

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student name: Victoria Gutierrez Date: 8/23/2024 DAS Assignment # 1

NOTICE OF DISCIPLINARY ACTION- 11/10/2020

Name of the defendant: Abrian, Myrna Mosquera RN

License number of the defendant: 508430

Date action was taken against the license: 11/10/2020

Type of action taken against the license: Warning with stipulations

Myrna Mosquera Abrian had made an unprofessional action while working as a registered nurse at the University Hospital, San Antonio, Texas which led to the disciplinary action. The action included: obtaining the incorrect dosage of medication from Pyxis, failing to document/scan medication correctly, and failing to conduct the correct number of checks. This action could have put the patients' life at risk for adverse reactions from possible overdose of the medication that was given.

Myrna was in a rush which resulted in not paying attention to how much she needed for the patient and not doing her checks to make sure it was accurate. While admitting to believing the medication for one tablet contained one milligram, she still failed to check the eMAR to confirm it was correct. As a result, false documentation in Pyxis was made and she took only four milligrams of Dilaudid instead of the two milligrams gathering double of what was ordered by the physician. Also, she falsely scanned the wrong number of tablets she had in the patients Medication Administration Record that she gave the patient only two tablets of Dilaudid not four.

The measures that the nurse could have taken to ensure the prevention of the unnecessary risk against the patient are more than one. First, she could have slowed down and took the time that was needed to ensure the correct medication and dosage was administered. Secondly, she could have also had another nurse with her to double check whether it was the right medication and dosage for the patient. This would have prevented her from giving her patient too much medication and the patient would not have been in danger of adverse reactions to the medication.

Safety and Security (emotional) was violated when the nurse gave the patient the incorrect dose while the patient trusted her to administer the medication.

Safety and Security (physical) was violated when the nurse failed to do all seven rights such as, administer the right dose and documentation.

Documentation was violated to not scan the right dosage in the eMAR medication.

Critical thinking was violated, as the nurse did not prioritize her actions when she was gathering the medication for the patient.

Professional Role was violated by completely ignoring all aspects of a registered nurse knowing and adhering to hospital policy resulting in medication error and hospital violation.

If I was the first person to discover the events, I would first go to the patient and watch them to see if they would have any reactions to the medication error. Then I would go to the charge nurse to inform them of what had happened and to report the patient's vital signs and if anything, abnormal happened. I would then go over the situation with Myrna and inform her of what she has done and try to understand her mind set while also figuring out how I may have helped her.