Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Lawson Sullivan Date: 11/1/24 DAS Assignment # 2

Name of the defendant: Linda Gail Tannos License number of the defendant: 920117

Date action was taken against the license: 01/09/2024

Type of action taken against the license: Remedial Education

- *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.*

What is interesting about this case is that even though TBON acted on it this year, this incident happened back on July 15, 2019. This shows that even though she may have moved and worked at different facilities in either Dallas or Houston, if you do something that impacts your patients or facility, it can come back to haunt you. Regardless, the actions that occurred to bring about this charge were due to a medication error. The nurse in this case withdrew two tablets of Tylenol #3 instead of just one tablet. Not only does she do this, but she failed to properly waste the tablet per facility policy.

Even though there was video evidence that shows she withdrew two tablets instead of one, the nurse states that she fails to recall withdrawing two. She still makes sure the patient receives their one tablet of Tylenol #3, and the patient attests to it. The nurse states that if another medication was pulled out, it would have been thrown away with all the other blister packs after the patient received all six of his ordered medication. Even though this med error did not harm this specific patient, this could have harmed either another patient by not getting their Tylenol #3 in time or harming the facility with improper documentation of not throwing it away properly.

- *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.*

This medication error could have been prevented simply by doing a few different things differently. Firstly, she should have been paying attention while withdrawing the medication. The nurse seemed to be confused about what had occurred while saying she does not recall pulling two. Even though she says this, according to video evidence she pulled two tablets instead of one. It does not say exactly whether she was distracted in the med room or not, but one way to prevent this is to remove all distractions and check the medications being pulled properly. If she spent even a few minutes looking over the blister packs, she could have seen that she had two tablets of Tylenol #3 instead of just one.

I'm going to assume that another way that this could have been prevented is if she did her three order/med checks like we have been taught. At any one of those incidences, she should have looked over all of her medications three times before administration and disposal of trash. You could argue that it may not have changed the situation, however I am a firm believer that if you checked your medications a few times properly you could have noticed that there were two Tylenol tablets instead of one. Another way that this could have prevented is to just verify with your coworkers if you have any doubts about any of the medications that you have pulled out. You may look a bit silly if you did make an error, but in this case, it could have been another thing that prevented these charges from occurring.

Thankfully the patient was not harmed in this occurrence. According to the document, the patient received only his one Tylenol #3 as ordered and all other medications were corrected. However, if the nurse was not properly paying attention, she could have given the patient two tablets and put them in danger. However, this does not only waste valuable medication, but it was not recorded properly. Therefore, the records that both the pharmacy and floor kept would have been wrong and it could have cost another patient or even the one involved to have their Tylenol #3 delayed. This would already be bad enough if a patient was experiencing immense pain, but if a patient was having a fever a delay could determine if a change of condition would happen or not.

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

The following universal competencies that were violated are as follows: **Critical Thinking, Documentation, Professional Role** and arguably **Physical Safety and Security**

Critical Thinking was violated because of both prioritization of tasks and improper evaluation of interventions. I feel that prioritization was violated because to me it seems that she was more worried about administering her medications instead of ensuring that all the medications are correct after pulling them from the dispensing unit. If she had just taken a few seconds to look over her medications and orders at least three times she may have caught that she had accidentally pulled out too much. For this reason, I feel that you can imply that improper evaluation of interventions occurred as well. She did not take the time to properly evaluate her medications and ensure that she pulled out the proper medication.

Documentation was violated simply because she did not properly document that she pulled out two tablets instead of one. Whether she knew that this had occurred or not, it happened and it did not get properly documented into the dispensing unit. Also, since this was a med error, and the proper steps of disposal were not followed another form of documentation did not occur to not properly following protocol.

Professional Role was violated since there was improper management of supplies. Not only were too many tablets pulled out, but one of them had to be wasted. Even if this was an accident that was caught and all the policies were followed correctly, the medication would still have to be wasted to keep standard precautions.

Lastly, **Physical Safety and Security** was violated by this nurse. I can see how people could say this did not occur, but I feel like it did. A part of the seven rights of medication administration is ensuring that you have the proper dosage of medications and should be explained. If the nurse properly did this, she could have also seen that she has too much and needs to dispose of it properly. However, I am going to argue that this may have occurred because once again she prioritized medicine administration instead of proper evaluation and safety.

- *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 prudent nurse in this situation, and found out this was happening, this is how I would have helped: Firstly, I would tell the charge nurse that a medication was wasted improperly, and we need to ensure that we have documented it correctly. If the charge nurse did not do this after I informed her, I would call the pharmacy and let them know as well. I would go and find the nurse and inform her that this occurred, and we would work together to ensure that the medication was properly wasted. Even though it was thrown away improperly at first, if we went together and found it in the trash still, me and her would properly follow protocol and waste it correctly.

Lastly, I would ask the nurse if there was anything she was doing that distracted her while she was in the med room. The reason I would do this is because I feel like this is an easy mistake to correct if it is caught in time. We would work together to figure out methods that will prevent her from accidentally doing this again. I would also ensure that she knows from now on the protocols that need to be adhered to in regard to medication disposal.

Thankfully, this did not result in the patient getting harmed immediately and can easily be corrected. I feel like that is why this nurse received a lighter charge of remedial education. This situation can be easily fixed and with the education I hope this nurse takes a little more time to think when pulling out her medications. However, I feel like this could have prevented another patient from receiving their Tylenol #3 medication in a timely fashion and could have harmed them. The most interesting thing that I found about this case is that this occurred five years before the charge was brought upon this nurse. This shows that you always need to be careful and considerate about everything you do as a nurse.