Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Rachel Hernandez Date:4/8/25 DAS Assignment # 2

Name of the defendant: Kimberly Dianna Stavena License number of the defendant: 769930

Date(s) and BON decision(s) taken against the license: Nov 10 2022, RN Revoked

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

Kimberly Dianna Stavena had charges against her license and failed to comply with the court due to these charges. The RN's license was suspended at first then led to the license being revoked. Previously to having her license being revoked she failed to comply with the TPAPN. This aids in nurses for their accountability, mental health condition, and to support them so they may practice nursing safely. Failing to do so led to the withdrawal of the license. Kimberly had past charges that was not hospital related, and the BON attempted to assist her so she may continue practicing. She continued to make mistakes, and these charges were in the hospital setting that resulted in these disciplinary actions. These included Kimberly having impaired behavior while on duty that put her patients in harm's way, tempering with an opioid medication that was for a patient, dispensing two vials of medication without a physician's order, falsifying documentation, not wasting an opioid correctly to hospital policy, and misappropriated medication that belonged to the patient.

Charge one Kimberly had displayed impaired behavior that affected her cognitively while practicing as a nurse. She showed erratic behavior and when presenting with these signs as a nurse it was concerning. Not being aware of your patients' conditions, symptoms, and signs in their health can lead to potential harm to the patient. Developing judgmental calls and making logical decisions for patients can be the difference between saving their life and putting them in jeopardy. It was clear she was not able to aid in her patents with exhibiting such behavior.

Charge two was given while employed at an Emergency Department which she then associated herself with intemperate of using Fentanyl and Benzodiazepines. Taking this opioid while on duty could impair a nurse's ability to make rational decisions for her patients. The side effects of this drug are also dangerous for the applicant receiving the medication. This could affect the decisions regarding patient care, and accurate assessments necessary to improve the patient's condition. She then submitted a urine sample for reasonable suspicion drug screen and came out positive for both drugs. Under such state was not fit to currently practice as a nurse. Proving negligence care to the patients could cause injury and harm.

The Findings of Fact were led by the judge's determination on what happened from the factual conclusions drawn from evidence.

Kimberly withdrew two vials of medication from the medication dispensing system for a patient in which she had no physicians order in doing so. Giving the patient a medication without an order could cause adverse reactions and suffering to a patient. This is a breach in medical ethics and professional responsibility giving the patient serious health complications. As well as falsely documenting medication administration in the eMAR. This led to an error in medical records and patient safety consequences. Falsifying medical records is malpractice and damaging to the patient's future health.

In addition, Kimberly withdrew opioids from the medication dispensing system and not wasting the unused portion accurately. Leaving medication unaccounted for could guide the pharmacy into violation. It is crucial that there is always a witness for narcotic waste, that is the law. These safety protocols for medical professionals are implanted for a reason when disposing remaining medication. Drug diversion can be prevented and lessens the risk of it being lost or stolen. Furthermore, there was misappropriated medication that belonged to the facility or the patient. Whether it was unauthorized use or taking someone's else medication there was no precautions taken to inhibit such misappropriation. This resulted in the cost of medication to deceive the facility and the patient.

Kimberly put the patients at risk with the carelessness of her actions. There are measures that could have been taken to prevent these unfortunate outcomes. Impaired behavior occurred while she was practicing her nursing duties and someone noticing her behavior by removing her from taking care of patients was the suitable thing to do. Noticing other nurses and their behavior is important because people's lives are in the hands including all other health care members. As well as checking the physicians order by doing the three checks. One by double checking the order, checking the pyxis, and at the bedside of the patient to ensure you have the correct medication. This decreases the chance of obtaining the wrong medication for the patient. Documenting at the bedside is important to describe what was in fact done after aiding your patient. Also, following the hospitals protocol in wasting narcotics. The significance in wasting medication the correct way it vital for the patient and for the nurse. With a witness to guarantee the medication was removed accurately and safely. With the facts presented Kimberly had a problem with handling medication inappropriately and prescription drug abuse. It did not disclose where she currently is working as a nurse.

Competencies that were violated were Safety and security, Professional role, Critical thinking, and Documentation.

Safety and security were violated when the seven rights were not implemented when administering medication to the patient. Kimberly left out time and documentation in the rights that should have been appointed to the patient. By not giving the correct medication and falsely documenting that it was given.

Professional role was violated by not giving clinically competent care to the patient when suspected of taking drugs while on duty. Her appearance was concerning to faculty and not maintaining supplies and medication efficiently. Also not adhering to hospital policy when disposing of narcotic medication.

Critical thinking was also violated regarding decision making of medication administration. Pulling the wrong medication and administering medication without the physician's order was negligent toward the patient putting them in harms way.

Lastly, documentation was violated due to falsely documenting medication administration when it was not given. This led to patient safety issues, and hindering communication within the health care team and negatively impacted the quality of care.

If I was the RN that discovered the unprofessional actions of another nurse I would report them to the charge nurse. To let them know that something inappropriate is taking place and so they may proceed on how to continue with the nurses' actions. I would also let the primary physician know the discrepancies that occurred and then see what damage was done to the pateints. I would do so by checking their labs and checking documentation that was wrongfully done if able. As well as talking with the nurse to ask what was going through their mind at the time and if they needed help. If I saw them practicing again, I would report them to the BON and let them be aware that this person was practicing again as a nurse.