

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Alexa Dobbins (Adv.-Brazil)

iu72Date:10/21/23

DAS Assignment # 1

Name of the defendant: Jill Leigh Smith **License number of the defendant:** 510652

Date action was taken against the license: 12/11/2018

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.

Jill Smith had multiple occurrences of pulling out Morphine Sulfate and Hydromorphone and not documenting the medications correctly in the MAR. By doing this, the nurse has committed a medication error because it increases the chances for a potential overdose if another nurse was to give that patient the same medication without knowing it was already given. The failed documentation also is concerning that Ms. Smith may also be diverting these medications for personal use.

In the second charge against Ms. Smith, Morphine Sulfate, Hydromorphone, and Oxycodone were pulled from the medication dispensing system and Ms. Smith failed to adhere to her hospitals policies for wasting unused medications from vials. If Ms. Smith is consistently failing to document this, it would appear to some that she may be using the rest of the medications for personal use. The nurses' notes for Morphine Sulfate and Hydromorphone are not completed, nor is the MAR. There is no documentation that the patients over the time span of April 13th through May 21st, received those medications. If the patients are not receiving their medications prescribed, their overall health is in jeopardy and can cause further complications.

In the third charge against Ms. Smith, the specific orders for medications had a pain scale written on each medication/patient. Ms. Smith failed to follow those orders for all 11 patients. If patients are given medications they do not need, they may be further injured at that time and their chances for further complications arise which is concerning of patient's safety.

In charge number 4 against Ms. Smith, she was giving patients orders for Hydromorphone when 4 of the 5 patients did not need that. If patients are receiving medications they do not, as previously stated above, the chances for complications increase and interferes with their safety.

All of these medications that the nurse is diverting are some type of narcotic, Ms. Smith should have been watched more carefully and it brings up the concern of where the witness was in this case.

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.

I think that it is clear from the dates on these charges that while it did not happen multiple times a day, it was happening over a span of about a month. Someone could have caught that quicker and could have brought someone in to oversee Ms. Smith in the medication administration process.

Also, if the nurses who took over at the next shift were seeing the EMAR and noticing there was no notes on these specific drugs, they should have brought it up to Ms. Smith or their charge nurse.

A notice from the charge nurse should have been given to the other coworkers to report any suspicious activity that they notice from Ms. Smith.

Identify which universal competencies were violated and explain how.

Safety and security (physical)- 7 rights for medication administration was broken when Ms. Smith pulled meds for administration when their pain was not matching the prescribers' orders (ex. Pulling morphine for a pain of 7-10 and Ms. Smith states no pain for patient).

Documentation: Ms. Smith failed to document correctly for her patients and her medications in multiple occasions. She failed to chart in the med room when wasting medications and this can lead to a problem when accounting for medications, specifically narcotics.

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 the nurse that came across this type of event, I would begin to become more aware of that specific coworker and the way they are acting during the shift. Paying special attention to the times they go into the med rooms, watching them get the medications ready, and seeing if they go into the patient's room and give the patient their medications. I could start by offering myself as a witness in the med room and then going from there. If I am suspecting a medication error that is causing harm to patients, I would go talk to my charge nurse immediately and explain the situation after obtaining a good amount of information as to why I suspect this problem.

Knowing that the nurse has not given the patients the meds they are needing, I would then go check on each patient and their EMAR to see what has been documented and if there is anything else I can do for them in that situation. It could be beneficial to go talk to my coworker who is withdrawing these medications, but most of the time in that situation, people will not admit it for multiple reasons.