Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Haylee Cruz Date: February 3rd, 2023 DAS Assignment # 4

Name of the defendant: Clintone Savio Alphonso License number of the defendant: 873910

Date action was taken against the license: January 24th, 2019

Type of action taken against the license: Reprimand With Stipulations

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.

-Formal Charges: Upon initial charges, Clintone Alphonso's status as a Registered Nurse was upheld, as long as he complied with all requirements necessary to retain his license.

-Charge 1: Texas Health and Safety Code - Controlled Substance Act, Chapter 481

-Roughly around June 15th, 2017, Clintone Alphonso withdrew Fentanyl from the EMAR at MD Anderson Cancer Center where he was employed, but against the requirement as a nurse to properly waste unused narcotics, he failed to follow the facility's policies. This lead to the medication unaccounted for, and "was likely to deceive the hospital pharmacy," and consequently placed this pharmacy in violation of Chapter 481 of Texas Health and Safety Code.

-Charge 2: Texas Health and Safety Code - Controlled Substance Act, Chapter 481

-Roughly around June 16th, 2017 through June 20th, 2017, the very next day after his initial mistake, Alphonso withdrew Hydrocodone/Acetaminophen from the EMAR for two different patients. After administration of these narcotics, Alphonso failed to document the administration of the medications in the patients. This action was stated to "likely injure the patients in that subsequent care givers would rely on his documentation to further medicate patients which could result in overdose." This consequently placed the hospital in violation of Chapter 481 of the Texas Health and Safety Code.

-In response, Alphonso admitted that he failed to document the medications were give at the times as ordered.

-Charges 3-7: Texas Occupations Code - Grounds For Disciplinary Action

-Roughly around September 16th, 2017, Alphonso took initiative to remove a foley catheter from a patient without a physician's orders. Alphonso also failed to document the removing of said foley catheter. This action was described as "unnecessarily exposing the patient to risk of harm, including infection or urinary retention…"

-In response, Alphonso admitted he removed the catheter and did not confirm the physician's order was in place.

-Roughly around October 15th, 2017, Alphonso was caught having multiple medications belonging to a patient with him in his pocket. These actions "exposed the patient and facility to a risk of harm from the cost of missed or misplaced medications."

-In response, Alphonso admitted he had the patient's medication in his pocket and he was going to administer them after he went to the restroom.

-Roughly around October 9th, 2017, Alphonso took initiative to replace the ordered nausea medication, Zofran, for Phenergan. The documents state that the first choice should be Zofran, but in the instance that it is ineffective, then Phenergan would be the next medication. Alphonso clearly went against the physicians orders, and subsequently sent the patient's respiration rate from 18 breaths per minute to 10 breaths per minute, with no response to sternal rub. This action lead to the charge nurse to administer Narcan, which helped the patient recover. This reckless action "was likely to injure the patient from adverse effects due to possible over dosage of medication."

-In response, Alphonso admitted he administered Phenergan to the patient instead of Zofran because the pharmacy delivered Phenergan first. Then claimed that he did not realize the physician's order noted to administer Zofran first.

-The same day, October 9th, 2017, Alphonso neglected a patient by failing to complete an assessment and document a pressure injury on said patient that had undergone a tracheostomy. This negligence was likely to injure this patient due to the possibility of ineffective treatment and delay of recovery.

-In response, Alphonso admitted he did not asses and document the pressure injury because he was not familiar with this type of wound, and lacked the experience to adequately assess it, and assumed the Wound Ostomy Care Nurse would assess the wound and document her assessment.

-Roughly around November 2nd, 2017, Alphonso failed to scan a barcode prior to medication administration, which would note the time, or that the medication was even administered. Alphonso also documented giving Zosyn 25 minutes early, though the medication had been pulled from the Pyxis at 1338, stated that it was administered at 1245, Cefazolin one hour late, and Magnesium 54 minutes later than time that these medications were due. These errors resulted in an inaccurate medical record, and was said to "likely injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's condition."

-In response to this, Alphonso admitted he failed to scan medication due to the facilities new scanning policy, and overlooked the scanning process. Yet the patients did, in fact, receive their medications.

-Roughly around December 8th, 2017, Alphonso failed to ensure that an IV antibiotic was administered. Another nurse found the IV bag hanging, spiked, ready for administration. Alphonso had documented in the MAR that this medication had been started. This also added to another count of Alphonso's inaccurate medical record.

-In response, Alphonso admitted that he hung the IV antibiotic, and while waiting for the medication to be completely dissolved, administered the patient's routine medications and then forgot to connect the IV antibiotic for infusion.

-The same day, December 8th, 2017, through December 9th, 2017, Alphonso failed to complete a total of five finger sticks to check a patient's glucose levels as ordered prior to treatments. Alphonso also failed to notify the physician to clarify any orders. This was said to "expose the patient to risk of harm from potentially adverse complications of undetected and untreated fluctuations in blood glucose."

-In response, Alphonso admitted that he did not complete the finger sticks because the patient was to inform him when meals arrived so he could do the sticks prior to a meal, but that the patient never informed him when the meals were delivered.

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.

-In this case, Alphonso's actions were unacceptable oversights, followed by horrible excuses. In each of these charges he defers the blame to some type of environmental situation that was happening. Our job as nurses include doing each and every one of the things that he made an excuse for. Especially when he blamed the patient for not notifying him of his meal times. This one upsets me because it is his job to ensure these checks are in place for his patients, not for them to remind him of. He is taking care of cancer patients, how does he expect them to be the ones responsibly for letting him know when their glucose checks should be taken? These aren't things that he didn't learn throughout nursing school. I think the remedial action is absolutely necessary, because each of the things he did were absolutely avoidable.

Identify which universal competencies were violated and explain how.

-Safety and Security (Physical) - This competency was violated in multiple ways. One, being that he did not provide professional interactions when he made his patient responsible for notifying him, the nurse, when their meal time is so they can get their glucose reading prior to eating. This is not professional towards the patient, nor is it their responsibility to do so. Second, being that he did not adhere to the 7 rights of medication administration in multiple ways. He did not give the correct ordered drug in one instance, instead he decided to administer another one he thought was similar enough, he did not administer multiple other drugs at the correct time in more than one case. Thirdly, he did not document administration of more than one occasion.

-Critical Thinking - Another competency that was violated more than once. One being that he lacked the accurate decision making when he took initiative to remove a foley catheter prematurely. Second, he did not follow through with an assessment related to a patients symptoms, in the case of lack of knowledge of pressure injuries.

-Documentation - This competency was clearly violated, in it's basic nature on more than one occasion. Alphonso did not scan certain medications, and he also did not document administration of certain medications.

-Professional Role - Another competency with many violations. Alphonso failed to manage his supplies, and equipment efficiently. He did not properly waste narcotics, he did not use the scanning technology due to “being unfamiliar with it,” he did not carry out administration of IV antibiotics, he carried medications with him to the bathroom, and lastly I believe that it was unprofessional that he did not take responsibilities for any of his actions, always diverting the blame elsewhere.

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.

-This case is upsetting to me in so many ways on a personal level. My father was a patient at the MD Anderson Cancer Center for many years throughout his cancer journey, and to know of a nurse that was so blatantly unprofessional makes me sick to think that he could have been the nurse that was taking care of my father at the most vulnerable and difficult time of his life. If I were the nurse that were to discover all of his negligent actions, I would absolutely report every single thing I had witnessed to the Charge Nurse, and urge them to take immediate action as he was putting so many fragile lives at great risk. It is honestly upsetting that he did not lose his license all together considering the multiple counts of neglect and inexcusable mistakes that he made during just SIX MONTHS.

The reason this case is the one I chose to write about, because it hit so close to home. And although Clintone Alphonso did not lose his license all together, I can only hope for the sake of cancer patients everywhere that he is doing all that he can to better himself, grow as a nurse and reconsider the care he gives to patients, and all that is at stake. Not for himself, but for their sake.