

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Kaci Penick

Date: 9/14/2023

DAS Assignment # 4

Name of the defendant: Annelle Frances Graham

License number of the defendant: 660429

Date action was taken against the license: 11/08/2016

Type of action taken against the license: Warning with stipulations

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.

(Patient Safety / Failure to document accordingly)

Between August 25, 2015, and November 4, 2015, Deer Park ISD hired Annelle Frances Graham, RN, as the school nurse for their Bonnette Junior High School location in Pasadena, Texas. While performing her duties at Bonnette Junior High School, Annelle neglected to provide Student T.F. with the appropriate dosage of amphetamine salts, a scheduled II controlled substance used to treat ADHD. In addition, rather than recording the prescribed dose of 10mg of Amphetamine Salts, Annelle entered 20mg of Amphetamine Salts into the eMAR. Annelle's lack of awareness resulted in student T.F. receiving twice the amount of Amphetamine salts than what was ordered.

Moreover, Annelle became aware of her mistake when the mother of student T.F. requested that Annelle increase the amount of medication from 10mg to 20mg. According to the prescription, Annelle was supposed to administer half a tablet to the student. However, Annelle had been administering a whole tablet of 20mg.

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.

Annelle stated that she neglected to take the time to properly verify medication orders for the student due to her hectic schedule on the first day of school. Annelle may have averted the implications if she had slowed down and taken the time to confirm the exact dose of medication before administration. Annelle should have used the valuable resource "7 Rights of Medication Administration" in this instance. Had she used this tool, she would have realized that the prescription was for a half-tablet of 10mg rather than a whole tablet of 20mg. Furthermore, Annelle should have double-checked the dosage before documenting the medication in the eMAR. In this case, incorrect documentation could lead to a chain effect of inaccurate medication dosage, putting the child at risk of harm.

Identify which universal competencies were violated and explain how.

- **Safety and Security- Physical**
 - Annelle violated the "7 Rights for Medication Administration" by failing to provide the student with physical safety and security. If Annelle had utilized this tool, she would have quickly realized what dosage the student needed, preventing any harm from occurring.
- **Safety and Security- Emotional**
 - I feel Annelle also violated this student's emotional safety and security. When parents drop their children off at school, they place a great deal of trust in the faculty that their children will be well cared for. Annelle broke that trust by failing to take her time to verify the students' medication dosage properly, placing the child in danger.
- **Communication**
 - Annelle also violated the Universal Competency of communication by failing to communicate appropriately with the child's mother. Annelle stated that she completed the appropriate forms required for the parent's request to increase the child's medication dosage. However, Annelle said that when she attempted to speak with the child's mother, she was conversing with another parent and signed the form without reading it. Annelle should have taken appropriate action to wait for the mother's conversation to end before allowing the mother to sign the documents. Had Annelle waited to speak with the parent, she would have been able to inform the child's mother of her error in administering the incorrect dosage.
- **Critical Thinking**
 - Annelle neglected to prioritize her duties as the school nurse. She should have taken the necessary precautions to ensure adequate time to double-check the "7 Rights of Medication Administration" for all students prior to administering medications or care.
- **Documentation**
 - Annelle failed to record the child's medication dosage in the eMAR accurately. She recorded 20 mg rather than the prescribed dose of 10 mg.
- **Professional Role**
 - As a nurse, Annelle's job is to provide patients with quality care while maintaining patient safety. Deficiency of professional duty as a nurse is seen in Annelle's poor interaction with the child's parent, medication dosage error, improper documentation, and a general absence of prioritization of her responsibilities.

Use the space below to describe what action you think a prudent nurse would take as the first 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 a prudent nurse, the first step I would have taken upon discovering the medication dosage error would have been to immediately contact the child's parents to inform them of the situation. I would have then explained the circumstance to my supervisor. In addition, regarding the documentation error, I would have verified the "7 Rights of Medication Administration" prior to administering any medication to a patient and documenting it in the eMAR. As nurses, we will frequently face time constraints, but we must prioritize our duties and responsibilities and double-check everything to ensure patient safety and quality care.