Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Jasmine Abalos Date: 10/22/2024 DAS Assignment #2

Name of the defendant: Shawna Amber Stuermer License number of the defendant: 919937 (1)

Date action was taken against the license: 3/29/2023

Type of action taken against the license: Enforced Suspension

- *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 October 2018, Shawna Stuermer, a registered nurse working at Covenant Medical Center, had several occurrences that led to disciplinary action. These occurrences were related to inaccurate documentation and malpractice when administering medications. For multiple patients, Stuermer withdrew medications from the dispensing system without accurately completing documentation for their administration and wastage. The nurse failed to document that medications were given to her patients and that the vial was not entirely used. Without proper documentation, information regarding her patients' care was inaccurate and incomplete. Not recording that medications were given could potentially cause patient harm and overdose. Her inability to document wastage also left the remaining medication unaccounted for. She was also guilty of dispensing more medications than necessary, regardless of the physicians order. Not following the physicians orders could also result in patient harm and overdose. Steuermer also failed to document/assess her patients pain score. This is typically required before administering pain medications, but regardless, it is important patient information that needed to be documented. Steurmer claims to have felt overworked and lacking in time management, which caused her to have these occurrences. It was later found that Steurmer did not have a substance dependence disorder, so she was cleared to not be using the medications for misconduct. These errors led to Steuermer receiving an enforced suspension. Even though no direct patient harm was accounted for, failure to document and administer medications properly can be harmful.

- *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.*

A nurse's inability to follow correct protocols involving documentation and medication administration can lead to potential harm towards their patients. In this case, measures that could have prevented these occurrences from happening include documentation verification (three checks of medication administration) and time management. This nurse failed to completely document administration and wastage of medications, so it is important to document accurately and as soon as possible. At bedside, the nurse should document when the medication is given to the patient, and wastage should be documented in the med room. Documenting as soon as possible would help avoid incomplete medication administration records, ensuring that all necessary

information is provided. Also, verifying the physicians order when pulling medications from the dispensing system and before administration is important. This nurse gave excess medication against the physician's order, which could have led to overdose and patient harm. As well as that, the nurse failed to assess her patients pain level before medication administration. This is important to assess prior to administration, since certain medications require a specific pain level before receiving it (ex: opioids). In this situation, the nurse may have forgotten to document/ask about the patient's pain, so it might be helpful prior to administration to include this question when verifying the patients name, date of birth, and allergies. Since that patient information is already required when entering the patient's room, it might help to "group" those questions together. The nurse needs to understand why the patient needs a medication and if it is appropriate to give before administration. So, before giving medications, it is essential to verify the physician's orders, document correctly and completely, and assess the patient. The nurse claims that all of these occurrences were due to poor time management and excessive workload. So, it would be helpful for the nurse to work on her time management skills by prioritizing tasks and asking for help when necessary. With proper time management, it would help the nurse from documentation and medication administration errors from occurring. These errors could have caused patient harm, so it is important to slow down and verify that proper protocol was enacted when administering medications and documenting.

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

Universal competencies that were violated in this case include safety and security, communication, documentation, critical thinking, and professional role. This nurse failed to properly perform medication administration by documenting incorrectly, going against the physicians orders, and not assessing the patients pain. Safety and security was violated when the nurse failed to do some of the 7 rights of medication administration (right dose, reason, and documentation) and the 4 P's (pain). This nurse did not properly complete documentation that medications were administered or wasted, so the patients eMAR lacked accurate information. She also pulled excess medications against the providers orders which could result in overdose. Failing to document the patients pain score before administering medications, goes against the 7 rights, since the nurse should understand when and why a medication should be given. Documentation was violated by incorrect and incomplete documentation of medication administration. This nurse failed to document that medications were given to her patients as well as the unused portions of the medications that were wasted. Because of this, there isn't accurate data in the patients medication administration records, therefore putting the patients care at risk due to incomplete data. Communication was violated due to lack of documentation, since the healthcare team and other nurses will not have complete information regarding the patient's care. Critical thinking was violated when this nurse failed to decision make, assess the patient, and prioritize tasks. When the nurse decided to give medications more frequently than what the provider ordered, though she might have deemed it necessary in the patients case, going against the providers order can be harmful to the patient. As well as that, since the nurse failed to document the patients pain scale, it is unclear if that was assessed before giving medications. Professional role was violated due to the nurses inability to perform her duties properly. Since the nurse claims that her workload and lack of time management is what caused these occurrences to happen, it is important to ask for help when needed, improve time management skills, and to verify when documenting.

- *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 events of a nurse inaccurately documenting medications and malpractice when administering medications, I would offer constructive feedback. Since these are mistakes that can potentially cause harm to patients, I would want to ensure that the nurse understands her mistakes and how to fix those errors. In this case, the nurse failed to completely document what is necessary during

medication administration, such as administration of the med, and wastage of what was not used. I would ensure that the nurse understands correct protocol when documenting medications, and reminding her to do it as soon as possible. I would recommend documenting and verifying that everything looks right as soon as the med is wasted in the med room, and given at the patients bedside. The nurse in this case also withdrew excess amounts of medication against the physicians order, which could have led to patient overdose. Going against the providers order and giving patients more medication than prescribed can be extremely unsafe and harmful for the patient. So, if I were to see this happening, I would ask what her reasoning is for it before she administered the med. In this case, since the nurse claimed to be stressed and she made these mistakes due to poor time management, I would offer to help if I am able. I would also remind the nurse to always verify the physicians orders before pulling the medication. However, if this problem continues to occur, I would report it to the charge nurse. In this case, the nurse also gave medications without assessing/documenting the patients pain score. To try and avoid this from happening, I'd recommend the nurse to ask about the patients pain score when first verifying their name, date of birth, and allergies. Since that information is already required before giving medications, it might be helpful for the nurse to include a pain assessment at this time. Because the nurse struggles with time management, I would offer help when she needs it, but also offer constructive feedback. I would ensure she understands correct protocol to limit medication errors from happening. Because these mistakes can potentially cause patient harm, it is important that the nurse understands where she needs improvement and how she can do better.