

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Eddie Hernandez

Date: 9/6/22

DAS Assignment # 2

Name of the defendant: Jennifer Jaymes Anderson

License number of the defendant: 781033

Date action was taken against the license: April 3rd, 2018

Type of action taken against the license: Remedial Education

On or about August 3rd, 2017, Nurse Anderson failed to clarify the location of a previous surgery with the physician before administering a Lovenox injection in the abdomen. In addition, she failed to document the location where she administered the Lovenox. This action resulted in an inaccurate medical record that was likely to injure the patient because subsequent care givers would not have accurate and complete information to base their decisions. In response to the incident, Nurse Anderson argued that Lovenox is administered in the abdomen per standard practice and that doctor's orders should specify if it is to be given in another area. Additionally, she claims that the off going RN was very specific that the injection should be given at 2200, but never said that it should be given anywhere other than the normal location. Nurse Anderson states that doctor's orders only indicated that she should not give the injection "in a surgical site" which she took to mean in or around an incision. She claims that the patient was tightly wrapped in binder around her mid section and thighs, but none of the surgical sites were noted in the patient chart. She responded that she did find a good injection site in the lower left abdomen that was not a surgical site per her judgement. She states that she did document the route of administration and the drug used, but she failed to indicate the location because she was very busy and she was unaccustomed to using paper charting.

Nurse Anderson failed to use proper critical thinking and professional role universal competencies before administering the injection in the abdomen area. A prudent nurse will always seek clarification when doctor's orders are unclear. She should have used her critical thinking skills and professional role universal competencies to realize that she needed more information before administering the injection and she should have sought clarification from the doctor or a nurse who knew exactly where the surgical site was located. In addition, she did not follow the documentation rules as taught in our universal competencies. A final universal competency that she probably would have helped avoid this error is communication. Better communication in the doctor's order and also with the off going nurse could have helped clarify any questions that she had.

For her actions, Nurse Anderson was required to complete remedial education courses in the following areas: nursing jurisprudence and ethics, medication administration, and sharpening critical thinking skills. I was actually surprised to see that she was not required to remedial education course specifically for proper documentation considering that the board found her deficient in that area and she admitted that she was unfamiliar with paper charting.

A prudent nurse is required to report any known incidents that might harm a patient or false documentation. I think the first step a nurse should take it to make sure that the patient is in no immediate danger as a result of the action taken by the other nurse. The next step should be to immediately notify the charge nurse and ask for his or her assistance to notify the proper authorities.