

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Kia Warren

Date: 01/18/2025

DAS Assignment # 2

Name of the defendant: Stephanie Ochoa-Neeley

License number of the defendant: 645254

Date action was taken against the license: 09/12/2023

Type of action taken against the license: Warning with stipulations and license inactivated

- *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*

Stephanie Ochoa-Neeley was working as a registered nurse in the Medical Intensive Care Unit at Dell Seton Medical Center in Austin Texas where she had been for four years. On August 28th 2021 Stephanie inaccurately documented the Versed rate for a patient. She documented a rate change from 22mg to 11mg but when the oncoming nurse received report the pump was still running at the previous 22mg setting. Stephanie had inaccurately documented the administration of Lasix on the same patient that day. She documented that she had administered the medication at 0600 but had not actually given said medication until 0719.

On August 30th she documented that she had administered potassium to the same patient at 0600 but did not actually give the medication to the patient until after the oncoming nurse had arrived. On September 13th she inaccurately documented multiple different sedation, paralytic and vasopressor rates on two separate patients. There were also several medications found within the room but were documented as given in the patients EMAR.

Stephanie accepted responsibility for these medication errors. She stated that after a work-related injury in August 2019 that resulted in surgery in February 2021 she was unable to return to work until August 2021. Stephanie stated that her unit had changed immensely during her absence and these medication errors occurred shortly after her returning.

- *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.*

Stephanie should have documented the medications she was giving as she was administering them to prevent falsifying documentation and ensuring correct medication administration protocols. She should have also ensured changing the rate on the pump so that she was correctly documenting the new changes to the medication orders. It is very important that your documentation is accurate, and all dates and times are current so that these situations are avoided all together.

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

Safety and security was violated because Stephanie was not accurately administering these medications at the bedside. This violated the patients' 7 rights for medication administration.

Communication was violated because Stephanie was inaccurately reporting certain drip rates that were actually never changed. On top of this she was documenting certain medications as administered when in reality they were sitting at the patients bedside not given.

Critical thinking was violated because she failed to evaluate the drip rates and continuously documented them incorrectly.

Documentation was violated because she was documenting medications early and not actually giving them until later causing falsified documents. She was inaccurately documenting drip rates and failing to comply with proper guidelines for documentation.

Professional role was violated as well because she was not acting professionally within her role as a registered nurse. She continuously failed to use the proper protocols when administering medications to patients.

- *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.*

As a prudent nurse i would expect these issues to be corrected. If I were the one to find these errors I would ensure leadership was notified and maybe more training might be needed for a nurse that is failing to comply with basic interventions within her role. I would ensure the patient was not harmed due to improper medication dosing and change the pump rates to what is ordered immediately and then assessing the patient for any possible harm due to the medication errors. It is important that proper education be given after incidents like these.