

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Brittany Fox

Date: 10/16/2024

DAS Assignment # 1

NOTICE OF DISCIPLINARY ACTION – 10/2022

Name of the defendant: Susan Touchstone

License number of the defendant: 757502

Date action was taken against the license: 07/21/2022

Type of action taken against the license: Enforced Suspension

- *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.*

Susan Touchstone had one occurrence of an unprofessional action that resulted in her nursing license being suspended. This unprofessional action occurred in the clinical setting at UTMB Galveston. Touchstone had administered a Heparin infusion to the wrong patient by not correctly identifying the patient prior to administration. The Heparin infusion was intended for another patient on the unit. This action exposed the patient to an increased risk of bleeding, which could result in further patient harm, such as cardiac arrest. The patient could have had an allergy to Heparin, which could have led to an anaphylactic reaction.

Not verifying the correct patient prior to administration resulted in the patient having adverse reactions. Once the Heparin infusion was initiated, the patient experienced hematemesis, seizures, and was eventually intubated. The patient became unstable and had to be moved to the ICU. He was admitted in the hospital for another month and had to receive fresh frozen plasma (FFP). FFP was given to the patient to stabilize his ability to form blood clots since Heparin is used to prevent the blood from clotting.

Since Touchstone administered the wrong medication, it resulted in the patient having a longer stay in the hospital. This put him at an increased risk of developing pressure ulcers, acquiring hospital infections, and distrust in the medical staff. Touchstone did not follow the 7 rights of medication administration and it resulted in the patient suffering serious complications.

- *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 a multitude of measures the nurse could have taken to prevent the unnecessary harm that was caused to the patient. Susan Touchstone could have verified the doctor's orders prior to administering the medication. She could have asked the patient to state his name upon entering the room and verified it against

the armband. Touchstone could have scanned the armband and medication prior to administration, alerting her that the patient was not intended to receive Heparin. The medication would not have matched the eMAR had she scanned it.

Additionally, the nurse could have asked the patient if he had any questions about the Heparin before administration, alerting him to a new medication he hadn't received yet. If she provided education about the medication and followed the 7 rights of medication administration, the incorrect administration could have been avoided. She also could have had another nurse in the room with her to confirm the dosing and order of Heparin for the patient.

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

The universal competencies that were violated by Susan Touchstone were safety and security, communication, critical thinking, documentation, and professional role.

Safety and security was violated when Touchstone did not verify the patient prior to administering the medication. She did not ask the patient their name and date of birth or check it against the patient's armband. She violated the 7 rights of medication administration by not verifying the patient, right medication, reason, and documentation.

Communication was violated by the nurse not providing teaching about the Heparin medication. Had the nurse taught the patient about Heparin, it could have resulted in the patient questioning why they were receiving a medication for issues they don't have. Or the patient could have questioned why they are receiving a new medication.

Critical thinking was violated when the nurse did not think about why she was administering Heparin to the patient. Had she known her patient and the needs of said patient, she could have realized that Heparin was not indicated.

Documentation was violated when the nurse did not scan the medication prior to administration. Had the nurse scanned the medication and compared it to the eMAR, she could have realized that the medication was not to be administered to the patient.

Professional role was violated as the nurse did not adhere to the standards of care. She completely disregarded medication safety and patient safety when it came to administering medications.

- *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.*

Had I been the nurse to discover this medication error, I would immediately notify the charge nurse and patient's physician. I would monitor the patient's aPTT lab values and watch for any signs of bleeding. I would be routinely checking on the patient every 5-10 minutes or I would have placed a sitter in the room to watch over the patient for any signs of decline in health. I would have left the patient's door open so I could listen for vomiting. I would also inform the patient to notify me if he experienced bleeding gums, bruising over his body, and blood in his urine, bowel movements, or vomit. Additionally, I would have blood or plasma transfusions ready to be set up in the patient's room. Lastly, I would have advanced airway equipment in the room to protect the patient's airway should the need arise.