Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Jailene Gonzalez Date: 08/29/2024 DAS Assignment # 2

Name of the defendant: Sandra Jean Rozell License number of the defendant: 921098

Date action was taken against the license: 11/12/2019

Type of action taken against the license: Revoked

Sandra Jean Rozell committed actions that compromised patient care/safety and the nursing profession while employed at St. David's South Austin Medical Center and at Seton Medical Center Hays. While working as a nurse in both sites, the respondent made a medication error with Hydrocodone, did not follow wastage protocol of Hydromorphone, misappropriated Hydromorphone, incorrectly documented various medications, and lacked fitness to practice.

On September 05, 2017, nurse Sandra administered Hydrocodone when the patient mentioned a pain level of seven. However, the correct admin was to provide the medication as needed for a 4-6 pain level. This is concerning since the patient's comfort needs were not addressed correctly. The incorrect administration also resulted in impotent patient treatment.

The respondent falsified administering medication in October 10,2017; six tablets of Hydrocodone/APAP and 6mg of Morphine Sulfate to the patient. The nurse documented that this medication was given to the patient, although the patient did not receive any of this medication noted. This action greatly influences the treatment the physician is planning for the patient and the approach caregivers decide on based on the documentation.

While at St David's South Austin Medical Center, the respondent misappropriated one mg of Hydromorphone and six tablets of Hydrocodone/APAP 5/325mg and three syringes of Morphine Sulfate 2mg. These medications were withdrawn for the medicine system inappropriately, in two separate occasions: September 16,2017 and October 10, 2017. The nurse jeopardized the legal standing of the medical center, and her license by violating 22 TEX ADMIN CODE, and making it seem as if the patient were responsible for the costs of these medications.

The facility's policy for wastage of unused medicine amounts were not followed on September 26,2017, when the nurse withdrew Hydromorphone. This policy is placed to follow the Controlled Substances Act, and for the facility/staff to avoid any legal repercussions when not adhered. Medication errors and diversion of unauthorized medication use is avoided as well with this regulation.

While at a different facility, Seton Medical Center, the respondent presented to their nursing shift disheveled, her gait was impaired, had difficulty in communicating verbally and was not able to keep her eyes open. The nurse was unable to meet the required fitness to practice on November 18,218 while on duty. She has abnormal behavior, significantly affecting her being able to complete nursing task to best take care of patients, and unable to properly observe or judge patient's condition. Other caregivers require her to have the ability to make rational, and accurate judgements on patient's care for them to do their part to ensure patient safety and treatment efficacy.

A step that was continuously overlooked by the respondent that could've greatly prevented her license being revoked was to seek counselling in possible substance abuse. Staff witnessed her behavior and fitness being impaired, this could be an indication of the behavior changes substance abuse can cause in many, even a registered nurse. A nurse will remain exposed to several medicines, including opioids, and drugs that have high risk of addiction. Self-awareness could've played a significant role in this situation, becoming aware of the conflict (drug use), how the conflict affects patient safety, and being aware that the environment facilitates the conflict. I imagine her peers may have seen a decline in her behavior, and by respectfully approaching her to ask if she needed help, could've prevented this situation.

Patient safety is a high priority as a nurse, as well for other caregivers, we all work as a team to ensure best of patient care. Also, there are regulations placed in each facility, such as waste protocol and proper documentation to minimize situations that involve patient safety and the legal standing of the facility from being compromised. The respondent could have prevented incorrect administration of Hydrocodone by providing the medication at the pain level the physician ordered.

The responded violated safety and security, standard precaution, communication, critical thinking, documentation, human caring, and professional role.

Safety and security were violated by documenting medication not administered, administering medication at a level 7 while the correct order was prn at a 4-6 pain level, and by not meeting the required fitness and mental state to make accurate decisions upon patient's care.

Communication was violating when she was not fit to properly express her thoughts, due to possible substance abuse). Also, through the improper documentation that other caregivers will read and base clinical judgement on.

Critical thinking was violated when administering Hydrocodone at a pain level 7, when the physician noted it should be giver when needed at a pain level of 4-6. The nurse should understand the importance of recognizing the patient's comfort needs, and how an incorrect judgement could cause a non-efficacious treatment.

Documentation was violated when she falsely documented that six Hydrocodone tablets and three 2mg syringes of Morphine Sulfate were administered. Improper documentation can result in a life threating situation by another caregiver accidently providing more mediation, and in result an overdose.

Human caring was violated by the respondent not prioritizing patient's safety and efficient treatment as demonstrated by being unfit, incorrectly administering medication, and not following facility protocols. The well-being of the patient was not met, again this could result in the passing or serious injured of a patient/s.

Professional Role was violated when she presented herself to her shift with a difficulty of keeping her eyes on, and not being able to stand well. It was not professional of her to not follow waste protocol and falsely documenting med admin.

One of the first steps I would take once aware of the situation is to ensure patient safety and treatment efficacy. If I were to be present during the day any of these events occurred, I would take the patient's vitals, observe for patient reaction, and communicate with charge nurse to explain to the healthcare team that medication was incorrectly administered. I would also recognize that the respondent may need help herself, therefore check her vitals, and once stable recommend counseling, and possibly resigning until recovered.