Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Olivia Smith Date: 10/1/2021 DAS Assignment # _1_____ (1-4)

Name of the defendant: Sally B Grant License number of the defendant: 619634

Date action was taken against the license:

Type of action taken against the license: Revoked

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.

There were several formal charges brought up against the nurse. The first charge states that the respondent showed visible signs of impairment including fatigue, weakness, sleepiness and poor boundaries. The next charge accused the nurse of being under the influence of alcohol while making a home health visit. This particular visit ended with the local police department being called and the nurse having to ride home with an officer because she was too impaired to drive a vehicle. The third charge included the nurse being visibly impaired again and slurring her words and rambling then stating, “I sure am glad that patient died so now I don’t have to go over there.” The nurse had one more charge brought up against her citing that she was impaired while working. The final charge the nurse had a positive urine sample for Morphine, Oxazepam and Nordiazepam.

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. Consider which universal competencies were violated.

There were several universal competences broken in this case. Being impaired while nursing is unacceptable behavior and can lead to an abundance of issues in providing safe quality care. In this case the nurse essentially abandoned her patient because of the fact that she had to be escorted home by a police officer from a home health visit. While it is unclear from the order of the board if she had completed the visit or not it is not unfair to assume that things were not done properly throughout the visit. This is a violation of human caring because she was unable to adequately listen to the patients needs and spend the needed time with the patient. This also affected her professionalism throughout her visits specifically with the comment made about being glad a patient had died. This is highly unprofessional and also a HIPPA violation. The Nurse should never had brought up the detail of another patient with the patient and or family of the patient she was with at the time. Also this could bring up the question of her willingness to help her patients. If I was a family member hearing a comment like that from the nurse who was supposed to be taking care of a loved one of mine I know

I would not trust her. The final straw was the positive drug test. Having illicit drugs in your system as a nurse is unacceptable. It can also mean that the nurse was potentially diverting drugs and not documenting on her patients appropriately. It is sort of mind boggling to wrap my head around the sheer volume of complaints against this nurse before action was taken. I think maybe offering her a peer to go with her to her clients homes could have helped to guide her in performing safe practices but I'm not even sure if that would have worked. I think counseling and remediation should have happened before the situation got as bad as it did and it is not clear if that was offered to her or not. But in all honesty in this case it is clear the nurse should not be licensed because she demonstrated a clear lack of regard for her patients and their wellbeing.

Use the space below to describe what action 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.

A prudent nurse should have immediately reported the incidents to their supervisors and it should have been handled within the company prior to the situation repeating itself multiple times. The fact that the nurse was able to continue meeting with clients alone even after having to be driven home by a police officer is unacceptable and if upper management was not addressing the situation it should have been reported to the board sooner. I think in this case it is more black and white than others and I would have reported and reported her to my superiors and their superiors until someone took me seriously. Even if that means I am the one reporting the situation to the board.