

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Tyquinisha Mitchell Date: 09-08-22 DAS Assignment # \_\_2\_\_ (1-4)

Name of the defendant: David Paul Brown License number of the defendant: 593775

Date action was taken against the license: Voluntary Surrender

Type of action taken against the license: December 11<sup>th</sup>, 2014

*Use the space below to describe the events which led to action taken against the license. If multiple charges were in play, be sure and cite them, e.g. drug diversion, HIPAA violation, abandonment, forfeiture on student loans, etc.*

June 23<sup>rd</sup>, 2012, David Paul Brown gave oral medications to a patient without wearing the proper protective equipment, which were gloves. This incident could have potentially brought harm to the patient by introducing potentially contaminated medications which could lead to infections upon entry into the patient's digestive system. June 24<sup>th</sup>, 2012, Mr. Brown placed a confused patient at risk for harm from an "accidental needle-stick or other injury" due to the careless act of leaving an insulin syringe in the patient's reach, on the bedside table. October 4<sup>th</sup>, 2012, David Brown then produced potential harm of over-medicating a patient due to administering 2 Ultram pills instead of administering the 1 pill based on the doctor's orders and tried to justify himself by documenting that he gave one as a scheduled medication and the other as a "PRN" medication which could have resulted in adverse reactions. October 18<sup>th</sup>, 2012, Mr. Brown caused a patient to develop a large hematoma from her elbow to her chest from unsafely transferring the patient from the commode, which resulted in injury and an elongated length of treatment. October 20<sup>th</sup>, 2012, David Brown did not properly medicate a patient during wound care, did not notify the doctor of inadequate pain control, and put this patient at risk for infection due to using the same gloves during wound care to the "patient's abdominal sutures, peg tube insertion site, and sacral decubitus ulcer". February 11<sup>th</sup>, 2013, David Brown may have unsafely transferred a patient which contributed to a "patient suffering from a dislocated hip prosthesis and acetabular fracture". Mr. Brown had decided to voluntarily surrender his rights, as he stated that he generally did not bring any intent to harm to these patients; and for each occurrence he gave an unjustifiable reason for his actions, which shows that he knew what he was doing was wrong but did not want to take those extra measures to ensure every one of these patient's safety.

*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. Consider which universal competencies were violated.*

*David Brown performed many actions that put many patients at risk for safety, infections, injury, and harm. For the incident on June 23<sup>rd</sup>, 2012, gloves should always be worn when giving any medication. The mouth could be a portal of entry to microorganisms and our hands are not free from germs especially in a hospital,*

therefor, he should have worn proper protective equipment to prevent the patient from an infection. For the incident on June 24<sup>th</sup>, 2012, there is a safety protocol for dispensing all syringes and needles into the sharps container to prevent an accidental needle-stick to patients and caregivers so leaving the insulin syringe on the patient's table was just careless. Even if the safety mechanism was latched or not, or if the nurse had something else to do, it would just take 2 seconds to dispose of that syringe properly to prevent any harm to a patient or caregiver. For the incident on October 4<sup>th</sup>, 2012, David Brown should have also performed the 7 right and the three safety checks, to medication administration to prevent the patient from potentially being overmedicated which could result in adverse reactions and can cause harm to the patient. He also shouldn't have falsified documentation because that could also potentiate risk of patient harm if that patient was administered or ordered more medications, or if there was an additional medication that was ordered but the current medication was not out of the system and there was a contraindication or potential increase in affects to the current medication. For the incident on October 18<sup>th</sup>, 2012, David Brown should have performed proper patient transfer to prevent the patient from harm due to falling, having an injury that resulted in a large hematoma, and an increased length of stay. For the incident on October 20<sup>th</sup>, 2012, Mr. Brown should have properly medicated the patient before treatment and notified the doctor so that pain level could be managed before starting wound care because the patient could have gotten up to an intolerable pain level which could affect the patient's mood, activities of daily living, safety due to potential falls, and even a change in vital signs. He also should have changed gloves through the different procedures to prevent a worsening spread of infection especially since this patient already had so much going on. On the incident of February 11<sup>th</sup>, 2013, David Brown should have had adequate help to transfer the patient as well as adequate lifting devices and could have used a gait belt for safety as well.

David Brown violated many universal competencies. He violated safety and security due to not performing the 7 rights during medication administration, not properly disposing the insulin syringe into the sharp's container, not properly transferring two of the patients, and not properly assessing one of the patient's pain levels and treating it. He broke Standard precautions for not wearing gloves during administering oral medications and cleaning hands and changing gloves in between the wound care procedures. For the patient with the hip fracture, he could have potentially violated communication and patient teaching which could have helped decrease the risk of dislocation to that hip which caused an injury to the patient. He also would have violated communication and teaching due to not teaching the patient about medications because it could have helped the patient catch that he was administering two pills instead of the one that was ordered. David Brown violated critical thinking because all these things could have been prevented, he just did not make the correct decisions on multiple attempts which resulted in safety risks, potential infections, and patient injuries. These incidents are just the ones that were caught. There is no telling how many other incidents where not caught which could have saved a patient from harm or injury. He also violated documentation because he falsified documentation when he administered the two meds that was only supposed to be one. He did not comply with human caring because he did not take the initiative to prevent harm, prevent falls/ injuries, prevent potential infections and so forth. These multiple accounts of breaching safety to these patients tell me that he just did not care what he was doing and therefore was not being a safe and prudent nurse, which also caused him to disregard his professional role that he is not to do any harm to all patients.

Use the space below to describe what action 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.

I think a prudent nurse would have noticed so many risks of patient harm and maybe made him take more classes, or even retrain him. Maybe it was time for a change for him because maybe he was burnt out which caused him to make so many mistakes. I believe all the injuries and potential harm he caused these patients could have been prevented if he would have taken a few extra seconds to dispose of things properly, plan things out before transferring, be safer with the things he did, wear and change those gloves and just be a

more prudent nurse for the safety of the patients. In these cases, you would go to the charge nurse and notify them and see what needs to be done to get him to comply with rules, and the safety mechanisms put in place to keep those patients safe. I don't think it should have taken this many incidents before seeing that he is not a safe and prudent nurse because a lot of the things he did was just beginning to be careless. He knew what he was supposed to be doing because he has had 15 years of experience and he also tried to justify what he did and therefore knew that there were risks and consequences at hand for each incident. He did not seek help or try to change his ways or take a break if needed he just kept violating these patients' safety. David Brown surrendering his license also shows that he knew what he was doing and that it was time to get out of the field, but it was at the suspense of harm to these patients and maybe many more.