

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Shallas Taylor

Date: 1/14/23

DAS Assignment # \_\_\_\_1\_\_\_\_ (1-4)

Name of the defendant: Suzanne Elaine Cutler

License number of the defendant: 789818

Date action was taken against the license: May 8<sup>th</sup>, 2012

Type of action taken against the license: Revoked

*The defendant was charged with the following: multiple gross misconducts, working under the influence, failure to follow physician's orders, failure to administer medication, and falsifying medical records. The first charge came as a result of the defendant falling asleep on the clock when caring for a pediatric patient. The defendant's second charge happened as a result of taking Klonopin prior to her shift. Ultimately impairing her ability to care for her patients with sound judgment and decision-making. The third charge came after the defendant failed to follow the physician's orders which resulted in a pediatric patient missing their medication/tube feeding, which in turn caused the patient to suffer adversely. The fourth charge was due to another instance where the defendant fell asleep while on the clock making her unable to properly care for her assigned patients. The fifth charge was due to the defendant working while disoriented. During this time the defendant was not able to make sound judgments putting herself, her coworkers, and her patients at risk. The sixth charge was the result of not following a physician's order/medication error. The defendant was given a physician's order to administer Clonazepam but failed to do so. In addition, the defendant falsely recorded that she had given this medication which resulted in her seventh charge.*

*I believe that each charge placed against the defendant could have been easily prevented. The defendant was found sleeping while on duty multiple times. Ensuring that the defendant gets plenty of rest before a shift, avoids picking up shifts that would overexert her, and communicating with management to let them know if she feels overworked are all solutions that could help prevent the defendant from falling asleep while on duty. As a nurse, we should have a working knowledge of medication not only for our patients but for ourselves as well. Given that the circumstances were not explained for her second charge, a measure that could have prevented this situation was for the defendant to have had the proper education on the possible side effects of Klonopin. With such knowledge, the defendant could have made the choice to not take the medication prior to her shift. If the defendant had to take the medication to be able to properly function, she should consult her doctor to find a medication that would not impair her ability to work. The charge concerning the defendant not following the physician's order that caused a pediatric patient to suffer adverse effects from not receiving their medications/tube feeding could have been prevented had the defendant actively read her patient's chart and used proper time management if busy. Regarding the fifth charge where the defendant came to work disoriented, the best preventative measure would have been for the defendant to have stayed home, be sent home, or be sent for evaluation to find out what might be the cause. Charge six and charge seven could have been potentially prevented had the defendant used the proper medication administration steps, and actively looked at the patient's chart for orders.*

*The defendant violated safety and security (physical) multiple times by falsifying medical records by documenting that she gave a drug when she had not. The defendant also violated the seven rights of medication administration by not giving a patient their medications/tube feedings when scheduled, which caused the patient to suffer adverse effects. The defendant violated professional interactions when she was found sleeping while on duty. The defendant violated the safety and security (emotionally) by breaking the trust and respect of the patients that were under her care when she was found sleeping and/or not following physician orders. The defendant also violated the critical thinking element by not using proper decision-making, by coming to work under the influence of a medication, working when disoriented, and sleeping on the job. All of which could have or did put a patient in harm's way. The defendant also violated the prioritization of tasks and procedures; by overlooking a physician's order multiple times. The defendant violated documentation by falsely documenting that she had given a medication. The defendant violated the professional role by violating appearance when she was found sleeping while on duty.*

*In the instances where the defendant was just found sleeping and no harm came to a patient, I feel that the appropriate thing would be to notify the charge nurse of the situation and allow her to handle it. In the situation where the defendant failed to give medication/tube feedings and the patient suffered adverse reactions I would assume care and stabilize the patient if they were in immediate danger and immediately notify the charge nurse. Had I noticed that the defendant was under the influence/disoriented I would also notify the charge nurse of the defendant's behavior. If the charge nurse is not available to handle this situation immediately and I knew that the defendant was not able to care for her patients without possibly harming them, I would pull her to the side and try and speak with her to find out what's going on and reason with her to wait for the charge nurse to arrive before attempting to see patients again.*