Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Krystal Leano Date: 4/1/2025 DAS Assignment # 1

NOTICE OF DISCIPLINARY ACTION – 4/2021

Name of the defendant: Gillin Michelle Rene, RN License # of the defendant: 690565

Date action was taken against the license: 11/10/2020

Type of action taken against the license: Revoked

Michelle Gillin had multiple occurrences of unprofessional actions while in the clinical setting which led to these disciplinary actions. These unprofessional actions included: incompetence for failing to address pain level of two patients in a timely manner, not performing a pain assessment after giving pain medication, failing to properly document removal and administration of controlled substances for four patients, and unprofessional conduct. These actions may have caused harm to the patients as well as having inaccurate medical records.

Gillin was incompetent when it came to addressing the pain level of two patient. In this situation, a patient had a pain level that was 8 out of 10 at 11:13 p.m. Gillin waited 48 minutes to address the patient's pain level after administering hydrocodone. With another patient, she had waited 52 minutes to address their pain level. This may have caused the patient more harm if the indicated medication given did not help or if there was a delay.

Nurse Michelle Gillin failed to properly document the removal of medications from Pyxis machine and the administration of controlled substances. It was said that at 2:58 a.m, Nurse Michelle withdrew 1mg/mL of hydromorphone

from the machine and documented at 3 am of the administration to the patient but five minutes later at 3:05 am, she had again documented another 1mg/mL of hydromorphone to patient but there was no record of removal with this second dose. Administering more than intended may cause the patient harm.

Also, she failed to accurately document what was administered and the wastage of medication. She had withdrawn 2mg/1mL of lorazepam from Pyxis and documented 1mg/0.5mL administered to patient but documented wastage of 1.5mg of lorazepam which is 0.5mg more than withdrawn. Failure to accurately document the administration of a medication is unprofessional and may cause harm to patients.

A couple of weeks later, Nurse Michelle documented an administration of medication but did not perform a pain re-assessment of the patient which she also then failed to document how the patient responded to the medication given. Not doing a re-assessment of a patient after administering a medication is not best practice as these medications may come with different types of reactions.

In conclusion, nurse Michelle Gillin failed to follow proper protocol that resulted in harmful risks to the patients.

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There are multiple ways that these could have been prevented so that the patients were not at risk and to not have one’s license revoked. As a nurse, they should promptly address any of their patient’s pain levels using the 0 out of 10 scale and this would be following the pain management protocols. Using the pain assessment and re-assessment as a routine would allow the nurse to ensure timely interventions. This can also help with making sure the patient is not facing any adverse reactions to the medications given.

To be sure that we are following proper protocol a nurse would need to do thorough documentation. It would provide clear evidence of patient care and be able to comply with the standards.

Lastly, a nurse must know how to properly handle controlled substances. They should be double-checking and having a witness when doing wastage of a medication. This would help with preventing any discrepancies and making sure everything is accurate.

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The universal competencies that were violated were safety and security, communication, critical thinking, documentation, human caring, and professional role.

Safety and security were violated because the RN did not do one of the 4Ps which was pain management. Nurse Michelle failed to address the patient's pain in a timely manner and did not do a pain re-assessment after giving medication. Also, she did not properly document the administration and removal of the controlled substance which violates the 7 rights of medication administration.

Communication was violated because Nurse Michelle did not reassess and communicate with the patient about their pain levels and since she did not reassess, it means that the patient wasn't informed about any side effects the medication can cause.

Critical thinking was violated because she did not prioritize pain management which means her decision-making and prioritization was not the patient or their well-being.

Documentation was violated by failing to properly document the record of the controlled substance administration and the wastage. She should have charted the pain reassessment but did not do that.

Human caring was another that was violated because if an RN fails to reassess pain or address any pain that the patient is feeling, it is disregarding the patient and the ability to just care for someone that is in the hospital.

Professional role was violated because Nurse Michelle neglected to do pain assessments and did not adhere to hospital policy as well as the aspects of their license.

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If I were the first person to witness or discover that the patient has been harmed by another nurse or happened to undergo any of the activities cited in the disciplinary action, I would report it to the charge nurse and my chain of command. I would also assess the patient to make sure that they were not harmed in any way by what the previous nurse had done. I would do my best to administer the necessary treatments for that patient if something had happened. Then, I'd document everything that I found and what types of things I have done to get it under control. Lastly, I just want to make sure that the patient is safe.