

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: David Oliva

Date: 08/21/2023

DAS Assignment # 1

Name of the defendant: Jennifer Morris Drissen License number of the defendant: 678522

Date action was taken against the license: August 18, 2009 (Warning with Stipulations), April 5, 2012 (voluntary surrender)

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.*

- First: (Warning with Stipulations)
  - Did not document the administration of the medications Morphine Sulfate, Lorazepam, Norco, Demerol, Nalbuphine, Diazepam, Hydrocodone, and Carisoprodol.
  - Withdrew the medication Morphine Sulfate without a doctor's order
  - Failed to waste the appropriate amount of the medications Lorazepam, Morphine Sulfate, Norco, Demerol, Nalbuphine, Diazepam, Hydrocodone, Carisoprodol as per facility policy
  - Withdrew Demerol in excessive dose of the doctor's orders
- 2nd (Formal Charges, Voluntary Surrender)
  - Did not adhere to the agreed order that was put in place due to their first "Warning with Stipulations"
    - Failed to adhere to the agreed order of successfully completing the courses; Sharpening Critical Thinking Skills, Nursing Documentation, Medication Administration, Texas Nursing Jurisprudence and ethics within one year of entry of the agreed order.

*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.*

- Drissen could have done all three checks of medication administration, continuously looking at the physician's order and eMAR, and checking the medication against the eMAR. For both gm having the right medication and right dose.
- If Drissen had a hard time remembering to document, a good practice would have been to make sure to document after EACH medication was administered before moving on.
- What could have helped with the waste could be having another nurse or faculty witness each waste of medication
- And for the formal charges, simply do the required courses.

*Identify which universal competencies were violated and explain how.*

- Safety and Security:
  - Did not have the 7 rights for med admin including right reason, right dose, and documentation
- Critical Thinking;
  - Did not have great decision making when not documenting, taking out medication in excessive dose, and not wasting the appropriate amount of medication
- Documentation
  - Failure to document multiple medications over and over again

*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.*

- I will first approach the nurse in question and try to understand what has been happening not assume the worst of them. But if a patient has been harmed or criminal activity has been done, regardless of who it is, I will report it to my superior and submit a formal report.