

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Alexandra Redman Date: May 19, 2022

DAS Assignment # 3

Name of the defendant: Adonica Waymire Twedt License number of the defendant: 544992

Date action was taken against the license: August 6, 2013

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.*

Charge 1: On January 25, 2012, Twedt documented she had administered Metronidazole to a patient at 1800. There was no medication withdrawn from the Pyxis associated with the documented time of administration. If there was no medication taken out of the Pyxis at this time, that is considered false documentation because she didn't actually take out the medication before documenting that she administered it.

Charge 2: On January 25, 2012, Twedt failed to administer Flexeril to a patient as it was ordered by the physician. Administration was documented at 1104 when the medication's order was for 2100. Twedt obviously did not read the orders if she administered the medication 10 hours before it was to be administered or 10 hours later than it was supposed to be administered. This would be considered a wrong-time medication administration error.

*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.*

Charge 1: With the wording of the charge, it is unknown whether Twedt withdrew the medication at a previous time and just administered and documented it at 1800, or if she never gave the medication and just documented that she did. This violates the "safety and security" universal competency. If the patient never received the medication, the oncoming nurse would never know because Twedt documented she had given it even though there was nothing taken out of the Pyxis around the time of administration. The physician reading the chart may decide that the patient doesn't need that medication the next day and could discontinue it, but in reality, the patient actually does need it because Twedt had never administered the medication to begin with. Numerous things can happen if a patient doesn't receive their medication, or if they receive it at the wrong time. Twedt could have prevented this by double checking the orders given by the physician to determine when the medication should have been administered, and checking again at the Pyxis. When scanning the meds in the patients' room, the computer will let you know that this medication isn't being administered at the correct time and asks for the reason why. If Twedt was paying attention, she would've noticed in the patient's room

that she was not giving the medication at the correct time. Always pull meds right before you are about to give them as well. If we pull meds and don't administer them right away, that increases the chance of us forgetting to administer them. Twedt could've pulled this medication hours before she administered it and had forgotten about it and just decided to give it when she noticed she still had it.

Charge 2: As stated before, make sure you are checking your HCP orders because they will tell you what time the medication needs to be administered. There are three different checks you do before administering the medication. If Twedt would've paid attention to the three different mandatory medication checks, she would've noticed that the medication was ordered for 2100. The medication was given at 1104, which means she gave it 10 hours too early, or she noticed she was late on giving the medication, or she had forgotten it from the night before and decided to give it when she noticed it was never administered. So as stated, if she would've just paid attention to the orders, she would've known when the medication was to be administered. This violates the safety and security universal competency as well as critical thinking because the nurse failed to think "should I give this med or not?" She should've told the charge nurse and they could have come up with a plan together.

*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 found out the medication was given at the wrong time, I would definitely tell the charge nurse. Giving meds at the wrong time or not giving them at all can be fatal to the patient. Documenting a medication was administered when it never was can also fall back on the oncoming nurse as well and I wouldn't want to be blamed for something the nurse before me did. I would also ask the nurse why the chart says the medication was administered at a certain time, but the Pyxis says something completely different. By pointing it out to the nurse, it may help them remember what the certain circumstances of that situation were and hopefully raise awareness that it isn't okay to do that. Either way, I would let the charge nurse know in hopes that something in the future changes.