Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Rachel Williams Date: 1/18/25 DAS Assignment # 1

Name of the defendant: Angela Griffin McMahon License number of the defendant: 932174

Date action was taken against the license: September 24. 2019

Type of action taken against the license: Suspended

- *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.*

Angela Griffin McMahon participated in multiple incidents of unethical actions while in the hospital setting which led to the suspension of her RN license. These unprofessional actions include: withdrawing one vial of Hydromorphone without following policy for wastage of the unused medication; withdrawing five vials of Hydromorphone from the medication dispensing system without a physician's order, withdrawing nine vials of Fentanyl and two vials of Morphine from the Pyxis without documenting the administration of the medication in the patient's medical record, and without following her facilities policy for wastage of the medication, and producing a drug screen specimen that tested positive for Amphetamine, Lorazepam, Fentanyl, Hydromorphone, and Morphine. All of these occurrences lead to unaccounted for narcotic medication, patient risk for adverse reactions and/or overdose due to not documenting medication administration in the EMAR, and the impairment of a registered nurse due to drug use while working in a clinical setting.

On June 30, 2018, the defendant broke her clinicals policy for wasting medication by failing to have another RN witness the wastage of a one vial of Hydromorphone that she withdrew from the medication dispensing system. This resulted in medication being unaccounted for placed the pharmacy in violation of the Controlled Substances Act of the Texas Health and Safety Code.

Between the dates of August 21, 2018 and September 21, 2018, the defendant withdrew 5 vials of Hydromorphone from the medication dispensing system without a valid physician's order. It was found that the nurse's intent for doing this was to injure patients.

Sometime between March 7, 2019 and April 29, 2019, Mrs. McMahon put patients under her care at risk for drug adverse effects and/or drug overdose due to not documenting the administration of 9 vials of Fentanyl and 2 vials of morphine that she dispensed from the medication dispensing system. This decision to not document medication administration put the patients at risk because other hospital caregivers depend on her documentation to further medicate the patients without harming them. Failing to document leads to misunderstandings, miscommunication, and the potential for patient harm or death. The nurse also did not follow her facility's unused wastage policy for these medications. Mrs.

McMahon said she didn't waste the medication correctly during this incident because there was no one to witness the wastage.

The substance abuse policy for the multiple hospitals the defendant worked at was not truthfully followed by the nurse when it was found that she tested positive for multiple opioids in her urine on May 1, 2019. The unlawful possession or consumption of Amphetamine, Lorazepam, Fentanyl, Hydromorphone, and Morphine is prohibited by the Controlled Substances Act of the Texas Health & Safety Code. The nurses' impairment due to the use of these drugs could hinder her ability to critically think, notice changes in patient's statuses, make appropriate and safe decisions, potentially putting her patient or patients in danger.

In summary, the nurse chose to not follow several principles of the nurse ethics code that not only put several patients in potential danger but also caused the suspension of her license and potential harm to herself by the unlawful possession or consumption of illegal drugs.

- *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 various measures that could have been put into practice to ensure safe patient care and the adherence of medical facility policies. The nurse should have had another nurse witness the wastage of narcotic medication because it is a hospital policy. Not doing so led to medication being unaccounted for and led to pharmacy violations.

No nurse should ever withdraw medication without a doctor's order. Withdrawing medication that was not ordered could result in serious patient harm or death if given. Registered nurses are not licensed to decide on what medications are to be prescribed to patients.

Not documenting medication administration or falsely documenting is considered fraudulent documentation and could be prevented if the nurse would only document medication that the patient has taken.

Since it is illegal to consume narcotic drugs without a doctor's prescription, Mrs. McMahon shouldn't have used the drugs that were not prescribed to her. This is not only illegal for the nurse to do but is illegal for everyone.

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

Competencies that were violated are medication wastage, drug diversion, documentation, and critical thinking.

Medication wastage was not adhered to when the RN withdrew several vials of narcotics and did not have another licensed nurse witness the wastage of the unused medication.

Drug Diversion was violated when the nurse withdrew medication that was not prescribed to her patients with the intent to keep the medication for her own personal use. This violates the safety and security of the patients and of herself.

Documentation was not correctly done when the RN provided no documentation of the medications that she withdrew from the medication dispensing system. This provides inadequate communication to other healthcare workers who may also need to take care of the patient.

Critical thinking of the nurse could have been impaired due to testing positive for narcotics during a urinary drug analysis test. Consuming the unprescribed medications could alter the nurse's judgement for safely caring for patients.

- *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 to discover another nurse not wasting medication or wasting medication without a witness, I would notify the charge nurse and the pharmacy. If I knew another nurse was withdrawing medication without their patient's prescribers' orders, I would make sure to let the head nurse know as well as the physician. I would make sure the patients are evaluated to ensure they are safe and not in any harm in case they were given medications that were not prescribed for them. If I knew a nurse wasn't documenting medication administration, I would let the charge nurse know and would also discuss with the nurse the importance of documenting. If documentation isn't done, that could lead to other healthcare workers putting patients in harm of adverse drug effects or overdose because they wouldn't know the last time a patient had any medication.