

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Alex Johnson

Date: 1/19/2025

DAS Assignment # 1

Name of the defendant: Nannette Andrada

License number of the defendant: 736578

Date action was taken against the license: 1/21/2021

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.*

Nannette had multiple incidences of documentation and medication errors in the clinical settings after switching work locations. Her being new to said location was her reasoning for making the errors which include: on 6/17/2019-Failure to accurately document the administration of 5 tablets, on 6/17/2019-Failure to follow the policy and procedure of documenting the wastage or return of unused medication, and on 6/17/2019-improper use of the Pyxis system.

On 6/17/2019, Nannette's first documentation error involving inaccurately documenting 5 tablets of medication was stated to be due to Nannette's lack of knowledge of the hospital system to which she was not previously accustomed. Nannette withdrew 10 Hydrocodone/APAP 5/325mg tablets but did not accurately document 5 of the tablets given to the patient in the MAR while the patient was under Nannette's care. Doing so could have aided in injury to the patient or further pain given that other nurses would read the MAR wrong and possibly give too much medication and overdose the patient given the documentation provided. This error violated Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act).

Again on 6/17/2019, Nannette did not accurately document the wastage or return of unused medication as stated by the policy and procedure for the hospital where she was recently hired. Medication was not accounted for and could have deceived the hospital's pharmacy into overstocking or understocking the medication. This error violated Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act).

Lastly, on 6/17/2019, Nannette Stated that she withdrew two Norco tablets from the Pyxis but only one tablet was administered. After attempting to return unused Norco tablets to the Pyxis they were asked to provide a count of the total tablets in the Pyxis however the instructions were not fully understood and Nannette had mistaken the count as how many were being returned and input a "1" into the machine which was the first error for this section. Secondly, over the next three days, Nannette would scan one Norco tablet twice rather than scanning each medication separately which was not registered by the system at the time of administration. As evidenced by, many doses of the medication were left unaccounted for and only one tablet was shown as being administered each time at bedside whether or not both tablets were given as stated by

Nannette. Given the severity of undocumented Narcotics. Nannette could have accidentally overdosed the patient under her care if she had forgotten that she had previously given 2 tablets of the medication. Nannette could have also been charged with malpractice given improper documentation of narcotics and could not prove that the undocumented medications were not diverted or given to the patient. Nannette volunteered to undergo drug testing which yielded a negative result.

As a result of Nannette's errors, Nannette's license was not revoked or suspended but was placed under remedial education. Nannette was to undergo A Board-approved course in Texas nursing jurisprudence and ethics (6 hours in length), A Board-approved course in medication administration(6 hours in length), a Board-approved course in nursing documentation(6 hours in length), and The course titled "Sharpening Critical Thinking Skills," (3.5 hours in length). After these courses were completed, Nannette's license would have all encumbrances removed, and would be eligible to follow nursing practice again.

In conclusion, Nannette was negligent in documenting the administration and wastage/return of medications in the MAR and Pyxis. This allowed room for error and risk of harm for the patient under Nannette's care.

- *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.*

The most important measure that could have been taken to prevent any errors made or patient harm that day would have been to ensure your knowledge of all procedures and protocols unique to the facility and then the correct procedure to use the new systems as well. Had Nannette done her due diligence on ensuring her knowledge of how to use the Pyxis, the narcotic situation would have never happened. Also, had Nannette made sure to accurately document everything done that day she would not have missed any critical documentation such as incorrectly documenting the use of all medications or wastage/return of said medications. Since Nannette was unsure of the system and protocol of the facility Nannette could have asked another nurse who has worked there for guidance on things Nannette was unfamiliar with or had questions about. If Nannette had done any of the measures listed above no risk of harm to the patient would have occurred and she would not need remedial education.

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

To begin, Nannete first violated the **Safety and Security (Physical)** universal competency by inaccurately documenting any extra tablets of hydrocodone given, the wastage/return of said medications, and not properly scanning the Norco tablets individually indicating in the system that only one tablet was given over 3 days.

Next, Nannete violated the **Critical Thinking** universal competency due to her decision-making. Had Nanette contacted another RN or someone of higher licensure for guidance this would not have happened. Instead, Nannete opted to wrongly document medication usage and disposal which in turn put her patient at risk of harm.

In another instance, Nannete violated the **Documentation** universal competency. Nannete incorrectly scanned and documented Norco tablets over a 3-day period. She also incorrectly documented the usage of hydrocodone tablets and the wastage/return of extra Norco tablets and hydrocodone tablets.

Lastly, Nannete violated the **Professional Role** universal competency by not properly managing equipment such as the Pyxis. Nannete stated that she was not familiar with the Pyxis system previously and made an error by doing an inaccurate count of Norco tablets.

- *Use the space below to describe what action you think a prudent nurse would take as the first 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 nurse who had witnessed these events I would begin by contacting the charge nurse and informing them of what I saw. I would follow the chain of command and let the physicians know of the mistakes in the chance that a patient was potentially harmed. I would also talk to Nannette and guide her in the proper usage of the Pyxis, how to properly scan meds, and a refresher on the proper way to document so that this mistake may not happen again. I would also assess the patient to make sure no harm was done and also request labs to be done to make sure the patient was getting their proper dosages of medication.