Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Zarin Gonzales Date: March 23rd, 2023 DAS Assignment # _1_ (1-4)

Name of the defendant: HANH MY NYGUYEN License number of the defendant: 789772

Date action was taken against the license: May 12th, 2015

Type of action taken against the license: Warning with Stipulations

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.

- Failure to administer medications (Dec. 2011)
- Failure to administer medications (Mar. 2012)
- DC infusion pump for pt. who needed portable (Apr. 2012)
- Failure to document complete wound assessment (Aug. 2012)
- Failure to assess and document INO levels (Aug. 2012)

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.

There are many things that the respondent could have done to have avoided any action taken against them. As far as the failure to administer medication, the circumstances may have been justifiable... but there was no reason that the nurse should have left medication on a bedside table. The nurse was following their orders with no orders to give vancomycin, and when was in question... the pharmacist finally gave the orders to give the medication to the patient. There should have been more communication between the nurse and the pharmacy as far as checking orders twice with the prescriber and or the pharmacist. With the DC infusion pump, the nurse did everything they were supposed to. There was some lack of communication between the nurse and the social worker than oversaw the patient outside of the hospital. As a nurse, it was their job to perform checks and make sure all their “ducks were in a row” before the patient was discharged. Failure to document is a big one. It is drilled in nursing school that documentation is the most important thing that you are supposed to do. It is never a bad thing to over document... but to under document is basically the one thing you are not supposed to do as a nurse. It is better to be thorough than not. Documentation is important because you are essentially altering their treatment with or without the documentation presented. If you don’t put enough documentation, there may be something not treated that should be. Failure to document INO levels is pertinent. Especially if the patient is on diuretics. Even though the nurse stated that there was someone in charge of documenting their INO, it is the job as a nurse to verify that things are documented. At the end of the

day, it is the nurse's patient not the PCT (Patient Care Technician). They all fall under one umbrella, but it is the nurse's job to ensure that those things are taken care of.

Identify which universal competencies were violated and explain how.

Critical Thinking was compromised when the decision of not administering meds was made.

Human Caring was also compromised when the patient was unaware of the steps that were going to be made as far as post hospital care was concerned. The patient did not know that they were going to be receiving medication from a third-party home health care facility.

The nurse also failed to follow the *Documentation* Universal Competency and failed to chart the findings of those things.

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.

If it were me, before I started pointing fingers and accusing people of things, I would first try to verify from orders, or previously logged documentation to ensure that something was not overlooked. Then I would start by asking the patient what they do and or don't remember and try to figure it out from the source. If the patient stated one thing and I found it in the system that it was written differently than I would try to verify from the nurse that oversaw the patient. If the nurse was not available, then I would inform the charge nurse and ask her how I should go about the situation. It is pertinent that you are held accountable/you hold those accountable that oversee big mistakes. It is also important that you have a good standing relationship with your coworkers and don't start any crazy accusations. At the end of the day, we must ensure that the patient is safe. They are always the priority.