

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Sadie Portillo

Date: 01/31/2025

DAS Assignment #2

Name of the defendant: Jami Warner

License number of the defendant: 913835

Date(s) and action(s) taken against the license: 09/18//2018

Type of action(s) taken against the license: Suspend/Probate

- *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.*

Jami Warner was a registered nurse at Longview Regional Medical Center in Longview, Texas. On or about April 5, 2018, during her shift, she had a medication order for Cardizem, and the registered nurse thought the medication order looked odd, but unfortunately, she did not take the necessary steps to clarify the dosage with the prescribing physician or the pharmacy. As a result, she mistakenly administered 1440 mg of Cardizem to the patient instead of the prescribed 60 mg. This medication error led to the patient's health being put at risk since it was an overdose of the medication.

- *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.*

For this significant medication error that unfortunately led to the patient's death, one of the main things this registered nurse could have done differently is to double-check the medication order as soon as it seemed questionable to her. Most importantly, she could have called the physician or consulted with the charge nurse for clarification. If this registered nurse felt uncertain about the medication order, especially concerning a large dosage of a cardiac medication, she should have never proceeded with administration without verifying it first. I believe that reaching out to the physician or having the charge nurse review the order could have prevented this tragic situation.

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

The universal competencies that were violated during this incident were safety and security (physical), communication, and critical thinking.

Safety and Security (Physical) was violated when this RN failed to follow the seven rights of medication administration. She reviewed the order but immediately recognized that it looked unusual, which should have raised a question in her mind, "Is this the right dose?" Despite her concerns, she proceeded to administer the large dose, and unfortunately, the patient passed away.

Communication was violated when the RN failed to effectively communicate with her team members and utilize available resources to ensure medication rights and patient safety.

Critical Thinking was violated when the RN failed to critically assess the situation regarding the unusually large dosage of medication. She did not consider the potential effects that such a high dose could have on the patient, nor did she take the time to double-check the medication order with a team member.

- *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.*

In this situation, if a nurse noticed the RN reading the medication order and observing something concerning, but she still proceeded to prescribe it, a prudent nurse would intervene by stopping her and double-checking the medication order. In another scenario, if a prudent nurse discovered that the RN had already administered a large dose of cardiac medication, they would notify the charge nurse, contact the physician, and call a rapid response team. Although it appeared that the RN followed the proper steps after noticing the patient was going into respiratory failure, the large amount of medication given resulted in the patient's death. It was crucial to identify this error before the medication was administered.