# Covenant School of Nursing

## Disciplinary Action Summary Assignment

## Instructional Module 2

Student Name: Mya Cardenas Date: January 27, 2023 DAS Assignment # ____2___ (1-4)

Name of the defendant: William Matthew Cross License number of the defendant: 872609

Date action was taken against the license: 11/10/2020

Type of action taken against the license: Revoked

*Leading up to the revoked licensure of RN William Cross, there was an occurrence with improper triage of an infant patient. The patient was an infant who came to the ER after the parents reported a hit to the head by a softball. The nurse triaged this patient at a low risk level delaying the reaction times in which the patient would be seen by a physician/provider, this then led to the finding of a brain bleed and the need to transport the patient to a different facility to continue care. After hearing his case the TBON set terms and stipulations in place to ensure the nurse would be better prepared in the future. The RN's failure to comply with his terms of orders from 2018 led to his license being revoked. These orders included a few remedial education courses on sharpening his critical thinking skills, preforming physical assessments in a clinical setting, and a board approved course in Texas nursing jurisprudence and ethics.*

*The nurse could have prevented the action of the infant being sent to another facility to advance care by using critical thinking skills and truly evaluating the patient's situation. Some universal competencies that were violated include the lack of critical thinking skills in his evaluation, human caring being disregarded, and the lack of safety and security he provided to his patient. William's documentation did not provide any evidence or results of any assessments that were performed on the patient, so how did we know if and when he performed them. By disregarding the patient's needs he lacked human caring as he is supposed to be advocating treatment for his patient. The nurse lacked communication when the parents were not educated on what to look out for regarding a head trauma for example watch for sleepiness, breathing rates, and visible changes in the area where they were hit. Safety and security were not present by the nurse creating a lack of trust after he failed to provide them with rapid care by putting down the patient is "reactiveness appropriate to age" and leaving out crucial details. All of this prolonged the wait time and could have ended critically if it was not caught in time.*

*As a prudent nurse if I would have encountered this Nurses' patient, I would immediately report to a CN. I would then properly assess the patient by preforming a neurological assessment and take into consideration that the patient is a baby and unable to talk. After the parents reported a hit to the head, I would have placed them under a need for urgency so they could be evaluated for hemorrhaging even if it wasn't visible to the naked eye. This is where we would use critical thinking as far as remembering the patient is an infant which indicates that their skull isn't fully developed.*