

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: **Alyssa Pagano** Date: **10-25-24**

DAS

Assignment #   1  

Name of the defendant: **Ann Sarah Daniel**  
defendant: **789925**

License number of the

Date action was taken against the license: **12-10-2019**

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.*

**Ann had multiple occurrences of unprofessional nursing practice in the clinical setting as well as putting her patients at risk. Ann's first instance was on November 19, 2018 while working at Baylor St. Luke's Medical Center, Ann failed to document an assessment of a central line and failed to document the patients refusal of the central line dressing change. This resulted in an incomplete medical record and was likely to injure the patient due to future caregivers relying on her charting to proceed with care.**

**Ann's second instance occurred on January 17, 2019 while working at Baylor St. Luke's Medical Center, Ann failed to document clarification with a physician regarding an order for eyedrops. Ann documented that she had given the medication but she gave the medication when it was not verified by the pharmacy due to a discrepancy between the dosage of the order and the medication itself. This resulted in an incomplete medical record and was also likely to injure the patient due to future caregivers not having accurate records to go off of and proceed with patient care.**

**Ann's third instance occurred on February 4th, 2019, while working at Baylor St. Luke's Medical Center, Ann failed to discontinue tube feeding for her patient at midnight, as ordered, in anticipation of a tentative procedure scheduled for the following day. This resulted in likely injury to the patient due to a delay in treatment related to failure to follow a physician's order to make her patient NPO by midnight for their procedure.**

- *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.*

**For Ann's first instance, this could have been easily avoided by charting in the patient's room at bedside. Central lines can get infected very easily and Ann could have also used this as a teaching moment for her patient to describe this to them.**

**For Ann's second instance, this could have been avoided through our required 3 medication checks. As well as through communication with the provider and/or the pharmacy, yes this may delay care for about an hour but at least the nurse would have known the medication she was administering to her patient was 100% correct and 100% what the patient needed. This would have also led to the patient's future caregivers to have an accurate record to refer to.**

**For Ann's third instance, this sounds as though this mistake was made by simply being forgotten and/or too busy. I think Ann could have avoided this situation by better prioritizing her patient's care and being more thorough in her critical thinking.**

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

**Documentation: Documentation was violated due to Ann deciding not to chart her CVAD assessment, not charting her patient's refusal to a CVAD change, not documenting her physician's specific medication order of eye drops, and documenting an inaccurate medication given to a patient.**

**Safety and Security (Physical):** This was violated due to Ann not following the seven rights of medication administration before administering eye drops to her patient.

**Communication:** This was violated due to Ann not communicating and clarifying her physician's orders on the correct dosage on a medication as well as not communicating with the pharmacy on this as well. Communication was also violated when the nurse did not document accurately in her patient's charts on the first 2 instances leading to communication errors with future care providers.

**Critical Thinking:** Ann violated the critical thinking universal competency by not making her patients NPO by midnight for thier procedure in the morning, delaying patient treatment. This was also violated due to not charting her assessment of her patients CVAD.

- *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.*

**As if I was the prudent nurse to encounter these violations, I would be very critical as to how mistakes like this can happen. There is a reason we have the universal competency guidelines that we do and all of these mistakes could have been easily avoided. It seems as though this nurse was either distracted, unprepared, or had no sense of urgency. Actions I would take against this would be a potential suspension as well as a course in documentation and communication because that is what Ann seemed to struggle with the most. All of this instances fell pretty close between eachother so that is another factor I would consider—distraction. I would take action against this by talking with Ann and seeing what else is going on.**