

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Allyson Jordan

Date: 10/25/24

DAS Assignment # 1

Name of the defendant: Virginia Bernice Woods

License number of the defendant: 607967

Date action was taken against the license: 01/21/21

Type of action taken against the license: License Revoked

The respondent, Virginia Bernice Woods, came to work at Northwest Texas Hospital in Amarillo, Texas exhibiting an unstable mental health capacity in January of 2014 resulting in her admittance into a behavioral facility. Furthermore, in July of 2014, she was admitted again to the behavioral facility because she was lacking the ability to practice nursing. Both instances could have resulted in the respondent's ability to note changes in status of her patients as well as use critical thinking skills in terms of assessments and decision-making. While employed at a Rehab Center in Kerrville, Texas in April of 2015, the wrong dosage of two separate medications for two separate patients was given. This could have resulted in ineffective treatment, causing harm or injury to the patients. In addition to giving the wrong dosage, the respondent also incorrectly transcribed a doctor's order for a longer frequency of medication administration which could have resulted in patients demise had the order been followed that way. Later in the month of April 2015, the respondent was observed acting erratically. A strong odor of alcohol could be smelled when a cup she was seen drinking from was opened. She also displayed tremors when involved in a meeting regarding the incident a few days later. Woods also failed to give ordered medication to two separate residents while employed at the Rehab, and it is noted that the medications were found in medication cups in the med cart. This action could have led to each residents' demise.

No harm toward the patients/residents was reported; however, that doesn't mean it didn't happen. Because the respondent failed to administer some medications or gave them too much, who knows what kind of adverse effects the patients/residents had. I would say to prevent having the action taken against the license,

proper care should have taken place when withdrawing medications. All 3 med administration checks should be taken to avoid giving the wrong dosage, which leads me to believe she did not do these checks. As far as drinking on the job, it should just not have happened. Being admitted into a facility was obviously needed for her due to her mental instability, but I just wonder if there were subtle signs earlier on that could have been caught.

Universal Competencies Violated:

Safety and Security (Physical & Emotional) – *It is clear the respondent violated this universal competency by failing to give medication in its proper dosage by making sure to do all 3 medication administration checks. Due to this as well as her mental incapacity, she did not promote trust with her patients/residents either.*

Critical Thinking – *The critical thinking aspect of the universal competencies was breached when the respondent was unable to complete shift work due to being inebriated as well as mentally unstable. It was noted that this was a hindrance to her ability to use evidence-based practice.*

Professional Role – *The mental incapacity of the respondent was clear when she was seen crying and threatening suicide while on shift. This is definitely seen as unprofessional as no one would like to be taken care of someone who is acting like this.*

First and foremost, I feel that the right thing to do would be to stick up for patient safety and advocate for the patient by way of stopping whatever could be harming them at the immediate time. I would then go directly to the charge nurse or anyone else above me to report my findings. It is crucial to do it right when the event happens so it can be addressed promptly. As hard as it is to report these things, patient care/safety is always the priority.