

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Alyssa Cruz

Date: 1/20/2023

DAS Assignment # ____1____ (1-4)

Name of the defendant: Crystal Marie Asher

License number of the defendant: 581352

Date action was taken against the license: February 18th, 2019

Type of action taken against the license: Remedial Education

Use the space below to describe the events which led to the action(s) 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.

There were two incidents that occurred while Ms. Asher was an RN at Audie Murphy VA Hospital. The first event occurred because Crystal Asher did not execute orders given to her by the physician that would have required PPE. She also did not document correctly or scan her distribution of medications to the patient's eMAR. The second incident of Ms. Asher's was that she drew medication from the medication machine and did not document it in a timely manner.

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.

I had this concern earlier in the week when it came to just a verbal order but seeing this becoming a problem and an incident for remedial education is kind of scary. I feel that maybe as soon as that verbal order happened, she could have immediately told the charge nurse the situation after it happened, instead of doing so at the end of her shift. Verbal orders are tricky and like the document says, "the nurses are at their mercy in terms of when orders are finally entered" (TBON, 2019). I feel like I would be messaging repeatedly to get the order placed for the safety of my license. As for the second portion of the first incident, I think while you should be prepping for a patient to leave the hospital to get better, you should not be entirely focused on finishing a patient's care because there could be a possible change in things like this. I feel like this could have been avoided, but I do understand her timely admission. Her second offense could have prevented harm to the patient's medical record if she just documented it. If the patient frequently does things like this, then as a nurse, do we not find a way to work with the patient's needs and be able to still do a fit job as a nurse? Even if the patient enjoyed going outside to do things, she could possibly try mobile documentation or bring him back to document.

Identify which universal competencies were violated and explain how.

Within safety and security, the 7 rights of medication administration were violated on the seventh right which was documentation. In both incidents, documentation was not done in a timely manner, and documentation was not provided—making the patient's record inaccurate. I mentioned it already, but this would also fall under

the documentation part with the eMAR medication scanning. Communication was a universal competency that was violated because I feel like she did not utilize resources to enable communication consistent with the agency's protocols. Hence the patient continuously being off the IV to go outside and not being able to do medication documentation half the time, she could have found a way within the agency's protocols to have fixed this. The same with communication during the physician's PPE order. Communication is a vital part of being a nurse.

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.

I know that the correct option would most likely be immediately going to the charge nurse to inform them, but I personally would go to the nurse at hand and ask for an explanation as to why this situation happened. I would like to hear out my colleague, we are a team of nurses, and we stand by each other. Depending on the situation at hand (a situation like this one), I could explain to them that immediately reporting this to the charge nurse would be the best course of action. If they refuse, I will still inform the charge nurse and if nothing is done about this, then I would go one step further to the person above the CN. Our responsibility as a nurse is to have our patient's best interests in mind and if anything should interfere with that, then we need to fix that problem.