Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Kallie Ybarra Date: 04/02/23 DAS Assignment #3 (1-4)

Name of the defendant: Jacob Warren Owens License number of the defendant: 792068

Date action was taken against the license: 11/9/2021
Type of action taken against the license: Probated Suspension

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.

Respondent, Jacob Warren Owens, was employed with Children's Health Dallas, Dallas, TX. On multiple occasions, Mr.Owens showed signs of impaired behavior in that he was groggy, fighting the urge to fall asleep, and slurred speech (Findings of Facts 7&9, pg.2). In Another instance the defendant appeared to show erratic behavior, making multiple trips for IV medications for patients who the defendant was not assigned to (Findings of Facts 8, pg.2). While the defendant was still employed for Childrens Health Dallas, Mr.Owens engaged in the unlawful use of Fentanyl, and was subjected to a drug screening. Mr.Owens drug screen was positive for Fentanyl (Findings of Facts 10, pg.3). Jacob Warren Owens then went on to work at Childrens Medical Center, Austin Texas, in the pediatric intensive care unit. Mr.Owens actions or lack there of did not stop at this new location either. Mr. Owens presented difficulty staying awake, repeating himself, and inarticulate speech (Findings of Facts 11, pg. 3). Not only did Jacob Owens present issues with remaining present in order to provide the best care to his patients but was also charged again with failing to follow hospital policy on wastage and takeing precautons to prevent missappropriations (Findings of Facts 12 &13 &14, pg. 3). Jacob Owens pleaded not guilty to any of the accusations/charges filled against him by the Texas Board of Nursing. He was ultimately placed on probated suspension. It is very scary to think that someone who is incapable of taking care of themselves especially in the sense of sleep deprivation, could be taking care of your child.

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.

There are several things Mr. Owens could have done to prevented these instances from occurring. If he was unable to get adequate sleep and knew the best care was not being provided to his patients he should have informed the charge nurse. Where I work I know that there are nurses on the unit who can be called in if staffing changes were to occur, I'm not sure if thats an

option where this nurse was working at but I'm sure that if he were to express this to the charge nurse that there could have been something done. He could have also called in to work, rather than put children at risk because hes inable to stay awake and focus. Mr. Owens could have seriously injurecd so many patients and put several of them at risk. As for his charges on mishandling fentanyl and inaccurate wastage, he should not have gotten that chances to mishandle opioids. I also believe that the charges and outcomes should have been based on his urine drug test instead of his hair follicle test. Mr. Owens Urine test came back positive for fentanyl and negative on his hair follicle test. My Aunt is a probationary officer and explained that if Mr. Owens had only been using fentanyl, especially in small amounts, a couple weeks prior to the drug test it would not show through his hair follicles that quickly. I'm glad that no patients were injured.

Identify which universal competencies were violated and explain how.

Safety and Security (Physical):

- 7 Rights of Medication administration were not completed by Mr. Owens as he did not document his medications, and as he most likely did not finish the rest of the 7 rights due to his lethargic state of mind.

Safety and Security (Emotional):

- Mr. Owens did not promote trust or respect for his patients.

Communication:

- Communication played a major factor in Mr. Owens Discplinary action summary, as he did not provide adequate communication to his patients nor to his co workers. I feel as though if he communicated his struggles about his sleep, then most of this could have been preventable.

Critical Thinking:

- Being lethargic and possibly under the influence of an opioid would cause your critical thinking skills to not be present. There are alot of patient harm that could have arose from this. His judgement was clouded and was not in a position to catch if his patients were declining.

Doccumentation:

- There was no medication documentation on behalf of his patients who recieved fetnanyl. Which means that whatever was not documented was not done.

Professional Role:

- Appearance
- Interactions with peers and staff

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.

I think it is really important to speak up when you feel something is off about one of your coworkers. No matter what it is, it is better to be safe than sorry. If I were to be the one witnessing Mr. Owens falling asleep, looking groggy, and seeming a more irritable I would have immediately let someone know. I would not want to be the reason a patient was harmed due to my silence and if it were one of my family members I would not someone whos at a risk of making mistakes taking care of my family. It is not to be facetious or to make the other person feel humiliated but to genuinely make sure we are taking care of ourselves so that we are capable to caring for those who are in their most vulnerable state.