Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Yari Lopez Date: 1/28/2025 DAS Assignment #2

Name of the defendant: Kasi Jo St. John, RN License number of the defendant: 905576

Date(s) and action(s) taken against the license: 3/10/2020

Type of action(s) taken against the license: Warning with Stipulation

- *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.*

Kasi Jo St. John, RN at the time of the incident was employed as a Registered Nurse at the Medical City McKinney Hospital, in Mckinney, Texas for an estimated one year and two months. During her time in her position, a very unprofessional judgment led to a charge of warning with stipulation. Kasi's incident occurred on December 23, 2017, she was responsible for a patient who was seeking "medical care for possible stroke with right-sided weakness, being unable to speak, and drooling". As this patient has a health history with multiple conditions that could be evaluated in our patient's chart, Kasi presented that the patient's main objective was their current condition. She administered Tissue Plasminogen Activator (TPA) without a provider order, which also was incompatible with all other health history conditions the patient has experienced. TPA is a protein that is used to break down blood clots that block blood flow to the brain, adverse effects include bleeding from puncture sites and wounds, coughing up blood, and difficulty with breathing or swallowing. As this patient recently underwent a procedure of cardiac catheterization for a non-STEMI and has a history of GI bleeding indicates that the best course of action should be prioritied what the physician ordered not from intel on the family and physician conversation. Kasi stated, "The patient's wife verbally consented to the TPA, and all contraindications were checked prior to administration." and also noted that the physician also communicated about the drug to the patient's wife. The main objective was that no physical drug order was placed and violated the 7 rights for medication administration of the first check which is order to mar, and the third check, med and mar at bed which concluded in a med error. This action goes violates "22 Tex. ADMIN. CODE 217.11 (1)(A), (1)(B), (1)(C)and(3)(A) as well as 22 Tex. ADMIN CODE 217.11 (1)(A), (1)(B) and (4). The stipulations required from this action taken against Kasi's RN license included: A board-approved course in Texas nursing jurisprudence and ethics course, A board-approved course in medication administration, and the last course that must be completed the "sharpening critical thinking skills" course.

- *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.*

The drug that was administered, Tissue Plasminogen Activator (TPA) also includes labs such as PT/INR levels, hemoglobin as well as platelet. Guidelines of "administration is only contraindicated if the hemorrhage occurred within 21 days.", vitals to be accounted for are blood pressure, as " blood pressure greater than 185 is contraindicated." The factors should have been accounted for in Kasi's actions of method. Being treated for a stroke but also having the history presented with the patient's best course of action can influence the best order of steps to prevent any future complications. As there were no stated indicates that no harm was done to the patient during this medication error the crucial thought of other outcomes is very worrisome, the thinning of the blood and having an open procedure recently prior to their visit roots for a hemorrhage. Kasi could have taken multiple different measures to prevent this medication error from happening. Kasi's first course of action could have been to communicate with the primary care physician the best nursing practice he wanted her to take whether that was to draw more labs, monitor blood pressure, or comfort the family until further notice. I would have personally contacted the primary care physician and clarified that the drug in question would need any further testing that requires me as the nurse to perform whether that included least invasive such as blood pressure to more invasive such a blood specimens. As the blood pressure medication, Labetolol was stated to have been administered noted no unlawful action occurred during that medication administration, and that medication could be the key factor that keeping the patient's blood pressure within range. As the provider ordered that medication I could have gathered more pharmacological knowledge of these drugs and helped gather my thought process of the compatibility of TPA. There are three checks for medication administration, I would have also questioned myself if I had performed the three checks, if I had also checked compatibility, and contacted the provider. As Kasi used her last check being her charger nurse, and another nurse in the end, it's our responsibility we use our third check at the bedside which would have halted the medication from being administered.

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

  Safety and Security (Physical): was violated when the RN had broken safety for the patient, violating the 7 medication rights of administration. Kasi failed to be able to identify any of the 7 rights due to there being no order but still committed to follow through with med administration.

  Communication: was violated when Kasi failed to communicate with the physician about a method of action for medication administration. Lack of communication resulted

in violating the agency protocols for patient-centered care and resulted in her unlawful actions of administering a medication that had no order.

Critical Thinking: was violated when the RN did not take into account the patient's health history. The medication Tissue Plasminogen Activator was discussed with a family member but didn't indicate that the physician had placed the order to confirm that was the best method of action for the patient that violated "decision making." As listed TPA could have helped the present condition, the history needed to be accounted for therefore violating another aspect of "evaluation and revision of interventions."

Documentation: was violated in an indication that if the RN had scanned the medication she was administering, Kasi would have viewed there was no order for TPA and would have prevented the medication error.

Professional Role: Kasi was held accountable for best nursing judgment but lacked knowledge of her unprofessional role in the action of taking on the final decision. These discrepancies fall under professional role which was violated when the interaction with the family member, charge nurse, and another coworker was in a position of authority of the best action and missed the interaction with the physician led to violation of action outside her scope of practice.

- *Use the space below to describe what <u>actions</u> 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.*

The main course of action as a coworker, I would have to question which medication was being administered to understand why that medication needed a witness. As working on a floor you are a team, I have witnessed that even though you're assigned to certain patients a thoughtful nurse has an idea of what each patient is there for. If I had seen TPA being administered I would have questioned my coworker about the compatibility and what is the reason for the medication which could have prevented the medication error from happening. If the medication error happened and I had noticed it after the fact I would take my first case of the action of checking on the patient since the pharmacological knowledge about this drug can have life-threatening effects. I would then notify my charge nurse and obtain the patient's vitals and any other required assessments that my charge nurse would need me to perform before contacting the provider with a complete SBAR and processing from there as ordered.