Covenant School of Nursing

Disciplinary Action Summary Assignment

Instruction Module 2

Student Name: Gracie Harrison Date: 10/25/2024 DAS Assignment # 1

NOTICE OF DISCIPLINARY ACTION –

Name of the defendant: DANIELLE ELIZABETH COPELAND, RN

License #: 929020

Date action was taken against the license: November 8, 2022

Type of action taken against the license: REVOKED

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.

1. On January 5, 2019, Danielle improperly inserted a peripheral intravenous catheter (IV). She inserted the catheter IV pointing downward toward the patient's hand, instead of pointing upwards toward the heart. Subsequently, the IV site became infiltrated, swollen, and developed blisters at the insertion site. Her conduct unnecessarily exposed the patient to risk of injury from adverse complications of peripheral IV infiltration: including pain, skin swelling, and blisters.
2. On September 12, 2019, Danielle improperly stopped vancomycin infusion without a physician order. This conduct exposed the patient to a risk of harm in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's cellulitis.
3. On October 12, 2019, Danielle inaccurately documented the administration of physician-ordered 75 units of NPH insulin. She only administered 7 units and was awaiting additional insulin from the pharmacy; however, she failed to administer the remaining insulin on delivery and failed to report the outstanding dosage to on-coming

nurse. This conduct created an inaccurate medical record and was likely to injure the patient from potentially adverse complications of untreated blood glucose levels.

In response to incident 1. Danielle states that she was placed on a personal development contract to improve her intravenous therapy skills. In response to incident 2. Danielle states that she mistook the vancomycin infusion for another medication and stopped the infusion without verifying the medication. In response to incident 3. Danielle states she did not document that only a partial dose was administered to the patient and that she forgot to correct her medication administration documentation.

In conclusion, nurse Danielle received the sanction of REPRIMAND WITH STIPULATIONS. She was ordered to complete the Board's online course, "Understanding Board Orders" within 30 days and submit course verification. She must also complete remedial education courses within 1 year: A (minimum of 6 hours) Board approved course in Texas nursing jurisprudence and ethics. A (minimum of 6 hours) Board approved course in nursing documentation. A (3.6 hour online) "sharpening Critical Thinking Skills" program by the National Council of State Boards of Nursing (NCSBN). There were also other stipulations of this order including: notifying each present employer and provide a copy of the court order, submit the Board's "Notification of Employment" form to the Board within 10 days, and be supervised by a RN with a minimum of 2 years' experience. Also, have each employer immediately submit and incident reports involving her to the Board's office and nurse performance evaluations every 3 months.

After compliance with the terms of this order and successful completion of the required courses, all encumbrances will be removed from Danielle's license.

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 some basic simple measures that nurse Danielle could have completed to prevent these actions and/or harm. Danielle should have asked for assistance with inserting the IV correctly if she did not know how to do so. She should have verified the medication on the fluid bag and in the patient's chart prior to discontinuing the infusion. Also, she should have confirmed

the physician’s order prior to ceasing the infusion. Lastly, she also should have had another nurse verify the NPH insulin units drawn up to administer to the patient and documented that she only gave 7 of the 75 units ordered. She also should have Reporting to the oncoming shift nurse that only part of the dosage was administered.

The Texas Board of Nursing provided Danielle with opportunities to comply with this order; however, with her failure to obey and comply it is out of the nursing board’s hands. The Board did take measures by providing her with ample time to complete the required courses for compliance with the order, but she chose not to; therefore, her license was revoked. No patients were reportedly harmed in this DAS; however, the potential was there.

Identify ALL universal competencies violated and explain how.

Competencies that were violated were:

Standard Precautions were violated when nurse Danielle improperly inserted a peripheral intravenous catheter (IV), stopped administration of a prescribed medication without an order, and inaccurately documented the administration of physician-ordered insulin while also failing to report the outstanding dosage to on-coming nurse.

Human Caring was violated in these circumstances as well. Nurse Danielle failed to comply with a nurse’s professional code of ethics.

Safety and security (physical) competency was violated when Danielle improperly inserted a peripheral intravenous catheter (IV), stopped medication without an order, administered incorrect dosage of insulin thus violating the 7 medication rights for administration. Nurse Danielle further violated safety and security with incorrect documentation regarding insulin administration.

Documentation was violated regarding inaccurately documenting the administration of physician-ordered insulin. These discrepancies fall under documentation, as one of the medications administered was not documented correctly.

Communication was violated when nurse Danielle did not communicate properly with the on-coming shift nurse regarding the insulin dosage administered and failed to report the outstanding dosage.

Critical thinking was violated, as nurse Danielle inserted a peripheral intravenous catheter (IV) pointing downward toward the patient's hand, instead of pointing upwards toward the heart. This was not only to ensure the IV fluids ordered were delivered properly, but a violation of basic nursing skills.

Professional Role was violated by ignoring many aspects of a licensed nurse (RN), chain of command, knowing and adhering to facilities policy.

Use the space below to describe what action you think a prudent nurse would take as the first 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 that this nurse inserted the IV incorrectly, I would first follow my facilities policies and procedures as a general guideline. My first priority is the patient's safety. So, I would assess the situation to determine if there are any immediate adverse effects. If needed, provide first aid or seek urgent medical assistance and notify my supervisior or charge nurse on duty immediately.

For the second action of stopping the vancomycin infusion without a physician order. I would follow my facilities policies and procedures as a general guideline. Again, my first priority is the patient's safety. So, I would assess the situation to determine if there are any immediate adverse effects and immediately report this to the charge nurse, physician, and/ or the patient's nurse. Only the physician has the legal authority to discontinue a physician order. As nurses we have a scope of practice that we must adhere to and not practice out of this scope.

Regarding the third action of inaccurately documenting the administration of physician-ordered insulin and failing to report the outstanding dosage to on-coming nurse. I would follow my facilities policies and procedures as a general guideline. I would establish the extent of the problem. Dealing with the patient's clinical safety is of course my first step. So, I would assess the situation to determine if there are any immediate adverse effects and immediately report this to the charge nurse, physician, and/ or the patient's nurse.