Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Marissa Torres Date: 01/26/2024 DAS Assignment_2_

Name of the defendant: Stephanie Carol Beyer License number of the defendant: 820885

Date action was taken against the license: 09/13/2022

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.*

-Around June 29, 2017 while working in a Dallas medical center, the respondent administered the wrong dose of medication to MRN 10381944. The medication order was for 2.5mg of methadone, and the respondent administered 25mg of methadone. The patient was then needed to be taken to the ICU due to being difficult to awaken, difficulty speaking, and respiratory depression.

-Around March 17,2018 while employed as a staff nurse, the respondent failed to report, and document repeated low blood pressures for MRN 10426394 during her shift.

-Around April 15,2018 the respondent did not provide appropriate, timely assessments for multiple patients during her shift. MRN 01385197, 10264532, and 10433702.

- *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.*
    - *In the care of MRN 10381944 the respondent could have prevented overdosing the patient by having another nurse check the dosage. The respondent was mentally distracted with family matters, should the nurse have called into her shift that day this patient would not have been placed at a high risk for demise due to complications the large dose of Methadone caused.*

    - *In the care of MRN 10423694 the respondent didn't follow protocol in documenting the vital signs of the patient. As a nurse knowing that a critical vital sign should be checked more frequently to keep close care for the overall health status of the patient, and any other complications that could have been caused by low pressures.*

    - *The respondent had yet another shift that she failed to document and provide multiple patients with the adequate assessments needed to monitor the stability of the patient.*

This could have caused the patients to go untreated for complications, infections, or illnesses acquired during the stay in the hospital.

- *Identify ALL universal competencies were violated and explain how.*

  -Safety & security (physical)- 7 rights for medication administration. Documentation, and promote trust & respect. Not allowing her patients to feel safe in her care providing them with the best care due to their reasons for being in the hospital.
  -Communication- The nurse failed to teach one of the patients about the medication she was giving and providing them the s/s to watch for in case there were an adverse reaction.
  -Critical thinking- the nurse did not evaluate or revise the interventions she did and didn't do for these patients. This could have resulted in the patients becoming unstable quickly, with no documentation of how it got to that point. Prevention!
  -Documentation- eMAR medication scan- the system would have recognized that she was giving the wrong dose and alerted her to re check.
  -Professional role- the nurse could have reported her personal distractions to an extent that would have allowed other staff to help with decision making and prioritizing the needs of her patients

- *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.*

As the prudent nurse in these cases, I would have reported my findings to the charge nurse in discretion. Discretion to prevent problems in the workplace, and to not alarm the patients about the lack of care they are receiving. Since the nurse claimed to have a lot on her mind during these times, she most likely would have been showing signs of distraction physically. I would have asked the nurse in a professional appropriate manner if she needed any help with the care of her assigned patients. Simply asking the nurse also if she was feeling okay could have prevented these actions. Open communication would have allowed the nurse to open up and maybe even admit to needing the day off due to her personal distractions.

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