

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Jasmine Abalos

Date: 10/19/2024

DAS Assignment # 1

Name of the defendant: Bailey Rose Twigg

License number of the defendant: 857659

Date action was taken against the license: 3/14/2023

Type of action taken against the license: Warning with Stipulations

- *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.*

In December 2019, Bailey Rose Twigg, a registered nurse employed at a San Antonio hospital, had multiple occurrences that led to disciplinary action. These occurrences were related to inaccurate/failure to document the administration and wastage of narcotic medications. With at least four patients, Twiggs failed to properly document the administration and wastage of Morphine and Hydromorphone injections. She failed to document that the medication was given, and that the vial was not entirely used, so the remaining amount was unaccounted for. Twiggs claims to have forgotten to chart the administration of these narcotic medications, and claims to have wasted what was not used for the patient's dose. However, without proper documentation, there is no way of telling if the medication was disposed or given. Twiggs denied misusing the medications for misconduct, but instead claims administrative errors. For three other patients, Twiggs withdrew Morphine from the dispensing system, but inaccurately documented the medications by documenting more administration and wastage than what was actually withdrawn. Due to these events, Bailey Rose Twigg was given a warning with stipulations. These occurrences led to inaccurate medication administration records, but no direct patient harm was accounted for. By completely failing to document the administration of the medication, patient harm could have occurred. Overall, Twiggs failed to follow her hospitals protocols and procedures for wasting the unused portions of medications, as well as failing to document the administration of the medication itself, both of which left medications unaccounted for.

- *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.*

In this case, the nurse failed to correctly document medication administration and wastage. Measures that could have prevented these occurrences include correct documentation at bedside and medication verification (three checks of med admin). As soon as the nurse administers the medication at bedside, she should document that it was given. As well as that, when pulling the medication, if the entire vial is not used for the patient's dose, the nurse should document wasting the leftover portion. Documenting as soon as you complete a task, would be helpful, so you will not forget to do it later. In this case, it is also important to be careful when dealing with narcotics, since these medications are addictive and can be harmful if misused. Since the nurse

had also incorrectly documented medication administration (documenting more than what she withdrew), it would be helpful to slow down and make sure everything is charted correctly. Also, asking for help from another nurse on how to correctly document can help ensure understanding if there is any confusion that she might have felt, since she had several occurrences of wrong documentation.

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

Universal competencies that were violated in this case were documentation, communication, and safety. Documentation was violated when the nurse failed to document the administration and wastage of Morphine and Hydromorphone. The nurse also incorrectly documented medications, by documenting more than what was withdrawn and leaving medications unaccounted for. Communication was violated when the nurse failed to document in the patient's eMAR that a medication was administered. By failing to document that a medication was given, there would be no proof of its administration, and other nurses will not have accurate information regarding the patient's care. Without proper communication/documentation, a patient's safety can be at risk, especially when dealing with narcotic medications that can heavily affect the patient. If another nurse later gave that same medication, it could put the patient at risk of overdose since an earlier dose was already given, but was not documented/properly communicated. Safety was violated when the nurse failed to perform some of the 7 rights of medication administration. Within these rights, she failed to do documentation. Overall, by failing to document and properly communicate that medications were given, the patient's safety would be at risk.

- *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 was the first person to discover the event of a nurse incorrectly documenting the administration/wastage of medications, I would first confront the nurse and offer some constructive feedback. I would go over the situation with the nurse, to understand her stance, whether it is because of her workload and she forgot to document, or if she does not understand how to properly document, etc. Because this nurse repeatedly forgot to document, I would give her tips to ensure documentation (right after administration at bedside). By communicating with the nurse about her thought process and the situation, I could see if there is anything I could do to help. Since she also documented the waste of a medication incorrectly, I would show her how to properly document when she first pulls and wastes the medication in the med room. And in this case, since narcotics were the medications in use, and a second nurse is usually required to witness its wastage, I would make sure to stay in the med room to watch that the medication was properly wasted. If I notice that these occurrences keep happening, then I would report it to the charge nurse. Since failing to document medication administration could be harmful to a patient, I would make sure to inform the chain of command, if errors kept occurring.