

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Dawson Delaney Date: March 31, 2023 DAS Assignment # 2

Name of the defendant: Mark Lastimoso Enriquez License number of the defendant: 822041

Date action was taken against the license: June 5th 2018

Type of action taken against the license: Voluntary Surrender of License

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.

There are two different time periods to examine in this case. The first is on or about August 18, 2015. During this time, the nurse in question the nurse was caring for a patient on the PACU floor, where he worked. It was reported that the nurse neglected to place telemetry on the patient as ordered, obtain and document vital signs and surgical dressing change. The nurse also failed to collect a sample for a BMP from the patient and did not administer acetaminophen as ordered. For this incident, the nurse was reprimanded with stipulations. Then, on or about June 28, 2017, the nurse was observed on his phone at the nurse's station while one of his patient's alarms was going off. He also on this day, completed a patient handoff to another nurse. The other nurse immediately recognized symptoms of oxygen deprivation, and applied O2 by NC. Not long after the second accusations were brought forth, the board accepted the voluntary surrender of his license.

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 there were many times that the nurse made mistakes, and all are preventable by being more focused and engaged with what is happening with his patients. There were a lot of accusations brought to this nurse but most of them involve the nurse being careless. The way to fix mistakes like this is to change the mindset while on shift. The nurse needed to be more alert and oriented to what was going on with the patients under his care.

Identify which universal competencies were violated and explain how.

There were a few different universal competencies violated in this case. First off, under critical thinking, the nurse did not provide an accurate SBAR when handing off the patient. He did not assess the patient before transporting. There are also a few different violations involving documentation. The nurse did not document vital signs and surgical dressing changes. I believe that he also violated his professional role by being on his phone while one of his patients was in distress.

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.

Many of the violations in this case would lead me to confront the nurse and tell him that some of the things happening on his watch are not okay and that he needs to come to work more focused. These violations would lead me to also notify the supervisor as to what is going on. As for the patient who was oxygen deprived when received by another nurse, I would *angrily* go to the supervisor and ask for disciplinary action. That patient's oxygen saturation was at 77%, I would be angry that the nurse did not notice the signs and try to intervene.