

Covenant School of Nursing  
Disciplinary Action Summary Assignment  
Instructional Module 2

Student Name: Ally Morrow

Date: 3/25/2024

DAS Assignment #   1  

Name of the defendant: Liliana Almeda

License number of the defendant: 758047

Date action was taken against the license: 7/22/2021

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

Liliana Almeda had several failed occurrences of medication administration and documentation in the hospital setting that led to the action taken against her license. These occurrences include failure to administer medication, documenting actions take three to four hours after her shift, inaccurately documenting medication administration, failure to timely administer medications, failure to document notifying physician of patient medication refusal, documented a progress note on the resident four days later and did not denote as a late entry.

Nurse Liliana put her patients in danger by failing to provide them with pain medication and breathing treatments. Nurse Liliana inaccurately documented three to four hours after her completed shift that the previous medications were “held” rather than “not given”. This action was not honest and unethical. Nurse Liliana states that she was unable to administer the medication because her patient was off the unit, the medication was not available due to technological issues with the medication dispensing system, or she held the medication because the patient had difficulty swallowing his medication.

Liliana Almeda failed to administer medication at the correct time. In response to this action, Nurse Liliana failed to document that she notified the physician that the resident had refused medication. Also, this nurse documented a progress note on her patient four days later and failed to denote the note as a late entry. Nurse Liliana responded to her actions by stating that she was waiting to give her patient the medication because they were having trouble

swallowing and she wanted to wait until they were ready to take the medication later. Liliana proceeds to state that she communicated with the physician when the physician called her regarding the patient's refusal to take medications, but she was unsure if she noted the time and which physician she was speaking to.

In conclusion, Nurse Liliana was careless with her documentation practice and administering medication. Ultimately, Liliana allowed her patient to be in harm's way by not providing their medication as effectively as possible. She added to this danger by inaccurately documenting these practices.

- *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.*

Measures that I think would have prevented Nurse Liliana from getting in trouble would have been to find a way to administer the medication to her patient and to provide accurate documentation. One reason she gave for not giving her patient medication was that the pyxis was out of order, so she could have called the pharmacy to see if they could send up the medication. Nurse Liliana also explained that she was unable to locate her patient. In this circumstance, she should have first determined exactly where they were and if she was not able to find the patient, then she should have documented the medication was not given for that reason. Another measure Liliana should have taken was to document as soon as possible that she was unable to give the medication.

Nurse Liliana should have used different measures to ensure timely administration of medication and proper documentation of communication to the healthcare provider. One measure she would benefit from would be to document that she was unable to give the medication due to her patient experiencing dysphagia. She then could check on her patient in thirty minutes and see if there is improvement in their ability to swallow medication. If the healthcare provider gives orders, then when your patient can take their medicine, the nurse can administer it to them. When communicating with the healthcare provider about not giving the medication at the correct time, the nurse should be sure to document the time, physician, and what was said.

In conclusion, Nurse Liliana should have used preventative measures to avoid these mistakes. After examining Nurse Liliana's situation, there are ways to avoid mistakes such as improper administration of medications and documentation.

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

**Critical Thinking-** The nurse violated critical thinking by deciding to withhold medication because she was unable to find her patient and obtain the medicine through the pyxis.

**Documentation-** Nurse Liliana violated documentation by documenting the medication that was not given as "held". The RN also documented three to four hours after the complete shift, and she did not document the time, physician and order when communicating with a healthcare provider.

**Professional Role-** The nurse violated the professional role by acting unprofessional when communicating with a physician by forgetting which physician she spoke and the time when the communication occurred.

- *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 realize that my patient did not receive their medication, I would find the patient's nurse and question her about this situation. Since Nurse Liliana explained that she was unable to obtain the medication due to the pyxis being out of order and she could not find her patient, I would tell the RN that she should call the pharmacy to obtain the medication, and then ask other healthcare providers if they have seen her patient. I would also remind the RN that she can always ask for help if she has any questions that could potentially put her patients in danger. Also, if I was the first nurse to realize how poor the RN's documentation was, I would bring my concerns to her attention, and I would encourage the nurse to improve this skill. I would also remind her that documentation is important because it is proof of every action the nurse completed on her shift.