Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Samantha Kendall Date: 1/20/23 DAS Assignment # 1 (1-4)

Name of the defendant: Vanessa Ann Ash License number of the defendant: 706840

Date action was taken against the license: 06/16/2015

Type of action taken against the license: Revoked

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.

The events that led to Vanessa losing her nursing license were multiple events where she was giving drugs without a doctor's order. In 2010, she was giving Versed as an IV push to a patient who was about to go to MRI without an order and obtained the medication from using a syringe to draw the medication out of the IV bag. She was ordered to do more education on medication administration and critical thinking as a nurse by the Board of Nursing. The final decision came to her license getting revoked in 2015 after she gave phenergan in 2014 without a physician's order, which was in direct violation of the order for her to not get charged with anything during her probationary period with the board of nursing after getting her license back. In both of the depositions that were listed, the nurse says that she was confused about which patient was on what medication and thought she had a PRN order from the doctor that led to her giving the medication to the patient.

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 think that the education that she was required to get after the first violation didn't seem to really make a difference if she did the same thing again to a patient that led to her license being in jeopardy in the first place. I think that when something like that happens that she should be paired with a mentor or some accountability as well as do education or get checked on by the board of nursing to understand how important her role truly is. She should have done the three medication checks that we do before giving any medication and actually looked at the eMAR and computer system before finding her own medication through the drip IV bag that was in use. I don't believe it was even a chance of anyone's fault but her own in the instance of this due to the negligence of even trying to get the medication out of the right storage instead of something already in use. I think that if the nurse had made sure the order was in, called if it wasn't in or even asked for help with her agitated patient that she wouldn't have missed that the medication wasn't ordered PRN. I also think the nurse could have prevented using the IV bag to pull her IV push medication out of because it was already in use and

doesn’t seem to me that the integrity of the medication could be fully verified unless it came from a sterile safe environment like the pyxis. I think overall that the nurse could have communicated better, used her nursing judgment to ask her charge nurse for help or even on avoiding getting the medication where she did in the first place. The nurse had multiple instances of the med admin seven rights being avoided that would have been crucial in preventing the harm that occurred to this patient.

Identify which universal competencies were violated and explain how.

Safety and Security (Physical): The nurse violated this by adhering to the seven rights of medication administration through not checking the right patient, right drug, right dose, and right documentation. The nurse didn’t document any of the medications that she gave without an order and also used the versed after it was discontinued as an IV push without an order. The nurse also didn’t ask patient identifiers either if she didn’t check the medication before giving it, she just gave the medication even when she wasn’t sure it was the right patient that was supposed to have the medication.

Standard Precautions: The nurse didn’t use standard precaution when she was doing medication preparation. She pulled the medication from the IV bag that had already been running into the patient instead of going to the Pyxis that is safe with new medication for the patient. She also didn’t dispose of contaminated materials which is a part of standard precautions because she had already used the bag of Versed medication on the patient and it was discontinued beforehand.

Critical Thinking: The nurse didn’t use decision making when she gave the multiple medications without an order. She wasn’t making sure that she was giving the patient medicine for the right reason or even making sure it was administered around the correct time. She also didn’t use the prioritization of tasks or resources because she could have used the charge nurse or asked for help to make sure that she got a doctor's order first, the situation for either patient wasn’t within an emergent situation.

Documentation: She didn’t document any of the medications that were given without an order and this could have created a lot of harm to potentially overdose the patient or cause an adverse reaction if the patient was given meds that weren’t compatible.

Professional Role: The nurse wasn’t prepared to teach the patient or show a good example of knowing how to adequately care for the patient. The nurse should be the person who gives them a safe working space and is going to be their advocate instead of giving them medication from an already used bag that was a different route or mixing up who the patient was that needed the order or even checking to make sure that everything got done.

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.

The prudent nurse who discovers that a patient would have been harmed needs to report it immediately to the charge nurse and the unit director who is in charge of education/employee disciplinary action. I think that charge nurse would help get authorities contacted who needed to depending on the situation and would see what else can be done to help the patient. I would write a report for the nurse manager of all the descriptions

and facts possible to make sure that this type of behavior doesn’t go unnoticed or swept under the rug. The doctor who is taking care of the patient would need to be notified as well in case they put in an order for the same thing that was just given that could potentially be too much in a certain amount of time. I would monitor the patient closely for any reactions or effects from the medication and make sure that if a medicine reversal could be ordered to help the effects not occur that I asked the physician for an order if needed. I think the main thing in this instance is holding your peer accountable because the patient is valuable and needs to be given the correct care that they are supposed to while at the hospital.