

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Cynthia Rodriguez

Date: 08/19/2024

DAS Assignment # 1

Name of the defendant: **Kaelyn Honeycut Boyd, RN**

License number of the defendant: **855582**

Date action was taken against the license: **07/22/2021**

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

- *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.*

Kaelyn Honeycut Boyd received two formal charges, filed on November 6, 2018. One charge for excessive dosage/frequency of physician order for Hydrocodone/APAP, and the second formal charge for failure to provide documentation per physician orders, Hydrocodone/APAP in the Medical Administration Records/Nurse's Notes.

Excessive dosage for pain medications may cause excessive harm to a patient, such as adverse reactions. Failure to document any medications provided to a patient is considered malpractice and could result in harm to a patient resulting in non-efficacious treatment.

- *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.*

Providing exceptional care for patients is key in nursing. Following protocol and the steps to ensure patient safety is top priority. When accessing medications, it is imperative that the nurse verifies physician's orders and checks the medication dispensing device to ensure the correct medication and amount is being withdrawn. Also, the nurse must provide each patient with the 7 rights, which also informs the patient of the medications, the amount, and description of what they will be receiving. This also provides the nurse with the opportunity to check the system to ensure that the patient is receiving the correct amount.

Failure to document medication or patient activity is considered malpractice and is punishable. A nurse is responsible for complying with the patient's rights and hospital policies and procedures. Each time a nurse is in the patient's room, preparing to administer medications, the system is pulled on the computer. This technology provides nurses the ability to quickly document each medication and time given. By not providing documentation, patient safety is breached, and the nurse is in violation.

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

Safety and security were breached when Mrs. Boyd, RN dispensed excessive amounts of Hydrocodone/APAP. The nurse could have cause injury to the patient by causing adverse reactions, which could lead to possible overdose and death.

Documentation was violated per hospital policies and procedures and patient rights. When medication is given and not documented properly, there is no way to ensure the patient has been given the medication, which could also cause possible overdose or neglect for patient needs to ease pain they may be suffering with.

Failure to provide documentation could also result in a co-worker who is also providing care to the patient, failing and cause medication error, by overdosing the patient. Communication and documentation is key to providing the upmost care.

Professional Role as a nurse ensures each patient that nurses respect and will provide them with proper care. If the nurse fails to demonstrate the ability to administer proper amounts of medication and failure to document the care provided, the nurse has violated patient trust.

- *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 ever was in a situation, observing a nurse in the medication room, withdrawing excessive amounts, I would verify they were dispensing the correct amount. I understand there are times when hospital floors are excessively busy, and a nurse can accidentally grab the wrong amount. However, if I was not present to observe the mistake, and I was in contact with the patient, and they informed me medication was given but they were not sure what it was, I would immediately speak to the charge nurse to inform them they may need to check with the previous nurse in charge of the patient to ensure documentation was done, and if the patient was given their rights to medication.