Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Andrew Romero Date: 3/29/2023 DAS Assignment # 2

Name of the defendant: Christopher James Allen License number of the defendant: 791402

Date action was taken against the license: August 14th, 2012

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.

- **Charge 1**: Allen failed to pay back his student loans which was taking away opportunities to other nursing students who may/are in need of financial help for school.
- **Charge 2**: Allen was withdrawing medications from the Pyxis station for his patients, but forgot to properly document that he gave the patients the medication – disregarding the Seven Rights of Medication Administration. His withdrawal of medications were as followed for the course of July 8, 2010 – August 23, 2010: Propoxyphene, Ambien (treat insomnia), Norco (brand name for hydrocodone/acetaminophen), Seroquel & Risperidone (treat schizophrenia, bipolar disorder, depression, and irritability), and Temazepam.
- **Charge 3**: Allen failed/disregard the policy & procedures for wastages of medications after usage to the patient. They believe that his behavior was to put the hospital's pharmacy at risk for violation.
- **Charge 4**: On July 28, 2010 – co-workers and staff noticed Allen to not be performing fit practice for his patients and the hospital because he "looked sedated, lethargic, walked with an unsteady gait, had trouble concentrating, and had trouble with the pyxis." Allen told his supervisor that was recently diagnosed with "temporal lobe epilepsy or psychomotor & that he wasn't sleeping well."
    - This was also a night when medications of ambien and norco was not wasted properly!
    - I wanted to add here: I am diagnosed with epilepsy and complex partial seizures – I myself have symptoms come up where I forget what I am doing but when that happens I tend to find a quiet room & recollect myself while that "anxiety feeling" goes away; that is what a complex partial seizure feels like. I can explain right now but it is long. If Allen was telling the truth, I would call-in sick and tell them I wouldn't come in if I had a seizure episode that night or wasn't feeling well. I would never put my patients at risk because of my medications making me drowsy or not being able to sleep.
- **Charge 5**: On August 23, 2010 – Allen told his supervisor that he was not "feeling well & was dizzy." Due to this he made incorrect errors throughout the night via pyxis, not recognizing signs and symptoms from his patients, and putting patients at harm.

- This was another night when Seroquel, Risperidone, and Temazepam was not wasted properly under Allen!!!

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.

- Before taking action to his license, they could have offered him some help via Texas Peer Assistance Program for Nurse (TPAPN). Seeking help if he is experiencing mental health, alcohol, or drug problems – and then offering that treatment and seeing if he is fit to return back to work under supervision/peer advocate.

Identify which universal competencies were violated and explain how.

- **Documentation** is the main one – we are stressed down to the bone about knowing the 7 Rights of Medication Administration & Allen was not competent to do his three checks, allowing the patient what & why they are receiving that medication and properly wasting that medication (if needing to be wasted).
- **Professional Role Performance:** Allen didn't display an effective, professional manner during his time at the hospital because he was lethargic and could barely work the Pyxis system. This let co-workers and patients see that he wasn't meeting the needs that he was meant to do coming into work.
- **Critical Thinking:** while being tired at work and telling his supervisor that he was not doing well – he was left to still perform the job. He wasn't thinking coherently and effectively for his peers and patients. Leaving the patients at risk for harm and neglect while Allen slugged through his shift.

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.

- First thing: if narcotics are monitored via the pyxis weekly why wasn't this documentation/wastage caught earlier until later on in late July or late August. If the patient wasn't receiving, I am sure the patient would have spoken up depending on their LOC.
- Second: Allen had reported to his supervisor TWICE that he was not feeling well, he hasn't been getting enough sleep, and he had been recently diagnosed with epilepsy and temporal lobe epilepsy.
    - If I was the charge nurse or supervisor at the time, I would have sent home Allen home and covered his patients because he is putting the patients at risk for harm by not putting his full-attention to them.
    - It it also sad because in the hospital/LTAC setting, short staffing is a real thing and maybe they didn't have enough people to cover all the patient's at the time. So, it would be hard to send Allen home for his tiredness because everyone is tired but what do we do?? But we can't just resort to storing narcotics and medications in our pockets – that is NEVER the way to go, that is just a way for us to get our license taken away from us & putting our patients more at harm.
- Third: if co-workers witnessed Allen stealing medications and never reported this – they aren't doing anyone a favor! They are leading Allen down a dark road because he is now just going to have an addiction if he doesn't seek help after that incident plus they are putting the hospital at risk. Many violations will be broken, patients will divert to other hospitals in hopes for better nurses/doctors, and you could have helped a fellow nursing friend if you would have just caught this in the beginning but it went on for far too long.