

Covenant School of Nursing  
Disciplinary Action Summary Assignment  
Instructional Module 2

Student Name: D'Leah Hill

Date: 04/10/2025

DAS Assignment #2

Name of the defendant: Marina Alyse Melchor

License number of the defendant: 959328

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

05/20/22 Probated Suspension

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

- *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.*

The nurse I selected made numerous prescription and documentation errors that would have compromised patient safety. These included insufficient pre-operative evaluations and documentation, inaccurate patient treatment information charting, and incorrect infusion and dosages of medications such as sodium acetate, morphine, and Demerol. Patients were at risk for problems like fluid overload, poor pain management, infection, and adverse pharmaceutical effects as a result of the nurse's activities, which were frequently based on insufficient evaluation dates. The nurse gave 5 mg of morphine (10 mg/5 ml) instead of 15 mg (10 mg/5 ml) in her first violation. The nurse then neglected to measure and record the patient's hourly respirations during a blood transfusion a few days later. Then, in the absence of a legitimate provider's order, the nurse gave out 50 mg of Demerol. Demerol had to be administered within 30 minutes of each Interleukin dosage, according to the directive. The nurse then neglected to fill out a pre-operative checklist that said that the patient had to take a bath with an antiseptic solution the night before a planned surgery, as required by the Infection Control in the Perioperative Surgical Setting Policy. The nurse then mistakenly recorded Lovenox rather than the existence of stockings. After that, the nurse dressed a melanoma lesion without the patient's doctor's permission. The nurse then gave the drug incorrectly. As directed by the provider, she did not provide 54 mg of doxorubicin intravenously at a rate of 20.8 ml/hour. When the patient's discomfort was scored as zero on a ten-point scale, the nurse then gave them two milligrams of Dilaudid. Subsequently, the nurse fabricated a patient's MAR by claiming that Dilaudid 2 mg was administered at a specific time, even though the MAR revealed that no record of the medication's scanning had ever been made. Finally, a patient who had previously received the following drugs from the nurse—25 mcg of fentanyl intravenously at 1901, 4 mg of hydromorphone orally at 2147, and a further dose of 25 mcg of fentanyl intravenously at 2325—had not had the Hester Davis Fall Risk assessment completed by the nurse. As a result, the patient collapsed when attempting to get from the chair to the bed on their own.

- *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 nurse should have carefully followed the provider's orders. Before giving medication and changing the dressing, the nurse should have carefully reviewed and verified each provider's order to make sure the right medication or dressing was given or changed. The nurse should have also confirmed infusion rates and medication doses. The nurse should have also been prudent to ensure the 7 rights were being used when administering medication to patients in their care.

- *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:** The nurse administered incorrect dosages of medications (e.g., Morphine, Demerol, Dilaudid, Fentanyl) and infused medications improperly (e.g., Sodium Acetate, Doxorubicin). Administering medications safely is a basic obligation. These mistakes jeopardized patient safety and treatment quality by exposing them to hazardous reactions, overdose, underdose, and inadequate pain management.

**Critical Thinking:** The nurse failed to assess and document vital signs during a blood transfusion and gave medications outside the ordered parameters. To evaluate patient conditions, identify complications, and take appropriate actions, nurses are supposed to apply clinical judgment. Poor clinical reasoning is seen when drugs are administered without a valid or current order and when an assessment is not recognized when it is necessary.

**Communication:** The nurse inaccurately documented the medication administration and failed to record accurate information in the MAR. Documentation that is timely, accurate, and clear is a universal ability. Continuity of care failures, legal problems, and prescription errors can result from incomplete or fabricated documentation.

**Professional Role:** The nurse administered medications without proper orders and altered patient treatment plans without physician authorization. Nurses maintain professional standards and take responsibility for their conduct. Serious transgressions of professional behavior include acting outside the area of practice and neglecting to assume responsibility for adhering to appropriate protocols.

- *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.*

Firstly, I would have taken immediate action to stop or rectify the nurse's harmful practice, like explaining an erroneous dose or stopping an inappropriate medicine infusion. The primary concern is patient safety, and prompt intervention can stop damage or other issues. Next, I would have urged the nurse to check with the prescribing physician about prescribed drug orders. This guarantees that the nurse adheres to the correct protocols and doesn't behave contrary to the directive. Next, I would have reported the nurse by filling an incident report and notifying a supervisor or the charge nurse about the

occurrences. This can lead to corrective actions and guarantees that the problem is properly documented and examined. If at this point, my immediate supervisors do not take action, I would escalate concerns to the nursing leadership team or the hospital's risk management department. Doing so provides institutional monitoring and accountability in cases of repeated wrongdoing or possible harm. Next, I speak with the nurse about the matter in a professional manner while providing advice or mentorship. Errors can occasionally result from a lack of understanding, and peer support can be a helpful means of correction and education. Above all, I would have behaved honorably, putting patient safety first and maintaining professional norms, particularly when I saw potentially harmful behavior.