Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Angela Cruz Date: 11/04/2022 DAS Assignment #2

Name of the defendant: Matthew Lindsay Otis License number of the defendant: 875392

Date action was taken against the license: May 15, 2019

Type of action taken against the license: Enforced Suspension

Mr. Otis was given an enforced suspension of his license due to misconduct with medications, specifically hydromorphone. The findings showcase that Mr. Otis would withdraw hydromorphone without a valid physician's order. Another was how he failed to properly waste unused medication based on the hospital's policy. Another was how Mr. Otis misappropriated 10 syringes of hydromorphone belonging to the patient and took them for personal use. He admitted to misappropriating the medications due to his opiate use disorder. Mr. Otis admitted withdrawing hydromorphone from the Pyxis and then using them in the bathroom. However, Mr. Otis was compliant with TPAPN, therefore, Mr. Otis's license will only be suspended until Mr. Otis fulfills all requirements of the TPAPN agreement.

Different measures could be taken against Mr. Otis which could be to have an active witness when withdrawing any opiates, or having a witness whenever he wasted unused opiates. Have the charge nurse become aware of Mr. Otis's issues dealing with opiates so the charge can keep an eye out. Have other nurses take notice if Mr. Otis is acting strange, especially while giving care to patients. The universal competencies that were violated by Mr. Otis were the following: Communication, Standard Precaution, Human Caring, Documentation, and Professionalism. For communication, Mr. Otis failed to communicate with his coworkers when performing proper wastage of opioid medication. He also lacked early communication for his opioid addiction, however, he was able to follow TPAPN guidelines, afterwards. For Standard Precaution, Mr. Otis failed to properly dispose of the hydromorphone syringe in the sharps container after personal use in the bathroom. Mr. Otis failed with Human Caring since he failed to involve their patients in their care plan. If the patient had known what medications they were expected to receive, the patient could be more of an advocate for themselves and realize that their medications ordered for them were not received. Based on the findings in Mr. Otis's case, Documentation was not properly implemented. He withdrew medication from the pyxis but did not document if the patient had received them. Lastly, Professionalism, because Mr. Otis did not

properly manage his medical supplies such as medications, therefore, instead of administering the medication to his patients who needed them, he took it for himself.

The prudent nurse would be observant of his/her colleagues when taking care of their patients or withdrawing/wasting narcotics or opiates. The prudent nurse would take notice if their colleague was acting strange while taking care of his/her patient. The prudent nurse would share this information with the charge nurse and potentially fill out a TPAPN referral form.