Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Madison North Date: 1/20/2023 DAS Assignment # 1 (1-4)

Name of the defendant: Fred Jason Beam License number of the defendant: RN734011

Date action was taken against the license: June 11th, 2013

Type of action taken against the license: Revoked

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 them, e.g., drug diversion, HIPAA violation, abandonment, forfeiture on student loans, etc.

On April 8th, 2012, Mr. Beam dispensed a "high alert" medication (2 mg Dilaudid) from the dispensing station at 0749, 1052, 1446, and 1757. However, he failed to administer and document the medication completely and accurately; this caused the first action and charge against Mr. Beam. The Texas Board of Nursing determined his actions would cause probable harm or overdose to the patient by future care.

Simultaneously, the second charge against Mr. Beam was the misuse of Dilaudid and his negligence to take precautionary measures. As well as, preventing the misappropriation of Dilaudid from faculty and patients. For example, he did not tell his superiors or charge nurse about the event or attempt to correct the errors. Another instance occurred if the patient were reporting the necessary pain level; the nurse would have brought harm to the patient because Dilaudid is used as a moderate to severe opioid pain reliever. Also, if he did not document the medication as given to the patient; there is a possibility of drug diversion and not disposing of the medication properly.

The final charge against Mr. Beam occurred on December 12, 2012, when the Garland Police Department arrested him for aggravated assault on a family member in a house with a weapon. This is a second-degree felony.

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.

Mr. Beam would have prevented the first and second charges, if he would have double-checked with the MAR three times and scanned the medication before giving it to the patient. In addition, he should have gone through the seven rights of medication administration which includes right documentation. By documenting correctly and completely, the following nurse would know the last time the patient received the "high alert" medication including adverse effects of the given opioid medicine. This would prevent the patient from an overdose. Furthermore, another nurse should have double-checked his management and disposal of the narcotic medication. If he still did not complete the above actions, he needs to tell his charge nurse and possible other superiors and physicians to prevent the possibility of an adverse drug reaction. Finally, he could

have prevented the second-degree felony by not assaulting a family member and maintaining decorum in his personal life.

Identify which universal competencies were violated and explain how.

Security & Safety (Physical) – 7 Rights of Medication Administration: He did not complete the right to document; therefore, he did not complete the preceding steps of right, patient, drug, dose, time, route, or reason. These rights help the patient be informed before administering the medication as a way of patient teaching and allowing the nurse to double-check the drug's intended purpose and side effects.

Documentation – eMAR medication scan: He did not scan the medication before giving the opioid to the patient or document giving the medication to the patient. If it is not written in the report, it was not completed. Based off the report, he took medication out of the dispensing station but kept the medication and did not give it to the patient.

Professional Role – Interaction with peers, staff, family: He assaulted his family and failed to maintain an ethical decorum needed to be a nurse.

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.

If I noticed the inaccurate documentation on the patient's chart, I would tell the charge nurse immediately. I would also double-check with the patient themselves and ask about their pain level, if the Dilaudid from yesterday helped relieve their pain; this will help me determine if the drug was actually administered to the patient. Additionally, I would monitor their vital signs, level of consciousness, perform a pulmonary and cardiac focused assessment and be aware of the possible adverse reactions and overdose signs and symptoms. The possible signs of an acute overdose are respiratory depression, lethargy escalating towards stupor or coma, flaccid muscles, cold and clammy skin, pupilar constriction, low blood pressure and heart rate. Also, I would be aware of naloxone, which is a pure opioid antagonist antidote for respiratory depression and hydromorphone overdose (United States Department of Justice [USDOJ], 2019).

References

United States Department of Justice. (2019, September). *Hydromorphone (trade name: Dilaudid®; street names: Dust, juice, smack* ... Drug Enforcement Administration. Retrieved January 15, 2023, from https://www.deadiversion.usdoj.gov/drug_chem_info/hydromorphone.pdf