

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Taylor Johnson

Date: 4/4/2025

DAS Assignment # 1

Name of the defendant: Bonnie Lou Garcia, RN

License number of the defendant: 606226

Date(s) and BON decision(s) taken against the license:

7/18/2024 Probated Suspension

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

Nurse Garcia was placed on a Probated Suspension with the following courses required:

A Board-Approved 6hour course in Texas Nursing Jurisprudence and ethics

A Board Approved 6-24hour course in Medication Administration with the clinical component focusing on proper medication administration

A 3hour contact course "Righting a Wrong"

A 5.5hour contact course "Upholding the Standard: Professional Accountability in Nursing"

Employment Requirements were also placed on Nurse Garcia requiring for the next 2 years she must work for a minimum of 64 hours a month, and any unemployment or employment that does not require Nursing Skills would not be eligible for the time period. Nurse Garcia is required to notify all present employers and any during the 2-year probation of this Order and provide to them, each employer will have to notify and verify with the board of her employment as a nurse, each employer shall designate an indirect on-site supervisor for Nurse Garcia while working and submit a performance evaluation for each quarter of her nursing abilities for the duration of time that she is on probation.

Nurse Garcia's license was reduced to a single-state license restricting her to Texas for employment.

- *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.*

On 8/7/2023, Respondent, Registered Nurse Bonnie Lou Garcia, made a medication error and caused severe harm to a patient. Nurse Garcia began an IV bolus of Precedex via IV pump, by only entering the duration of the infusion and not the correct rate. Nurse Garcia bypassed the alarm indicating there may be an error, and did not verify and visualize the screen after initiating the infusion. This medication error caused severe harm to

the patient by bolus infusing 400mcg of Precedex, a sedative medication, instead of the ordered amount of 24.5mcg of Precedex. The patient went into cardiac arrest and could not be revived.

- *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.*

Measures to be taken in this instance would be the numerous medication checks, and using the pump correctly. Nurse Garcia's response to the incident takes no ownership or accountability. There is blame put on the system, the IV pump, and the hospital training. Taking ownership of her actions and ensuring proper training would be my first measure in this circumstance. Patient safety is top priority, and an excuse of "staff not being trained to enter a rate on any IV infusion" and depending on the machine to "calculate the rate automatically" does not adhere to nursing standards for patient safety. Ensuring that she was comfortable, confident, and safely utilizing the pump the way it was intended, while also not bypassing the alarm and completing medication errors, that was indicating an issue, may have prevented the demise of the patient.

- *Identify ALL universal competencies (4-5) that were violated and explain how in detail to reflect your understanding and importance of the universal competencies.*

### **Safety and Security (Physical)**

This was violated by not following the 7rights for medication administration. There are numerous checks in place for medication administration up to and including at the IV pump. Nurse Garcia did not verify the dose (rate) for the patient, and bolused more than 16x the amount of medication intended. Medication Errors are far less likely to happen by following the 7rights, following all med checks, and ensuring that the nurse is competent in performing this task.

### **Critical Thinking**

This was violated by not using proper decision-making. Nurse Garcia made the choice to bypass an alarm and not verify the medication correctly. This was also a breach of clinically competent care. She was not competent in using an IV pump appropriately and did not ask for help. Being able to think critically and competently is vital in nursing for the safety of our patients

### **Professional Role**

This was violated by not managing the IV pump efficiently, and by not reaching out to management about proper training on the IV pump prior to using it. The bypass of the alarm and not validating settings and infusion rate resulted in the death of a patient. This could have been avoided through following the steps to be educated properly. This is vital in ensuring patient safety.

### **Communication**

This violation is not a communication error with the patient, but with the hospital management and coworkers. Communication about professional responsibility in education on the proper way to administer a medication via an IV pump in or out of the drug index programmed into the pump. This is vital in ensuring patient safety.

- *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.*

If I was the person to discover the patient and error I would stop the infusion and call a code. Once no longer working the code, I would verify the med amount given, and communicate with the charge nurse. Together an incident form would be filled out, as well as documenting the sequence of events from finding the patient, stopping the infusion if still running, calling and completing the code, to notifying the charge nurse. I would speak with Nurse Garcia to understand the disconnect and the WHY, educate where appropriate on proper IV pump usage,