Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Crystal Melendez Date: 8/4/19 DAS Assignment # ____1____ (1-4)

Name of the defendant: Cherie Yvette Adams License number of the defendant: RN 536967

Date action was taken against the license: Sep. 08, 2015

Type of action taken against the license: Warning with Stipulations

Use the space below to describe the events which led to action 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.

Cherie Yvette Adams was a registered nurse at Osteopathic Medical Center in Fort Worth, Texas. She had been employed for about eight years on the Med/Surg floor when her first incident occurred. Adams was administering a 25mg dose of Demerol for her patient at 0307, but failed to correctly document the time it was actually administered. Instead she recorded the medication at 0250 which increases the risk of liability issues for the hospital and nurse, too. The following day, Adams again, made a mistake with the same patient's medication administration record. She withdrew another dose of 25mg of Demerol and didn't document the administration on the patient's MAR or Nurses Notes. This mistake puts the patient at risk of overdosing since there is no written proof that it was administered. The final incident occurred two days later, as Adams falsely used a nurse's name to state as a witness to wastage of Morphine for another patient. This occurred twice that day, one at 0249 and another at 0625. Adams put the hospital at risk again in violation of guidelines and regulations towards the proper removal of controlled substances.

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.

If Adams would have documented the correct time in which she first administered the 25mg dose of Demerol to the patient, these charges against her licenses wouldn't be existing today. However, there was a 2nd medication administration error made on the exact, same patient which makes me question if she had a motive to harm the patient. Adams did not document the administration of another dose of Demerol nor did she write it down in the Nurse Notes. This error could have been easily prevented if she would have documented everything properly. Adams's 3rd offense is one where she wrongly used another nurse's credentials as a witness of wastage of Morphine. She could have used her pager to call a nurse before she withdrew the Morphine instead of lying.

Use the space below to describe what action you think a prudent nurse would take as the first 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 nurse it is our responsibility to effectively care for our patients. If I was a prudent nurse in this hospital facility, I would have first questioned the administration of the medication and asked if everything is going well. There was a dose of Demerol that was not recorded on the patient's MAR or Nurse Notes. This would have been a good opportunity to ask what happened before it is brought to the Charge Nurse. As for the false witness to wastage of Morphine, I believe this event requires the Charge Nurse to be involved immediately since it occurred twice and could create bad habits and problems.