

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Rachel Williams

Date: January 30, 2025

DAS Assignment # 2

Name of the defendant: Victoria Catherine Carter

License number of the defendant: 903399

Date(s) and action(s) taken against the license: 9/10/2019

Type of action(s) taken against the license: Warning with stipulations and fine

- *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 each of them, e.g. drug diversion, HIPAA violation, abandonment, etc.*

While being employed as a Registered Nurse at St. David's Georgetown Hospital in Georgetown, Texas, Victoria Carter engaged in unethical incidents while working in the clinical setting which led to disciplinary action against her. These unprofessional incidents include: Falsely documenting the dosage of Lorazepam administered to a patient in the medication administration record, failing to administer the correct dosage of Lorazepam to a patient that was ordered by the physician, putting saline into a lorazepam vial to try to cover a mistake, and discarding of a Lorazepam vial in an unsecured bin. These incidents led to inaccurate documentation in the medication record and a patient receiving a higher dose of medication than what the physician prescribed, putting the patient in harm.

On about July 31, 2019, the nurse falsely documented the dosage of Lorazepam administered to a patient in the Medication Administration Record. The nurse documented that the patient received 1 mg of Lorazepam, however, the nurse administered 2 mg of Lorazepam to their patient. Eventually, the nurse admitted to the Senior Director of Clinical Operations that she administered 2 mg instead of 1 mg to the patient.

Victoria Carter failed to follow a physician's medication order when she gave a patient more Lorazepam than what was ordered. Nurses should always follow the physician's orders when administering medication to prevent the patient from potential harm or even death.

The nurse stated that she panicked when she realized she made an error and tried to cover up her mistake by putting saline in the Lorazepam vial. This unprofessional action would alter the care of another patient that would need Lorazepam because they would be getting saline administered to them instead of Lorazepam.

While being in a rush, the nurse added 1 mg of normal saline to the empty Lorazepam vial so that it appeared she didn't make an error. This unethical act shows the nurse is lacking professional integrity.

Additionally, after the nurse put normal saline in the vial, she didn't place the used vial in the sharps container. Placing all used needles and vials in the sharps container is standard clinical policy for safety and to mitigate potential drug diversion.

In conclusion, Victoria Carter proved to be negligent towards her patient's safety, and acted unprofessionally by not following hospital policies.

- *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.*

There are various measures that the nurse could have carried out to prevent her patient from potentially being at risk and from her facing disciplinary action towards her RN license. To begin with, the nurse should not have falsely documented the incorrect dosage of Lorazepam that was administered to the patient. In doing so, the patient is put at risk because other healthcare workers who might continue care later wouldn't know the actual amount that was given to the patient beforehand. The nurse would have been protecting the patient from future harm if she had correctly documented the dosage that was administered to the patient.

Ms. Carter administered 2 mg of Lorazepam to a patient even though the patient's physician ordered 1 mg. Giving patients medication in excess could put the patient at risk for adverse effects, overdose, or death. This could have been prevented if the nurse had administered only the amount of medication that was in the order from the prescriber.

By adding normal saline to a drug vial, the nurse is putting other patients who may need Lorazepam at risk because other healthcare workers wouldn't know that the vial was altered or replaced with something else besides the drug that it is supposed to be. This could have been prevented if the nurse chose to not put anything back into the vial and notified the charge nurse of the error she made right away.

Finally, the nurse would have been following clinical policy by disposing of a medication vial in the sharps bin instead of an unsecured bin.

- *Identify ALL universal competencies (4-5) that were violated and explain how.*

Safety and Security was violated when the nurse administered their patient more medication than what was ordered. The nurse further violated safety and security by falsely documenting that the correct dosage was given to the patient when it was not.

Standard Precaution (Asepsis) was violated when the nurse didn't dispose of a used vial in the sharps container but instead disposed of it in an unsecured bin.

Critical thinking was violated when the nurse chose to put normal saline into an empty vial of Lorazepam. When the nurse realized she made a medication error she should have taken responsibility for her action instead of trying to cover up her error.

Professional Role was violated when the nurse didn't adhere to hospital policies or maintain an ethical standard of practicing for which a registered nurse license depicts she is qualified to do so.

- *Use the space below to describe what actions 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 witnessed a nurse injecting normal saline back into a Lorazepam vial I would notify the charge nurse or supervisor about the nurse's unethical occurrence and would insinuate that the patient be closely monitored for adverse effects since receiving Lorazepam in excess to what was ordered. I would also discuss with the nurse the dangers that this action could put other patients in if they were to be administered a vial of normal saline when they would need Lorazepam instead.