Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Bre Allen Date: 10/22/24 DAS Assignment # 1_____

Name of the defendant: Lisa Ann Wilson License number of the defendant:742094

Date action was taken against the license: 06/08/2021

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.*

Nurse Wilson had several similar occurrences of medication administration errors while working at Medical City Plano. On one day Ms. Wilson had two different patients in which she failed to document administration of hydrocodone 10/325 mg or complete the documentation. In the following days she went on to commit further violations of the 7 rights of medication administration, by not properly checking orders for PRN administration of hydrocodone based on parameters set by the provider.

Failing to provide documentation of any medication administration is always important. However, failure to provide documentation of hydrocodone could be fatal to patient. Improper documentation of an opioid could lead to patient receiving medication to soon, leading to an adverse reaction. No documentation of administration could also lead to pt. harm in unnecessary suffering, with a delay of administration due to the following nurse not knowing what time pt. received last dose of pain medication. Failure to document could also leave the nurse open to suspicion of unprofessional conduct rule 217.12.

By administering hydrocodone for a pain level rated below the physician's indicative parameters of severe pain level 7 out of 10, the patient was administered medication incorrectly. This puts the patient at risk for adverse reactions such as dependency or increased tolerance at current dose. When Ms. Wilson administered hydrocodone for a pain level above the indicated parameter ordered by the physician for moderate pain of 4-6 out of 10, patient was potentially harmed by receiving inadequate treatment for pain. This also exposed pt. to delayed treatment for correct intervention.

When notified of the errors listed above, Nurse Wilson states she didn't scan the medications upon administration in the MAR, but she documented them in the patient's chart. This is still inadequate documentation and lacks an accurate timeline of when patient was given medication, as this should have been done at bed side. In response to administering pain medication outside of the parameters she states she used her judgment based on her observations the patients. With out the proper documentation, this still shows a lack of competency for medication administration.

Based on the findings Ms. Wilson exhibits a lack of competency if the 7 rights of medication administration and the importance of documentation. Her actions exposed her patients to unnecessary risk to adverse reactions.

All of Ms. Wilson's errors could have been avoided with no unnecessary risk to patient having adverse reactions. First, she could have avoided giving pain meds outside of the physicians ordered parameters, by reviewing the orders thoroughly, not by what the patient was comfortable taking in this instance. She could have consulted with the charge nurse and physician regarding her observations, then proceeded if the physician agreed. Second, she could have made sure to scan patient's wrist band, and hydrocodone at bed side and marked given to establish accurate timeline and proof of administration.

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

Safety and security was violated when the nurse failed to scan patient wrist band, or medication at bedside, along with marking given. Nurse failed to adhere to physician order when she gave pain medication outside of the instructed parameters. All of these violated the 7 rights of medication administration.

Documentation was violated when nurse failed to document administration, and her observations that led to her decision to give medication outside of parameter.

Communication was violated when nurse didn't call a charge nurse or physician to discuss her observations before giving medication incorrectly.

Critical thinking was violated when nurse did not consider the domino effect of not documenting medication administration, and the effects could happen if patient had been dosed to soon with an opioid due to no record of when medication was administered.

Professional Role was violated when patient didn't document giving the narcotic that she pulled from the pixies, didn't follow the 7 rights of medication administration, and did exhibit the application of knowledge and patient safety expected from a registered nurse.

- *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 were the one to first notice these violations, I would first review the nurse's progress notes from her care of pt. If on the same day I would check with patient to ensure pain is managed, and that they received their medication if alert and oriented. I would notify the charge nurse of the medication error, and no record of administration of medication. I would also verify with nurse Wilson on what time she last administered pt. medication to avoid early or late dosing if possible. I would also show her that she failed to follow the physician's order, and properly document.