Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Rafael Alegre Date: October 16, 2021 DAS Assignment # 4

Name of the defendant: Debra Lynn Frankhouser License number of the defendant: 940147

Date action was taken against the license: November 10, 2020

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.

In October 2019, while working for Covenant Medical Center, Ms. Frankhouser has made multiple errors. **Her first error** was the 1st of October 2019 where she failed to document the administration of 4 mg Morphine in the MAR or the nurses' notes. Her inaction to document might cause the other nurses to administer without prior knowledge, which may lead to overdose. **Her second error** was two days after her first error October 3. She placed a normal hub device instead of a clave needless connector on a patient's port-a-cath. **Her third error** was on the same day wherein the used a non-sterile towel to apply pressure on a newly discontinued central line.

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.

In her first error, Ms. Frankhouser defended herself by stating that she has scanned the morphine but have the computer might not have saved it. To avoid this incident, always double check after scanning and administration of said medications.

In her second error, the defendant notes that the patient's lines should have been de-accessed since the patient decided to cease life-saving measures. The swab cap was used since the line was open and patient wanted to shower. In this scenario, I agreed with her judgement. However, after the patient has showered, the nurse should have immediately replaced the hub cap with a Clave.

Her third error, the defendant states that upon removal of central line, the patient bled profusely, and the sterile gauze used was soaked. She asked another nurse for a gauze, but the nurse handed her a clean wash rag. Her action might cause a severe risk for infection to her patient. Although she wanted what was best for her patient, the defendant should have declined the use of the clean wash rag and insisted that the nurse gave her a bunch of sterile gauze.

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.

As a prudent nurse that discovered that my nurse failed to document drug administration, I would immediately report her to my nurse leader. On that note, whenever I am giving a medication, I must always double check if a prior drug was administered and what time it was given. If there were no records of administration, always be vigilant and always consult the previous nurse or your direct supervisor. As for the hub cap usage, I would immediately advise the defendant to replace the hub cap with the proper one. She might only have done so as a reaction of seeing her patient in the bathroom. As for the usage of a clean towel, a prudent nurse would and should NEVER give a clean towel as an alternative to sterile gauze. Central lines need to be kept sterile and a clean towel is no way sterile. The defendant should also have not accepted the clean towel.