Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Rachel Hernandez Date: 3/31/25 DAS Assignment # 1

Name of the defendant: Jamie Maria Luckey Johnson RN. License number of the defendant: 927236

Date(s) and BON decision(s) taken against the license: 11/8/22 License Revoked

Type of action(s) imposed to retain or regain licensure, if applicable (ex.: warning with stipulations, etc.)-

Jaime Maria Luckey Johnson had numerous charges against her nursing skills that were unsafe, unprofessional, and unreliable in a hospital setting. These actions include failing to administer electrolyte replacement for a patient, failing to administer Humalog to a patient with incorrect documentation of that medication, faulting to administer a continuous intravenous fluid as ordered, not intervening when the patient had little to no urinary output the whole shift, failed to re- site the peripheral intravenous access, not following through a standing order from the physician, incomplete documentation for repositioning a patient, failing to administer medication for a patient with a low potassium level, as well as not documenting rounds. These actions led to the license being revoked and when charged with these failed to show up to court.

Charge 1 was failing to administer electrolyte replacement for the patient when it was ordered and put this patient in jeopardy. This was essential since the patient's potassium levels were considered low and was also on a diuretic. It states, "exposed the patient to a risk of harm in that failure to administer medication as ordered by the physician could have resulted in non-efficacious treatment of the patient" (BON pg.4 2022). This medication was ordered for a reason and was required to aid in the patent for their low potassium. This is negligent because of the absence of not providing the patient with their correct medication as well as a medication error.

Charge 2 was another failed medication administration. The nurse did not administer 3 units of fast acting insulin. It was reported the patient had a high glucose level of over 200 and the nurse scanned it, but did not administer it. Along with incorrectly documenting that the medication was given. The goal was to lower the patients' blood glucose levels and failing to do so could give the patent serious health complications. It could have been potentially life threatening if the blood glucose were not controlled. When other health professionals read the patients chart and see that the medicine was given, they are reading false information. This led to incomplete records and can cause incorrect future treatment plans. In addition, the nurse left the syringe and that vial of medication on a computer keyboard. This is concerning because as a nurse you do not leave medication unattended or at the patient's bedside.

For charge 3 the nurse failed a third medication administration for a continuous intravenous fluid that was ordered by the physician. The patient could have needed this intravenous fluid for a few reasons if it was nutritional support, dehydration, or maintaining fluid balance. All are critical in caring for the patient.

Charge 4 was failing to interfere with a lack of output of urine. In the text it states, “the oncoming shift performed a bladder scan on the patient and found over 800 mL of retained urine” (BON pg. 5 2022). A patient that retains that much urine is having difficulty urinating naturally and may need a urinary catheter in place. In which the other shift ended up doing so to help relieve the patient. This extended the patient stay in hospital and put distress on the patient.

Charge 5 the nurse did not re-site a peripheral intravenous access. Failure to do this could lead to many serious health complications. Putting the patient at risk for harm and discomfort. The individuals’ needs were not given correctly and ultimately exposed the patient to many problems.

Charge 6 was neglecting to proceed with a physician’s standing order. The order was over a patient that had hypoglycemia with a blood glucose under 60. This action is liable for life threatening situations and is damaging to the patient’s body. This order was crucial for the patient and will result in negative outcomes. Including inadequate treatment and medical negligence.

Charge 7 the nurse failed to document the turning and repositioning of the patient that had a high Braden Score. If it was not documented, it was not done. Not adequately documenting the nurses’ actions negatively affects the quality of patient care. Other members of the health care team will not know whether something was done or not if it was not stated and cannot give sufficient care decisions for the patient.

Charge 8 was regrettably another unsuccessful medication administration. Potassium was ordered by the physician to give to the patient who had a potassium below 4. To aid the patient the medication should have been given at a certain time and not doing so is bringing harm to the patient. Potassium is essential to the heart and not giving the patient their medication brings future complications and negatively impacts the patients’ health.

Charge 9 was given because of failing to document rounds once the nurse enters the patient’s room. There was a period of nine hours that was not documented throughout the day. During that long of a shift many things can occur to a patient and their health could change drastically at any time. Failing to document the patients’ health could give misunderstandings to the health team and affects treatment plans. Lacking essential information gives gaps in patient care and results in inconclusive findings in the future.

There are many measures that could have been taken to prevent these unfortunate situations from occurring. Many of the charges were from failing to administer medication to the patient. Doing all three checks at the pyxis, eMAR, and bedside to ensure you have the correct medication for that specific patient. As well as do not document before you give a medication that is falsifying an action that was never implemented. It is best to document after you give medications right at the bedside. Disposing of medication correctly is crucial and leaving medications around is dangerous and unprofessional. Checking on the patient every time the nurse enters the room is vital to observe any changes in their health from the last time they were checked on. In the instance for charge 5 not re-siting the peripheral intravenous for access could cause serious health complications. Paying attention to verbal and non-verbal cues will let the nurse know what could be going astray for their patient. Adding or double-checking steps the nurse takes could be the difference between putting the patient at risk or benefitting them.

Competencies that were violated were Safety and Security, Professional Role, Critical Thinking, and Documentation.

For Safety and Security violation the RN did not follow through with the 7 rights of medication administration. Not providing the necessary measures to give the medication correctly along with false documentation was illicit and inaccurate.

Professional Role violation was when the RN did not manage supplies efficiently and safely. The RN left medication unattended and did not act in accordance with what the physician ordered. As well as not maintaining clinically competent care.

Critical Thinking was not used when the RN did assess the patient when a patient had no urinary output the whole shift and chose to completely disregard it. Along with inappropriate decision making concerning the patients' health and safety.

Documentation was another violation because the RN administered medication and did not document that it was given. As well as vice versa documented the medication was administered except never gave it to the patient ultimately. This fraudulent activity can lead to serious harm and deathly consequences to the patient.

If I was the RN and discovered another nurse was not fulfilling their duties safely and appropriately. I would let the charge nurse know and explain what I saw and let the primary physicians know as well. Next go to their patient's room and ensure that they are safe and taken care of. By looking at their chart see what was done and not done to help the patient and attempt to fix what was needed the best I could. Then I would ask the RN what was going on and why they made this mistake. Maybe the RN needed help and chose to neglect their patients instead of asking. If they continued to practice as a nurse, I would report them to the Board of Nursing or let my charge nurse be aware as well.

Work Cited

Thomas A Katherine. "*Before The Texas Board of Nursing Eligibility and Disciplinary Committee*". May 10, 2022.

https://www.bon.texas.gov/discipline_and_complaints_disciplinary_action_042023.asp.html