

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Gabriela Marinelarena Date: 1/19/24 DAS Assignment # 1

Name of the defendant: Andrew Michael Ashworth, RN License number of the defendant: 941091

Date action was taken against the license: 2/11/2020

Type of action taken against the license: Warning of 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.***

In summary, the defendant known as “RN/Andrew” was a new-grad nurse who was employed for one month at Parkland Health and Hospital Systems. During the month that Andrew was held accountable for, he was shadowing and following another nurse known as a “preceptor”.

(Page 2, line 7) in conclusion states that on April 17, 2018, the defendant, “incorrectly crushed and diluted oxycodone, an oral pain medication, and administered intravenously” (Texas Board of Nursing, pg. 2). Additionally, while administering it incorrectly the defendant did not chart/ document that he had given the oxycodone.

(Page 2, line 8) in conclusion, this line states the actions that the defendant should have done. This tells us the actions that led up to him administering the medicine. The defendant states the way that he had prepped his medication was that he crushed the medicine into a bag. Next, the defendant states, “he turned on the water faucet and collected water into a small cup. Respondent states reports that he then drew up tap water and mixed in the crushed medication” (Texas Board of Nursing, pg. 2). The defendant next stated that, “he lifted the patient’s gown to access the gastric tube, but there was no gastric tube as he had anticipated” (Texas Board of Nursing, pg. 2). The next action led to the defendant, “he screwed the syringe onto the intravenous line and began administering the medication. Respondent states he monitored the patient as the medication was slowly infusing and about halfway through met resistance” (Texas Board of Nursing, pg. 2).

Due to these actions that were taken, this resulted in terms of the order that the defendant must do. The first terms of order consist of, “Sanction and Applicability” consists of an official order and that the defendant, “may not work outside the State of Texas in another nurse licensure compact part state” (Texas Board of Nursing, pg. 3). The second term consisted of that the defendant agrees to follow the rules that are given to him. The third term is known as the “Knowledge, Skills, Training, Assessment And Research (KSTAR) Program” the defendant must complete within a year. This order requires that the defendant “apply to and enroll in the KSTAR Program, including payment of any fees and costs” (Texas Board of Nursing, pg. 4) within 45 days. The defendant during this course should complete the assessments, follow requirements, “successfully complete a Board- - approved course in Texas nursing jurisprudence and ethics” (Texas Board of Nursing, pg. 4), and

supply documentation to the Board's office. The fourth term known as "Further Competency Issues And Violations" states it depends on the results of the assessment from the KSTAR Program. The fifth term is "Restoration of Unencumbered License(s)". In conclusion, this KSTAR Program is a remediation program, which would be beneficial to the defendant to reassess his knowledge and skills.

- ***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.***

After reading this document and the charges that were held against the defendant, there are some measures I would have taken to prevent this event from occurring.

Overall, the defendant should have read up on the patient's medication lists. Such as checking the orders three times, which would include the first check at the nurse's station, the second check in the eMAR at the Pyxis, and lastly the third check in the patient's room. If the defendant had looked at the eMAR three times, the defendant would have most likely realized that the medicine was needed PO, not IV. The defendant giving the med IV instead of PO could have led to events that could have turned fatal or caused harm to the patient.

The defendant also did not chart the medication that was being given, in this case, after scanning the medicine and giving it to the patient. The defendant then should have charted that he had given the medicine. Lack of documentation is important when it comes to medication so that we can see what we have given on that shift and that other healthcare providers for that patient can see.

In addition, the defendant could have checked the patient charts such as if the patient had any other tubes or drains. The third action was knowing that the defendant had a preceptor, this could have been prevented if the defendant clarified with the preceptor of the medicine he was about to give. Additionally, a lack of communication overall could have prevented this.

- *Identify ALL universal competencies that were violated and explain how.*
 - o *Safety and Security (Physical)- 7 Rights for Medication Administration-* The defendant did not clarify the route, this incident could have been prevented if the defendant had checked what the orders had said and verified it three times to the EMAR. *Promote trust-* This caused the patient to not promote trust in the defendant due to him giving the wrong route for his medication. Patients expect us to know how to do our jobs and do it the right way.
 - o *Standard Precaution-* When the defendant prepared the medication, he used tap water to mix the medication. Using tap water is known as contamination, which is why he should have used sterile water.
 - o *Communication- Utilize resources to enable communication consistent with agency protocols-* This was a big element due to the lack of communication that was between the defendant and the preceptor. If only a few words or clarifications had been made, this would have not caused this incident.
 - o *Critical thinking- Decision making-* This played a factor in the defendant such as whether he should have given the med or not due to first him going to a PEG site and not finding it there. This should have been the first sign to not give it yet before clarifying the route.
 - o *Documentation- Save all documentation/ eMAR medication scan-* Documentation had a huge impact due to this incident. If the defendant had scanned the medication and verified per each eMAR, he would have seen the route to give. Additionally, he did not scan the medication or save anything due to a lack of charting.

- *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 had discovered that this patient had been given the wrong route, I would go find the charge nurse and let her be aware of what had happened.

Cited Source

Texas Board of Nursing 1909, *Texas Board of Nursing website*, accessed 19 January 2024, <https://www.bon.texas.gov/>.