Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Samantha Kendall Date: 1/27/23 DAS Assignment # 2 (1-4)

Name of the defendant: Kasie L. Brown License number of the defendant: 638955

Date action was taken against the license: 06/08/2015

Type of action taken against the license: Voluntary Surrender

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 Kasie losing her license had to deal with drug diversion while she was a nurse at multiple hospitals. She had 3 different drugs in 2003 that weren't accounted for at her facility, multiple positive drug tests in 2005 that were positive for drugs that she didn't have a prescription for, and then in 2014 she removed medications from the Pyxis without a doctor's order. Kasie had multiple events over her career as a nurse that she was obtaining drugs from the Pyxis without orders, was positive on drug tests herself, or didn't have the appropriate waste of narcotics at the facilities she worked at. Kasie was required to enroll in TPAPN which is the Texas Peer Assistance Program for Nurses that helps hold nurses accountable and get help when events like sobriety is something that is a concern. She ultimately got her license surrendered due to struggling with continuing to meet the requirements of a prior order to maintain her commitment to TPAPN required assistance with her struggle of sobriety that led to her drug diverting.

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 understand that Kasie was required to enroll in TPAPN to help her deal with her sobriety issues but I think that she could have been held more accountable by her unit, facility, and even administration. I understand that everyone deals with difficult things in their life but I can't imagine the potential of patient care being decreased due to her being under the influence from her drug addiction while on shift. Kasie was caught multiple times, across many facilities, for drug diversion but I think she would have benefitted from having a hand from the administration to hold her accountable. I think that if the Pyxis had been regularly counted or video cameras were in the med room that she might have been more reluctant to actually get the drugs from the pyxis that wasn't needed for a patient. The medications should have been kept a better eye on by the pharmacy but also the peers that come in to count the vials or medication after that saw a count was off. I know that technology could have been different throughout the years but it makes it hard for me to believe that no one noticed the drugs were missing out of the medication storage. I think the discipline being stricter to catching this only a few

times before being let go or being persuaded to join TPAPN before the addiction really got rooted down for so many years would have really helped her. I also think more education on these issues or talking about how to be aware of something like this happening could also help peers know of potential warning signs to stop this from occurring.

Identify which universal competencies were violated and explain how.

Safety and Security (Physical): The nurse violated this by not following the seven rights of medication administration. The nurse didn't have a reason to be pulling the medication out, no patient that she was pulling the meds for, didn't document after taking the extra medication, and also was pulling too much drugs or highly addictive ones. The nurse also couldn't provide trust or privacy if the nurse was using the extra medication or was under the influence of drugs that might have altered her ability to fully care for the patients in this capacity.

Standard Precautions: The nurse didn't use standard precautions when she didn't follow the standard of medication preparation or disposal of contaminated materials. In nursing school, we are taught that all of the medication comes out of the vials, scan, and then dispose of them appropriately during medication preparation. The nurse was not following proper technique if she was taking these home for personal use or pulling meds out that shouldn't have out of the pyxis. The nurse also was cited for not wasting narcotics like she was supposed to, which is a major standard precaution that helps keep the patient safe from overdose and the environment from having narcotics easily accessible for anyone in reach.

Communication: The nurse didn't use any resources to help her agency policy when she was struggling or if there was truly a medication error that led to the medications being taken out of the storage system with being unaccounted for. The nurse would have a hard time dealing with teaching about patient safety with medications when she was potentially under the influence upon shift as her positive drug tests account for in the record.

Critical Thinking: The nurse didn't use decision making when she was pulling out medications out of the pyxis without a physician order or was under the influence while working. Her critical thinking skills could have been flawed heavily with the sobriety issues while working under the influence. The prioritization of tasks/procedures that weren't fully being taken into account when the documentation or following a doctor's order wasn't happening by the RN while on shift.

Documentation: The nurse didn't scan or document any of the medications that she took out without an order or any of the waste that was needed after using a narcotic medication. This is important because if it wasn't documented, then it has no proof that it was given and we need to make sure that the patients fully receive their medications as ordered in the eMAR.

Professional Role: The nurse didn't keep up with the supplies or maintain resources efficiently when she was misplacing medications and not documenting the expensive medications that were going missing out of the Pyxis.

Use the space below to describe what action you think a prudent nurse would take as the first 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.

As a prudent nurse, I would try to be there for my peer but also report what I noticed so that it doesn't continue to get worse. I think that she truly needed help but wasn't ever caught and held to discipline to help show her to change. The addiction that she had didn't just start with one time but this was something that happened over time without being noticed at all. I would make sure that her patients were taken care of on the shift that I noticed it and let the charge nurse know in case anything happened. I think Kasie needed help on a local, individual level and that she wasn't noticed until it was too late. I think having a mentor or even cameras within the medication room could have helped her before she got her license threatened. I also would have made her attend the TPAPN meetings as her employer without giving her a chance to miss if she wanted to continue working or having someone as a mentor outside of the program to help her with struggles on attendance.