

Covenant School of Nursing  
Disciplinary Action Summary Assignment  
Instructional Module 2

Student Name: Payton Conger

Date: 08/24/2023

DAS Assignment # 1

Name of Defendant: Anne Andersen

License Number of the Defendant: 743104

Date Action was Taken Against the License: May 2<sup>nd</sup>, 2011

Type of action taken against the license: Enforced Suspension

On or about July 1<sup>st</sup>, 2009, through January 3<sup>rd</sup>, 2010, RN Anne Andersen committed multiple violations while working at Scott & White hospital, located in Round Rock, Texas. These violations include withdrawing an excessive amount of Morphine from the Pyxis system, withdrawing Fentanyl, Hydromorphone, and Morphine from the Pyxis system, and failing to accurately document the administration of said medications, withdrawing Fentanyl, Hydromorphone, and Morphine and failing to follow Scott & White's policy and procedure on wasting the unused portions of said medications, and misappropriating Fentanyl, Hydromorphone, and Morphine from the facility.

There are several measures that could have been taken to prevent the above violations from taking place. When Miss Andersen pulled an excess amount of Morphine out, she failed to perform the seven rights of medication administration. Had she checked these rights the recommended three times she was supposed to, she would have noticed that the dosage she withdrew was incorrect and taken the necessary steps to correct it.

For a nurse to withdraw medication, proper documentation must be done to prevent violations, such as Miss Andersen's second violation, from occurring. Upon pulling out Fentanyl, Hydromorphone, and Morphine, separate accounts of documentation should have been done in various places. The Pyxis has certain checks and documentation procedures programmed into it to make sure the count stays accurate; documentation should also have been done within the patient record system. Again, all that was needed to prevent this violation from occurring was to take the time to walk-through the seven rights of medication administration.

Miss Andersen's third violation was failure to properly waste the remaining amounts of all three narcotics listed above. The documentation provided does not state whether the waste of these medications ever occurred or the proper witnessing of said wastes ever occurred. However, both possibilities could have been prevented by Miss Andersen slowing down, following the facility's protocol on wasting medications, and doing so with the correct licensed personnel there to witness the proper disposal.

The final violation committed by Miss Andersen was the misappropriation of Fentanyl, Hydromorphone, and Morphine. Because of the lack of documentation on these medications and not having a witness when said medications were, or were not, wasted, it is impossible to know what exactly happened with the remaining medication amounts. It is unclear as to whether Miss Andersen wasted them, as she was supposed to, or removed them from the facility altogether. This violation could have been avoided by Miss Andersen having a documented witness testimony to the wasting of these medications.

Miss Andersen violated several universal competencies in the case described. Of the eight universal competencies provided to us, Miss Anderson broke the following four:

- A breach in **Physical Safety and Security** occurred when the RN failed to complete the seven rights of medication administration on several occurrences, leading to incorrect dosages and improper administration.
- Failure to use proper **Critical Thinking** skills caused the RN to fault all decision making regarding whether it was appropriate to administer said medications.
- The RN mistakenly failed to **Document** the medications and amounts she was administering.
- The RN failed to maintain her **Professional Role** by failing to manage the supplies provided and by failing to appropriately interact with her fellow staff members.

As a prudent nurse, seeing the events listed above, a choice would have been made to confront Miss Andersen on her actions, then follow up by speaking with a direct superior, such as a Charge Nurse, Nurse Manager, or Hospital Representative. By taking this action, these violations could have been prevented before fully developing into what they did. The patient(s) would have never received, or almost received, improper doses and/or incorrect medications. Had a prudent nurse been there to stop Miss Andersen during her very first violation, this case might not have reached the levels that it did.