Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Andrea Egert-Perez Date: 1-29-2025 DAS Assignment # _2_

Name of the defendant: Susan Mumbai Wikina License number of the defendant: 933571

Date(s) and action(s) taken against the license: September 8, 2020

Type of action(s) taken against the license: Reprimand with Stipulations

- *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.*

  This nurse had four medication errors on one patient that caused the board of nursing to take action and reprimand her with stipulations. The nurse was taking care of a patient on September 10, 2019 when she failed to administer four medications correctly. This happened in Denison, Texas at Texoma Medical Center. The nurse reported she was in the room with the patient and that she already scanned the patient's band and entered in the EMAR the medication was given. The nurse reported she went through the 7 rights of medication administration with the patient and the family when the patient's daughter asked if the medications could be held until she was done feeding the patient. The nurse reported "yes" and left the medication in the room with the family members. The first medication that was supposed to be given was Tramadol. This medication was shown to be given in the EMAR system, but was found in the patient's room on the bed side table. The other medication was Namzaric, which is a extended release medication for Alzheimer's. This medication was also shown being given, but the capsule was found pulled apart with the medication not being in it. The nurse reported that she explained the way the medication was supposed to be given and that after patient was fed, the daughter administered the medication.The third medication that was supposed to be given was called Rythmol, this medication is shown to be given for irregular heartbeats. This medication was supposed to be administered at 2100 but the nurse delayed treatment and administered the medication a little over five hours later at 0117. The nurse reported the delay in administering this medication was due to the medication not being available in the Pyxis. The nurse reported, she contacted the pharmacy and asked for the medication, which was sent but another team member retrieved it and did not inform her. This process took hours and that was the reason for the delay. The last medication that was supposed to be given was Ativan. The nurse administered the medication even though the patient was found to have decreased level of consciousness. In the report she wrote she took the medication out of the EMAR but how it was written it was unsure if she gave the medication once or twice due to having to scan another vial after she lost the first one.

- *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 first issue was that the nurse documented that she gave the patient their medications, however, she left the medications in the room. There were several medications that needed to be given in a timely manner and a certain way. By leaving them in the room, she left it up to the family to give them. There is no way she knows if the patient ever received them or if the family took them. The patient also was given Ativan even with an altered level of consciousness. This could have resulted in harm to the patient. A prudent nurse would have more properly handled all of these medications and only scanned and documented administration when the medication was actually given.

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

  The universal competencies the nurse violated were the safety and security (physical), critical thinking, and documentation.

  Safety and Security (Physical)

  The nurse violated the physical aspect in safety and security because she did not properly follow the seven rights for medication administration. The nurse reported she informed the family of the right patient, drug, dose, time, route, reason, and documentation. Although, the nurse never administered the medication due to the family member asking to wait due to the patient eating. The nurse reported giving the medication, except she left the Tramadol on the bed side table next to the patent with a family member in the room. Tramadol is a scheduled PO drug and needs to be seen given and witnessed by another nurse that the medication was given. The other medication Namzaric was also supposed to be administered and the nurse reported in the EMAR that she administered the medication but did not. The medication was withheld due to patient eating, the medication was left in the room and the nurse explained to the nurse how the medication was supposed to be given. The patient's daughter administered the medication by taking the substance out of the capsule and administering it to the patient. The nurse failed to advocate for her patient and placed the patient in danger due to the medication being an extended release and given all at once. By giving an extended release medication, it puts the patient at risk for overdose due to all the medication given at once. Also, the nurse did not administer the medication, she allowed an unlicensed personal (daughter) give the medication. The third infraction was the Rythmol. The nurse failed to give the medication in a timely manner when it was scheduled. This can harm the patient due to administering it late and the next dose was supposed to be given in a few hours. This could cause an adverse reaction and cause the patient to have toxicity. The last medication was a controlled substance called Ativan. This medication was given while the patient had an altered mental status. The medication has side effects of respiratory depression, altered LOC, and hypotension. By giving this medication with already an altered mental status, there is a significant risk of these side effects occurring.

  Critical Thinking

  In critical thinking, the nurse violated the decision making in medication administration and prioritization of task and procedures. The nurse made the wrong decision on leaving the first two medications in the room with the family present. If the family told the nurse to withhold the medication after feeding the patient, then the nurse should have taken the medication back to the medication room and reported the medication was not given and documented why. On the third medication, the nurse failed to prioritize her time and gave the medication 5 hours after the doctor ordered.

  Documentation

The nurse failed in documentation due to reporting in EMAR that the medications were given even though they were not at the time. Also, the nurse never documented that the patient had an altered mental status before giving the Ativan.

- *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.*

  If I was the nurse that discovered the Tramadol on the table and the Namzaric capsule that did not have the medication in it, then I would have immediately reported it to the charge nurse. I would also fully assess my patient to make sure there was no harm done to the patient. I would then write a report to the nurse supervisor due to the medication being a scheduled drug. Lastly, I would call the physician and receive direction on when to resume scheduled medications.