

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Vee Castillo

Date: 04/10/2025

DAS Assignment #2_____

Name of the defendant: Annette Williams

License number of the defendant: 542121

Date(s) and BON decision(s) taken against the license:

January 4, 2024 Reprimand with Stipulations

Type of action(s) imposed to retain or regain licensure, if applicable (ex.: warning with stipulations, etc.)

_____ Terms of Order: The Rn is to comply with the Nursing Practice Act, Texas Occupations Code and Rules and Regulations relating to Nursing education, Licensure and Practice. In addition to that she must complete the Board's online course "Understanding Board Orders", continuing education and remedial education courses within one year of signed order.

- *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 each of them, e.g. drug diversion, HIPAA violation, abandonment, etc.*

Incident #1- June 13, 2022 While working as a Rn at UT Southwestern Medical Center Annette Williams did not assess a patient's level of pain. She failed to assess before and after administering the medication tramadol.

Incident #2- June 16, 2022 Mrs. Williams failed to assess a patient yet again after a Dobhoff tube was placed. Upon her failing to assess the equipment a guide wire was not removed. Feedings were given to said patient and they suffered pain during the feeding.

Incident #3- June 16, 2022 Rn failed to give medications Latanoprost, Calcium Carbonate, Atorvastatin, Sodium Bicarbonate and Lidocaine as ordered by Physician.

Incident #4- July 2, 2022 Mrs. Williams withdrew 1 mg of hydromorphone from medication pyxis and failed to document administration of medication.

Incident #5- July 2, 2022 Rn failed to waste 0.5 mg of hydromorphone. This caused an incorrect count of medications in the pharmacy. It also caused the pharmacy to receive a violation of the Texas Health and safety code.

Incident #6- July 3, 2022 Mrs. Williams did not hold a prescribed immunosuppressive medication tacrolimus of 4 mg. The Health care provider ordered a lesser dose of 2 mg at a later time. The result ended in the patient digesting both doses.

- *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 quite a few things that the RN could have done to avoid actions being taken against her. Her failing to assess the patient before giving medication was a lack in determining the severity or reason for pain. Failing to assess after was needed to verify if the medicine was effective or not. Secondly, she did not assess a patient after a dohoff tube was placed. This resulted in a guide wire from being removed. If she would have assessed the patient correctly she would have noticed the wire. The overlooking of it ended up causing the patient discomfort and pain while feeding. The Rn also failed to hold and deliver medications, document medications and properly dispose of medications.

- *Identify ALL universal competencies (4-5) that were violated and explain how in detail to reflect your understanding and importance of the universal competencies.*

Safety and Security- Failing to assess the patient before administering medication is a violation of the 7 rights for medication and critical thinking. The Rn did not verify the reason for the administering of tramadol before or after. This could have been avoided simply by completing necessary assessments. The patient may not have needed the medication or could have had an adverse reaction to it. She also failed to adhere to the 7 rights for medication administration by not verifying a medication order and failing to hold it. The physician ordered a lesser dose of the medication. The patient ingested both dosages unfortunately. Secondly, not providing necessary assessments on the placement of a dohoff tube resulted in pain and discomfort to the patient during feeding. This is negligence of critical thinking, and clinical judgement as she failed to provide clinically competent care. Safety and Security and Documentation- Failing to administer medication causes medication errors which can result in harm or delayed treatment. Improper documentation fails to provide safe and effective patient care. Documentation is needed to make sure a legal record is kept to provide appropriate care. Communication- The Rn failed to dispose of unused medication. Improper communication or documentation of wasted medication can result in confusion, inaccurate legal records and medication discrepancies.

- *Use the space below to describe what actions 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.*

As a prudent nurse it is vital to demonstrate integrity, professionalism and patient safety. If any of the above stated are witnessed it is our job to intervene. We are to make sure we protect the patients at all times. We are to report to the appropriate staff following the correct chain of command. And last but not least make sure we include any incident or safety reports as needed.