lumpkins made a poor decision by leaving the blood specimen on the counter. Following administration of any medication you need to reassess your patient. Lumpkins failed to realize that her patient had an IV medication being administered without a pump.

Professional Role: Lumpkins failed to handle the blood specimen appropriately which resulted in the death of her patient.

- *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, I would have ensured that my patient's room was clean and free of anything left behind from the previous patient. Despite the chaos of the room, it is a provider's responsibility to ensure their patient's safety. If I had found the double-labeled specimen I would have immediately contacted everyone, blood bank, the charge nurse, the doctor, and the house supervisor. This careless mistake cost a patient their life and a family lost a loved one. I feel like this may have deserved stronger disciplinary action.

If I were the nurse who found the patient's medication was being administered without an IV pump, I would have immediately stopped the administration and notified the charge nurse. I would have retrieved an IV pump and continued the medication administration correctly. I would also notify the doctor and ask if they had any further instructions or orders for the patient regarding testing or medications due to the error.