

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Valerie Mendez

Date: 09/08/2023

DAS Assignment # 3 (1-4)

Name of the defendant: Stacy K. Cline

License number of the defendant: 718535

Date action was taken against the license: July 27, 2017

Type of action taken against the license: Remedial Education

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.

On July 7, 2015 Stacy K. Cline withdrew one tablet of Norco 5/325mg to administer to a patient of hers. Stacy failed to document that she administered the medication to the patient in the eMAR and nurse's notes. Stacy failed to enter any information of administering the Norco at all. At this point she put her patient at risk for injury because if it wasn't documented it wasn't done. Therefore, Stacy herself put the patient at risk for an overdose because she didn't document the previous administration of medication. Stacy also failed to follow procedure and policy of the facility for wastage of the Norco medication and the unused portion she wasted out and put the hospital pharmacy in violation. She failed to count the medications and enter what she had taken out so she put herself in a position to possibly get her license taken away. On that same day Stacy withdrew one tablet of Norco 10/325mg from the pyxis to give to another patient without a physician's order and documented that she administered the medication. When patient was asked if he/she was given the Norco medication he/she denied getting any pain medication. Stacy put her patient at risk for injury because she administered the medication without a physician's order and the patient could have had an adverse reaction. Stacy misappropriated Norco for her own use and her actions were likely to defraud the hospital and patients of the cost for the medication she possibly had taken.

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.

If Stacy would have just followed protocol and policies of the hospital, then she would have never been in the situation she was in putting her license on the line. She should have withdrawn the Norco tablet of 5/325mg and did the correct steps in counting how many tablets were in the pocket before removing any tablets. Then Stacy should have input that she withdrew one tablet before closing the drawer. Then the correct thing to do was call another nurse to witness the portion of the medication that she wasted in the proper receptacle bin. When Stacy went to administer the Norco to the patient, she then should have documented in the patient's room that the Norco was administered, for what reason, and the time it was administered. Documenting the

administration would have saved Stacy from getting into trouble and putting the hospital and pharmacy in violation as well as not putting her patient at risk for harm or any kind of injury. Then for her other patient, she should have never even withdrawn or administered the medication because she did not have a physician's order at all. If the patient needed Norco for pain, then she should have consulted the physician first to receive an order. Once order was placed then she could have administered the medication. It seems to me that Stacy was withdrawing these Norco medications to her use, if not then she was not properly trained on how to handle Norco medications.

Identify which universal competencies were violated and explain how.

Safety and Security (Physical)- Stacy failed to do her 7 Rights of medication administration because she did not check to see if it was the right dose because she failed to waste the Norco properly, right time because she did not document that it was ever administered, right reason because she did not document for what reason she administered the medication, and right documentation because she did not document anything about the Norco medication for the first patient. She put her patient at risk for a possible overdose due to her not documenting any of care given. For the second patient, Stacy failed to professionally interact with her patient by not ever going into the room to administer the Norco tablet 10/325mg that she had withdrawn and documented that she administered. **Safety and Security (Emotional)**- Stacy failed to promote trust and respect with both of her patients because she put both patients at harm when administering Norco and not documenting on one patient and falsely documenting the administration of Norco without a physician's order on the other patient. Stacy did not respect her patients financially because she was willing to let them pay for medication that she was taking for herself. **Standard Precaution**- because she failed to prepare the Norco medication right when he was in the med room because she did not get another nurse to witness that she had wasted a portion on the Norco medication in the proper bin. **Communication**- because she failed to follow correct protocol of the hospital policies, as well as failed to communicate with someone about getting herself help if she had an addiction or not enough money to pay for medications. **Critical Thinking**- because as a nurse she knew right from wrong and she did not critically think about the consequences that were to come with her actions. She put her patients at risk for harm and injury, she put her license on the line, and she put the hospital and pharmacy in violation. **Documentation**- because she failed to document the administration of the Norco tablet 5/325mg that she administered to the first patient as well as forgetting to document the wastage that she did not need. Stacy did not document any care, reason, dose, and time of the Norco that was given to the first patient. **Human Caring**- Because she did not care that the patients would have to pay for the medications, she did not involve the second patient in the care or administration of the medication because she never gave the Norco to the second patient. She also did not care that she hospital or pharmacy would be in violation for what she had done. **Professional Nurse**- because she failed to act as a professional nurse by doing wrong and not following protocol and policies. She should have documented as a professional nurse would have done and she went against policies and took Norco and then falsely documented that she had given it without a physician's order. She needs better training if she plans to stay a nurse.

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 I was working the unit and had seen Stacy withdrawing the Norco medication, then I would have gone into the med room to see if she needed a witness to make sure she wasted the unused medication in the proper receptacle bin. If I was in the med room and would have seen her withdraw the Norco 5/325mg tablet without counting then I would have stopped her before she did anything and prompted her to count and enter the number into the pyxis when it was asking how much was in the pocket. Then I would have made sure she put down how any she withdrew from the pocket. At this time, I would have been suspicious and followed Stacy to the room to make sure the Norco was administered correctly and documented in the eMAR as well as nurse's notes. I would have then walked out, found the Charge Nurse or someone in higher authority and reported what Stacy had mistakenly done and let them know I had suspicions that maybe she was wanting to use it herself or wasn't properly trained. That would have possibly prevented Stacy from taking the other Norco tablet. If I would have seen Stacy removing another Norco tablet 10/325mg from the Pyxis, I would have asked her for what patient and what was the order given so I can make sure she is doing the proper steps when getting ready to withdraw and administer. If there was not an order from the physician, then I would have questioned Stacy as to what she was doing and if she needed help herself. I would ask Stacy to give me the Norco and place it back into the Pyxis or have her put it back into the Pyxis, then I would call the Charge Nurse and report what I had seen Stacy doing and try to get her help if she needed it. That would have stopped Stacy from getting into trouble as well as protecting her patients from harm or injury. In my opinion, Stacy should have gotten in worse trouble than Remedial Education. I think she should have gotten suspended and had to take classes.