

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: **Angelique A. Fuambu**
____2____ (1-4)

Date:5/13/22

DAS Assignment #

Name of the defendant: **Cynthia Anne Fleming**
RN 927563

License number of the defendant:

Date action was taken against the license: **May 31, 2018**

Type of action taken against the license: **Suspended upon proof of Ms. Fleming entry in contact with the Virginia Health Practitioner's Monitoring Program, or an alternative program in Texas.**

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.

On May 31,2018, multiple charges such as drugs (Narcotics drugs) diversion, and lies were place against Cynthia Fleming; Register Nurse working at the Mary Washington Healthcare facility in Virginia at the time the incidents happened.

From December 25,2015 – December 26 ,2015, on three separated occasions, Cynthia withdrew Dilaudid IV 1mg (hydromorphone, C-II) for the patient A, who was ordered to receive Dilaudid IV 0.5 mg every fifteen minutes PRN. On each, she documented given 0.5 mg but never get another to witness the remaining 0.5 mg of the medication being wasted or nor documented what she did with it.

Few days later, on December 28 ,2015, Cynthia withdrew ordered morphine IV 4 mg (C-II) for patient B, she failed to document administration of the drug and at the same time failed to document if the medication was wasted or return to the medication room.

On December 30, of the same year, She withdrew ordered Valium 5mg (Diazepam (C-IV)) and Percocet 5/325 mg (Oxycodone and acetaminophen, (CI)) for patient

D. Cynthia still did not document the medication wastage or the return to the medication room.

On January 3,2016, Cynthia withdrew Ativan IV 2mg for her patient C who had be ordered Ativan 1mg to be given PO. She gave 1 mg IV instead of the PO and never documented that is was given or mention what happen to the rest of the medication.

The next day of the same year 2016, Ms. Fleming another Dilaudid 1mg for Patient E, but never gave it and still did not document wastage or return to the pharmacy or medication room.

AS a result of all these incomplete medical records, a suspicion drug screen revealed Ms. Fleming positive for morphine, and therefore get her employment with Mary Washington Healthcare terminated.

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.

During Ms. Fleming 's first medication administration in May, she violated the rule of medication administration on the protocol to follow when giving narcotics. She should have had a second nurse comes in the Medication room with her to witness the wastage of the 0.5 mg of narcotics that was not used.

Parallelly on the same month of December ,2015, she withdrew her patient Medication and did not give it, since she took the medication and did not document, this action put the others nurses taking care of that patient to not know how to follow up with the care, or to evaluate the changes and more to know if their goals were being met or not. As a professional, it is important to document every intervention that is done to the patient, so they can be able to determine if the patient is getting better or if they should change the plan of care on that particular patient.

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.

If I was the first person to have discovered that Ms. Fleming too withdrew narcotics medications and did not give the correct dose and did document, I

would have been very concern about those patients safety and outcomes since, nothing was document, this shows that no care was being provided . I would have reported to my direct chief of command (my Charge Nurse) and let them take the next action.