

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Olivia Samarripas

Date: 10/31/2024

DAS Assignment # 2

Name of the defendant: Megan Leigh Dutton

License number of the defendant: 886457

Date action was taken against the license: 08/13/2019

Type of action taken against the license: REVOKED

Megan Dutton was charged with eight charges (mistakenly numbered as 9), which ultimately led to the revocation of her RN license. On 9/27/2017, Megan falsely documented the start time, rate, and rate verification of Vasopressin. On 02/26/2018, Megan displayed very concerning behaviors such as slurring and stumbling, as well as other signs she may be under the use of a chemical substance. On 02/26/2018, a nurse noted that a bag of Fentanyl was empty while Megan's charting and the pump showed that there should have still been some Fentanyl remaining. During the period of 04/09/2018 – 05/01/2018, Megan pulled several controlled medications that she failed to document correctly or fully. On 04/02/2018 - 04/03/2018, Megan pulled controlled medications in increased dosages and frequencies compared to what was ordered by the physician. From 04/02/2018 to 05/01/2018, the nurse failed to document the waste of controlled medicines. On 04/02/2018 - 04/03/2018, the nurse pulled medications for a pain scale that was either not noted or was not in the ordered range for administration. On 04/01/2018 – 05/01/2018, the nurse pulled controlled medications in excess, leaving Morphine, Fentanyl, Midazolam, and Hydrocodone/APAP unaccounted for.

Megan Dutton got herself into a lot of trouble due to the mishandling of controlled substances; without making assumptions, I feel that Megan should have sought out help. In the state of Texas, the board of nursing has a program called TPAPN; this program allows you to self-report problems with drugs or alcohol. They may require routine drug testing, therapy, and stipulations around your handling of medications with a high potential

for abuse or misuse. Because of the routine drug testing (usually weekly until improvement is seen), the nurse is under constant supervision, and it is unlikely that the nurse could resume mishandling medications without it showing or without an assigned nursing peer noticing.

The universal competencies violated were safety and security, documentation, human caring, and professional role. The safety and security of her patients were violated every single time she withdrew more medication than she shouldn't have or when she pulled the medication and failed to provide it to the patient. These intentional medication errors could have resulted in catastrophic patient outcomes. Safety was violated, and Megan falsified her documentation by charting incorrect times, dosages, and frequencies. Falsifying that information could mislead another nurse into believing that the patient received more than they did. If the oncoming nurse didn't catch the mistakes, this could lead to excess pain or, on the other side of things, overdose. The professional role was violated when the nurse was seen slurring and stumbling, alongside all the medication errors. Human caring and professional roles were violated when the nurse charted that her patients got more medication than they really did. Patients are charged for every medication they take, every mL, mg, unit, or whatever it may be. The nurse essentially used the patient to purchase these drugs for herself.

If I were the nurse who discovered all these many drug falsifications, I would immediately take it to the charge nurse and the unit's nurse director. It would be imperative to contact the appropriate faculty to resolve this problem as soon as possible to ensure that the nurse couldn't cause any more harm to patients. While the nurse made severe mistakes, handling this matter with discretion would be essential to avoid making the situation any worse.