

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Quinton Sherrod

Student Name^

Date: 8/24/23

DAS Assignment # 1 (1-4)

Name of the defendant: Brandy Curry

License number of the defendant: 658688

Date action was taken against the license: 1/2012

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.

Charge 1: The defendant Brandy Curry was charged with the violation of "chapter 481 of the Texas Health and Safety Code (Controlled Substance Act)". Brandy violated this law by not documenting or accurately documenting the withdraw of Narco from the medication Dispensing System. By doing this the Nurse pit the patient at risk for unintentional harm from other healthcare providers.

Charge 2: The defendant Brandy Curry was charged with the violation of "chapter 481 of the Texas Health and Safety Code (Controlled Substance Act)". Brandy Curry failed to follow the facilities protocol for proper wastage of the unused medication (Narco). Under further investigation the nurse was found to have not followed protocol for wastage on multiply occasions ranging from 5/24/10 to 5/24/10 with multiple patients.

Charge 3: The defendant Brandy Curry was charged with the violation of "chapter 481 of the Texas Health and Safety Code (Controlled Substance Act)". This charge was given for the misappropriate use or handing of narco the belonged to the faculty/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.

Although it was not clear whether or not this particular nurses' patients were ever harmed or not, this nurse did indeed put his patients in harm's way. With the first charge of failing to document the withdraw/use of Narco this patient could have been accidentally harmed by another healthcare provider by giving another unnecessary use dose of narco. This could have simply been been fixed by documenting that the patient's Received their dose of Narco immediately after giving the med in the patient's room. With the second charge of not properly discarding the unused Narco I am not sure if the nurse just didn't have a witness, or if they were taking the narcotic themselves. However, since this was not clarified, I am going to assume that the Nurse just did not have an appropriate witness for the excess Narco that was not given to the patient. We know that with any Narcotic you need another nurse to watch you dispose of the excess narcotic, this is a simple prevention of this charge. The nurse just needed another nurse to take a second out of their day to make sure there was no suspicion of diverting this narcotic. The third charge could have been prevented by just following the

facilities rules of documentation and handing of a narcotic, simply documenting and having a witness for the disposal of the excess narcotic this could have been prevented.

Identify which universal competencies were violated and explain how.

I found that this nurse violated standard precautions, documentation. Standard precautions tell us the appropriate way of disposing and handling a medication/narcotic, in this case both the handling and disposition of Narco were not properly conducted. The non documentation of the administration of Narco to the patient directly goes against the Universal Competency of documentation.

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.

Honestly upon discovery of something of this nature happening I would not know what else to do besides informing the charge nurse. It's simply a direct breach on everything that we have been taught. Patient safety is something that is preached to us every day as student nurses, and frankly this nurse was very lucky that none of their patients were harmed. It was simply a blessing that someone noticed these violations as fast as they did. In response to the question, I would have done exactly what was done in this case, once I realized the misuse and directly placing these patients in harm's way, I would have reported this nurse to the proper authorities which in this case I believe would be the charge nurse.