

Covenant School of Nursing  
Disciplinary Action Summary Assignment  
Instructional Module 2

Student Name: Makenzie Lovato      Date: 12/06/2021      DAS Assignment # 2

Name of the defendant: Bryan S. Bridges      License number of the defendant: 617954

Date action was taken against the license: March 26, 2013

Type of action taken against the license: Enforced Suspension

On or about June 22, 2009, through July 13, 2009, Bryan withdrew Fentanyl from the Medication Dispensing System and administered the medication to patients in excess of the dosage/frequency of the physicians' orders. This was likely to injure the patients and could result in the patients suffering from adverse reactions, including respiratory depression.

On or about June 22, 2009, through July 13, 2009, Bryan misappropriated Fentanyl belonging to the facility and patients thereof, or failed to take the precautions to prevent such misappropriation. This conduct was likely to defraud the facility and patients of the cost of medications, and is a violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

On or about July 16, 2009, Bryan engaged in the intemperate use of Propoxyphene. Without a valid prescription for Propoxyphene, it is prohibited by Chapter 481 of the Texas Health and Safety Code (Controlled Substance Act). The use of Propoxyphene by an RN, while subject to call or duty, could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, putting the patients in potential danger.

On or about July 22, 2011, while a licensed RN in the State of Texas, Bryan engaged in the intemperate use of Alcohol and Hydrocodone, in which he produced a specimen for a drug screen requested by the Texas Peer Assistance Program for Nurses, which resulted positive for Alcohol and Hydrocodone. Unlawful possession of Hydrocodone is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). Use of Alcohol and Hydrocodone by an RN, which subject to call or duty, could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, therefore putting the patients in potential danger.

Bryan could have double checked the Fentanyl with the Medication Dispensing System to make sure that the dose was correct, cross checked it with the eMAR and also made sure that the dosage was appropriate for the patient (being the patient's advocate). He disregarded the patient's 7 rights, took advantage of the patient's trust, and also didn't do much critical thinking when he came to deciding whether to give the med or not; he didn't even question it. I feel that after this occurrence, he should have been suspended and made to attend a class over those subjects.

Bryan flat out should not have taken the Fentanyl from the hospital. Someone should have been double checking the meds that he was giving because of the first occurrence with Fentanyl.

The third occurrence shouldn't have even happened. He should have been suspended or fired after the second offense. He is putting a lot of patients in harm's way by using Drugs and Alcohol! Bryan definitely wasn't being an advocate for his patients and didn't really care to think about his career.

The last offense could have been avoided by not hiring him due to his past mistakes. At this point, I feel that he should be fired from this new job and have his license taken away. He has put a lot of people in danger and all of that could be avoided. Bryan seems to not care about his Drug problem or that he is putting patients in danger.

With the first offense, if I was the nurse to have discovered the event described, I would have gone to the charge nurse immediately to report what I had witnessed. Hopefully the charge nurse would remove the nurse from the floor and have them do classes or have another nurse follow them when they are on shift for at least a month or longer. I would want to make sure that the patient gets the correct treatment to reverse the overdose of meds given. In all of these situations, I would report them as soon as I knew. These situations could have been prevented after knowing about the first event that occurred. After knowing that Bryan had a drug problem, other interventions could have been put in place so that the future events didn't occur.