Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Second Best Nurse, Ever! Date: 1/18/1958 DAS Assignment # 333

NOTICE OF DISCIPLINARY ACTION – 10/1001

Name of the defendant: Silly Me, RN License number of the defendant: 123456789

Date action was taken against the license: 6/9/1959

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.*

Silly Me had multiple occurrences of unprofessional actions while in the clinical setting which led to these disciplinary actions. These unprofessional actions included: Incorrect documentation of intravenous saline administration, incorrect documentation of Aspirin, failing to clarify discharge orders when labs were still pending, failing to document a head-to-toe assessment while under Silly Me's care, documenting medication administrations that they did not witness, and letting a nursing student not under their care give dimetapp subcutaneously when it was needed intravenously. These occurrences all lead to inaccurate medical records and exposed the patients to a risk of harm due to the inaccurate medical records, in which medical personnel need to base their decisions on.

The inaccurate documentation of dimetapp is multifold. In this, not only was the medication not administered the right route of intravenous, but instead was given subcutaneously, the medication was given by a nursing student not under nurse Silly Me's care. This action led to the patient being exposed to the risk of an unauthorized non-licensed person to have any complication with the administration of that medication. Furthermore, the medication may have been given a specific route for a reason due to the individual's medical needs. Thereby opening the patient to potential medical harm and a potentially harmful dose in the wrong route.

Nurse Silly Me gave an inaccurate documentation of aspirin. In this situation, nurse Silly Me had to leave for a rapid response for one of his other patients and before leaving told the patient to take the medication after completing a blood draw from a phlebotomist in the room. Nurse Silly Me did not know if the patient knew how to properly take the medication, nor if the medication was taken properly or at all. Documenting a medical administration that one did not witness, is a false record, and can lead to improper decisions based upon inaccurate data, thereby leading a patient to a multitude of potential harm.

Silly Me also failed to follow proper protocol when discharging a patient. Nurse Silly Me believed they had read a valid discharge order and gave the patient the paperwork along with the visit summary. However, a month

later, Silly Me was notified that the patient was discharged by an unauthorized student who had been given access to discharge, that they had failed to document a head-to-toe assessment, and discharged the patient while labs were pending. This could be potentially catastrophic for the patient, as the labs and Head to toe assessment could have revealed unsuitable results. In addition, with the patient leaving the hospital, there would be no way to rectify any unsuitable results, unless the patient returned or was notified, thereby exposing the patient to unnecessary risk of harm.

In conclusion, nurse Silly Me was negligent of multiple inaccurate documentations and not following proper protocol which resulted in the numerous risks for the patients.

· *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.*

There are multiple measures that could have been implemented to ensure the prevention of unnecessary risk against the patient. For starters, only documenting medication one administers would prohibit fraudulent medical documentation. With the need to respond to another patient under the RNs care, the RN could have delayed the medication administration until after he was done handling the life-threatening situation. This would have allowed the RN to observe and ensure the medication was taken properly and that no side effects occurred.

Adhering to the hospital protocol of preceptorship, would help negate the potential of mishaps of having unauthorized personnel, such as students, not practicing within their scope. The RN could have gone through the nursing student's preceptor to know what the student was authorized to do and if the student was properly trained. If it was found that the student was allowed to follow the RN and perform the procedure, it would have been helpful if the RN had gone through the process with the student to ensure the understanding, thus mitigating potential risk.

In the instance of not discharging correctly, the RN could have verified with another nurse if there was any confusion. Another route the RN could have gone, is to slow down and take the time to make sure everything in their chart was completed such as the labs.

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

Competencies that were violated were Safety and security, communication, critical thinking, documentation, and Professional Role.

Safety and security was violated when the RN allowed a student nurse to give medication via the wrong route thus violating the 7 medication rights for administration. Nurse Silly Me further violated safety and security with incorrect and illegal documentation.

Documentation was violated regarding fraudulently documenting the medications for this patient and for a patient they did not witness the administration for. These discrepancies fall under documentation, as one of the medication administrations were not observed and the other one was not put in correctly.

Communication was violated when the RN did not communicate properly with agency protocols over a student nurse administering medications, and whether he had valid discharge orders for the patient, as the tests from the lab were still waiting to be received.

Critical thinking was violated, as the RN did not prioritize his actions correctly when he left for a Rapid response for another patient, while simultaneously leaving a patient to administer his medication himself. Silly Me should have waited till after the situation was handled, so they could give their full attention to the patient needing the medication administration. This was not only to ensure the meds were delivered properly, but to be available in case an adverse reaction occurred.

Professional Role was violated by completely ignoring all aspects of a licensed nurse (RN), chain of command, knowing and adhering to hospital policy and finally practicing under their licensed scope of practice.

· *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 first person to discover these events, I would first report this to the charge nurse, the head nurse and ensure all physicians in charge of this patient and verify no other damage has occurred and ensure the patients' needs were met. I would do this by calling a patient to return after an unauthorized discharge and have them wait to receive their labs to ensure safety. I would also run labs on the two medication administrations to see how each patient was faring. I would then go over the situations with Silly Me to communicate the discrepancies and see where their train of thought was and what I may be able to help. I would turn in to the state board if I ever saw or knew this person was practicing again as a nurse.