

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Isaias Lopez

Date: 1/25/24

DAS Assignment # 2

Name of the defendant: Anna Maria Perry

License number of the defendant: 989328

Date action was taken against the license: 2/14/2023

Type of action taken against the license: 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.*
 - Charge 1- The nurse did not give the medication, Cefazolin, at all per physician orders thus rendering inadequate care for the patient's diagnoses.*
 - Charge 2- The nurse did not properly waste Morphine which included the actual wasting of the medication, having a witness to the wasting, and improper documentation of the waste. The error was discovered by a nurse from the next shift when the PCA pump was found with morphine still present in the room thus violating the Controlled Substance Act and jeopardizing the patient and hospital.*
 - Charge 3- Does not get very specific, but determined she either did not perform a proper assessment and/or document the assessment correctly.*
 - Charge 4- The defendant showed up to work in a state unfit to care for patients including an impaired demeanor, slurred speech, and closed eyelids with no fatigue.*
 - Charge 5- The nurse took a urine drug test (due to suspicion of usage) which yielded positive results for amphetamines, alprazolam, and lorazepam. Not only violated Controlled Substance Act but also impaired nursing ability and judgement.*
- *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.*
 - Charge 1- Ensuring that I give medications in a timely order while reviewing the 7 Rights of the patient, ensuring that IF I were to withhold a medication it would be for specific parameters not being met. If I withheld a med, I would ensure to document appropriately and to consult with next person on chain of command ie. Charge nurse, physician, etc.*

Charge 2- Ensuring that ALL medication unused is wasted appropriately regardless of class of drug. Also ensure that documentation is done immediately after wasting and that another HCW visually witnesses me waste narcotics appropriately prior to they, themselves, documenting the act of witnessing.

Charge 3- Ensure to perform any assessments relevant to patient diagnosis and problems. Also, making sure to document any and all findings whether abnormal or normal.

Charge 4- I would not come to work knowing that my physical and cognitive abilities are not up to par. It is better to call in and face potential punishment from your boss over potentially injuring or even killing a patient due to the selfish act of coming in impaired whether it be due to illness, alcohol, or drugs altering your ability to care.

Charge 5- To be very simple, I would not take any drugs. Any prescription narcotics would be consulted with my chain of command to notify them of designated usage OUTSIDE of work. Any narcotics would lessen HCW's ability to care for patients. Taking them on shift or going into shift with effects still present is extremely dangerous to patients, coworkers, and even themselves.

- Identify ALL universal competencies were violated and explain how.
Charges 1,2,4, and 5 violate safety and security wherein all leave patient at risk of injury, further illness, or even death.
 1. Failure to give medication resulted in no treatment thus violating the patient's 7 rights
 2. Leaving the PCA pump with morphine not only left clutter but also could have put patient at risk if they were drug seeking and had a free line to take from.
 3. (charge 4) Showing up in an altered state does not promote trust and respect to patients and easily could have resulted in many missed steps for patient safety.
 4. (charge 5) Drug usage, also, does not result in the promotion of trust and respect and (As state prior) an altered mental status can also have physical manifestations resulting in a decreased ability to care for patients and putting them at risks with forgotten steps and improper techniques.

-ALL charge violate the category of critical thinking by showing the defendants lack of decision making ie. Not giving a medication at all, leaving morphine in a patient room open to anyone, not performing a shift-change assessment or documenting said assessment properly if at all, (for both 4,5) showing up to work in unfit mental and physical condition to care for patients in an adequate and safe manner thus putting them at risk of further harm or death.

-Documentation was violated in charges 2 and 3. Charge 2 showed no other HCW witnessing the waste of morphine and improper documentation of the waste by the defendant. Charge 3 was either an improper documentation of assessments or no documentation if assessments were done at all.

- Human caring was violated in all charges as they resulted in a lack of respect for the patient by not documenting correctly, being in a poor condition mentally and physically, and providing an unsafe environment resulting in improper care of patients and potential further complications.

-Professional role was violated by coming to work in a state unwell enough to care for patients which was noticeable enough to be reported.

- 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.

Charge 1- If I noticed the drug being withheld, I would go to the charge nurse so she could discuss the reasoning and decision making of the nurse.

Charge 2- If I walked into a room with a pump full of morphine or meds improperly wasted in a patient's room, I would firstly remove the meds from the room and have another HCW witness me waste any narcotics as well as noting any wasted medications to make sure that it is noted meds were either not given or refused and left in patient room. Then, I would go to the charge nurse and allow the chain of command to assess further.

Charge 3- I would perform the missed assessments and document findings, then I would go to charge nurse to discuss whether assessments were done as documentation is non-existent or incomplete from shift prior.

Charge 4,5- (essentially the same issue)- If I noticed a fellow provider in a altered mental status, I would notify my charge nurse of next chain of command in order to have them further evaluate and take the steps necessary to ensure that they (defendant) is okay or to ensure that if use of substances are suspected then steps are taken to confirm or disprove. The only reason I would not go to the HCW directly, themselves, is due to the fact that it is a high risk to patient care and the help they need would need to reach someone on the chain of command higher than I.