Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Torrey Hogan Date: 10/21/2024 DAS Assignment # 1

Name of the defendant: Michelle Miller RN License number of the defendant: 763456

Date action was taken against the license: 4/21/2022 and 8/8/2023

Type of action taken against the license: RN license suspended/probation (2 years minimum) and later 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.*
    - Michelle Miller was employed as a Registered Nurse at HCA Houston Healthcare Kingwood in Kingwood, Texas. She had several charges against her including patient neglect leading to physical and emotional harm to the patient. Miller was responsible for taping a patient's mouth closed in addition to using tape to secure her hands to the bed rails. Miller claimed she did this to "prevent the patient from biting her" while removing a bleeding catheter. The actions of Miller resulted in a suspension of her RN license and she was placed on a two-year minimum probation. The defendant was also put on a "single state" license that prohibited her from working in any other state outside of Texas.
    - Michelle Miller, now working at Kingwood Pines Hospital in Kingwood, Texas, had three other formal charges against her that resulted in her license being permanently revoked. The first charge was the failure to administer insulin to the patient in a timely manner. The patient was scheduled to receive the medication at 2100, but Miller did not give the Insulin until 2316 (over two hours late). This action could have resulted in patient harm including hyperglycemia and potentially death. The second charge was failure to maintain accurate controlled substance logs. Miller removed 2mg of Ativan from the MAR, but failed to document that she removed the medication entirely and identifying information about the receiving patient. This action could have led to medication diversion, patient harm, or a medication error. The last charge filed against Miller was the failure to verify medications before administration. This led to the patient receiving double the required medication. The patient was scheduled to receive Vistaril 50mg, but Miller's failure to check the amount resulted in the patient receiving Vistaril 100mg. This action resulted in a medication error and could have led to an adverse reaction in the patient.

- *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.*

- Restrictions would be appropriate for this patient, however the actions taken by Miller were not acceptable. Miller should have sought to have an order placed for restraints and then applied them to the patient according to hospital guidelines. This would have protected the patient from physical and emotional harm, while also protecting Miller's license.
- As we learned in class, Insulin is a medication that must be administered to the patient within minutes of drawing up. Insulin is also based on either a sliding scale, routine, or scheduled order, therefore must be given to the patient on time. Miller should have ensured that the proper amount of time was set aside to administer Insulin to this patient when scheduled to do so. This would prevent the patient from being hyperglycemic. The longer a patient goes without insulin, the more dangerous and at risk the patient is for life-threatening adverse reactions.
- Ativan is a controlled substance and therefore requires questions in the eMAR that ensure medication diversion does not occur. An example would be asking for the number of Ativan tablets that are remaining in the eMAR after dispensation. It is essential during medication administration that all 7 (8 if one includes side effects) rights are checked, including the right patient. Miller should have taken the time to answer the questions on the eMAR and ensure that the patient was identified correctly. This would protect the patient from a possible medication error and would not put Miller at risk of losing her license due to drug diversion. Although Miller might not have diverted medications, there is no proof indicating where the 2mg Ativan went after being dispensed.
- As previously stated, all 7 rights of medication administration must be checked. In this situation, Miller did not check to make sure that Vistaril 50mg had been given. This also could be a potential failure to document either on Miller's part or the nurse before her. However, based on the court case, all documentation was properly filled out before administration If Miller had taken the time to verify the medication and when the last dose of Vistaril was given, the patient would not have received a double dose and Miller would not have made a medication error.

- *Identify ALL universal competencies that were violated and explain how.*
  - Safety and Security (physical)- 7 Rights for medication administration were breached. Miller failed to identify the right patient and failed to identify the right time on two separate occasions. Miller also taped the mouth of the patient and taped her hands to the side rails.
  - Documentation- eMAR medication verification was breached. Miller failed to answer questions on the eMAR related to controlled substances and patient identification.
  - Critical Thinking- Prioritization of tasks/ procedures was breached. Miller did not prioritize giving Insulin to the patient when scheduled. She took over two hours to give life-saving medication.
  - Human Caring- Treating the patient with respect and dignity was breached. This is a form of human neglect and is detrimental to the patient's mental and emotional well-being. It is a very dehumanizing action taken by Miller.

- *Use the space below to describe what action you think a prudent nurse would take as the first 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.*
  - There were several actions taken by Miller that would need immediate intervention by another nurse. If I were to see any of these actions, I would take the time to try and correct the action before the error occurred. I would ensure that all questions were answered on the eMAR, proper restraints were applied, Insulin was given on time, and the correct amount of medication was

administered by Miller. If she refused, then the proper authority would be notified. Although this seems unlikely due to most of the nurses being independent, I would be sure to notify either the CN or human resources to report Miller and what I saw. Some might call this snitching, but integrity is a vital element of nursing and these actions could cause harm to the patient. In addition, if I was to discover the patient with tape over her mouth and hands, I would take the time to remove the tape and assess the well-being of the patient. The first action I would take if I discovered that the patient was given a double dose of Vistaril is to ensure the patient is not experiencing adverse effects.