Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Kallie Ybarra Date: 03/27/2023 DAS Assignment #2 (1-4)

Name of the defendant: Sue Ellen Turley License number of the defendant: 453841

Date action was taken against the license: 11/9/2021
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 respondent Sue Ellen Turley was charged with failure to administer medications as prescribed by the physician, failure to document medication in the patient's electronic medical record, and failure to follow hospital policy on the wastage of unused medications. Sue Ellen Turley was supposed to administer Hydrocodone/Acetaminophen Elixer, Morphine, and Diluaded, however, the nurse failed to get a witness to her wastage which resulted in these medications being left unaccounted for (Finding of Facts (7) pg. 2) . This was not the only incident, the nurse then goes on to withdraw Clonidine (Sedative and Antihypertensive drug), Dilaudid (Narcotic), and Clonazepam (Sedative/Benzodiazepam) but proceeded to not administer the medications to the patients, as well as failed to document the administration of medications (Findings of Facts (9,10,11) pg.3) . Due to the nurse's lack of responsibility, there could have been major patient harm due to a possible overdose. Since the nurse did not document the administration, the patient's next nurse could have administered the medication again. Documentation is required due to reasons like this because we rely on accurate documentation in order to provide the best care for the patients.

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 believe that this could have been easily prevented. We are taught in nursing school the rules of medication administration and the rules of documentation. The nurse chose to break these policies, which could have resulted in patient harm. We are taught that narcotic wasting HAS to be witnessed by another nurse, it is a process that is done everyday by every nurse. I feel as though this nurse felt that these steps in the nursing process were unnecessary and that she could have easily gotten away with these actions. There was not enough evidence to indicate drug diversion, however I feel as though this falls under that category. As for the failure to document falls under patient negligence and failure to complete tasks.

Identify which universal competencies were violated and explain how.

Safety and Security (Physical):

- 7 rights of medication administration, this was violated due to failure of documenting the medications. I cannot assume that the patients never recieved the medications becuse there were no reports of this, but if so all of the 7 rights of medication would have been violated.

Safety and Security (Emotional):

- Failure to promote trust and respect, the nurse is no longer trustworthy due to improper wasting of medications and not documenting. If I knew that my nurse was doing these things I would not feel safe under her care.

Communication:

- The violation of communication was of major part of why this nurses liscnence was revoked, failure to communicate with other nurses about the care provided to the patients can result in irreversible patient harm and is not tolerated.

Crititcal Thinking:

- The nurse violated critical thinking by not implementing decision making by failing to get a witness for the wasting of multiple narcotic medications.
- This nurse also violated critical thinking by not prioritizing tasks or her patient, I believe this is the case because I do not understand why else she would have not documented the care she provided. Because if documentation is not completed then those tasks were not actually "done".

Documentation:

- eMAR medication scan:
- Any narrative or exception charting of findings:
- Save all documentation: All parts of documentation were neglected by Sue Turley. If the medication were to of been scanned it would have pulled up into the chart, and then all she would have had to do was finish the documentation including her reassessment of the patient and how they were responding to the medications administered.

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.

As the prudent nurse I understand that it is my responsibility to inform a charge nurse or someone of higher authority when observing discrepenties in the workplace. It is everyones duty to ensure safety and trustworthiness in the workplace, and I would be harming patients myself if I did not say anything. Something as significant as not properly disposing narcotics can cause harm to not only the patient but the nurse themselves. Not documenting your medications is also being neglectful and simply being lazy.