

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Aaron Link                      Date: 1/18/2024                      NOTICE OF DISCIPLINARY ACTION –  
10/20                      DAS Assignment #1

Name of the defendant: Young, Hong Shu  
[851343](#)

License number of the defendant: [RN](#)

Date action was taken against the license: 6/9/2020

Type of action taken against the license: Warning 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.*

RN Young had multiple occurrences of unprofessional actions while in the clinical setting which lead to his disciplinary actions. These unprofessional actions included: Incorrect documentation of intravenous insulin administration, incorrect documentation of Prograf, failing to clarify discharge orders when labs were still pending, failing to document a head to toe assessment while under RN Young's care, documenting medication administrations that he did not witness, and letting a nursing student not under his care give insulin subcutaneously when it was needed intravenously. These occurrences all lead to inaccurate medical records and exposed the patients to a risk of harm due to the inaccurate medical records, in which medical personnel need to base their decisions on.

The inaccurate documentation of insulin is multifold. In this, not only was the medication not administered the right route of intravenous, but instead was given subcutaneously, the medication was given by a nursing student not under RN Young's care. This action lead to the patient being exposed to the risk of an unauthorized non-licensed person to have any complication with the administration of that medication. Furthermore, the medication may have been given a specific route for a reason due to the individual's medical needs. Thereby opening the patient to potential medical harm, and a potentially harmful dose in the wrong route.

RN Young gave an inaccurate documentation of Prograf. In this situation, RN Young had to leave for a rapid response for one of his other patients and before leaving told the patient to take the medication after completing a blood draw from a phlebotomist in the room. RN Young did not know if the patient knew how to properly take the medication, nor if the medication was taken properly or at all. Documenting a medical administration that one did not witness, is a false record, and can lead to improper decisions based upon inaccurate data, thereby leading a patient to a multitude of potential harm.

RN failed to follow proper protocol when discharging a patient. RN Young believed that had read a valid discharge order, and gave the patient the paperwork along with the visit summary. However, a month later, RN

Young was notified that the patient was discharged by an unauthorized student who had been given access to discharge, that he had failed to document a head to toe assessment, and discharged the patient while labs were pending. This could be potentially catastrophic for the patient, as the labs and Head to toe assessment could have revealed unsuitable results. In addition, with the patient leaving the hospital, there would be no way to rectify any unsuitable results, unless the patient returned or was notified, thereby exposing the patient to unnecessary risk of harm.

In conclusion, RN Young was negligent of multiple inaccurate documentations and not following proper protocol which resulted in the numerous risks for the patients.

· *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 multiple measures that could have been implemented to ensure the prevention of unnecessary risk against the patient. For starters, only documenting medication one administers would prohibit fraudulent medical documentation. With the need to respond to another patient under the RNs care, the RN could have delayed the medication administration until after he was done handling the life threatening situation. This would have allowed the RN to observe and ensure the medication was taken properly and that no side effects occurred.

Adhering to the hospital protocol of preceptorship, would help negate the potential of mishaps of having unauthorized personnel, such as students, not practicing within their scope. The RN could have gone through the nursing student's preceptor to know what the student was authorized to do and if the student was properly trained. If it was found that the student was allowed to follow the RN and perform the procedure, it would have been helpful if the RN had gone through the process with the student to ensure the understanding, thus mitigating potential risk.

In the instance of not discharging correctly, the RN could have verified with another nurse if there was any confusion. Another route the RN could have gone, is to slow down and take the time to make sure everything in their chart was completed such as the labs.

· *Identify ALL universal competencies were violated and explain how.*

Competencies that were violated were Safety and security, communication, critical thinking, and documentation.

Safety and security was violated when the RN allowed a student nurse to give medication via the wrong route thus violating the 7 medication rights for administration. RN Young further violated safety and security when he documented the medication fraudulently for this patient and for a patient he did not witness the administration for. These discrepancies also fall under documentation, as one of the medication administrations were not observed and the other one was not put in correctly.

Communication was violated when the RN did not communicate properly with agency protocols over a student nurse administering medications, and whether or not he had valid discharge orders for the patient, as the tests from the lab were still waiting to be received.

Critical thinking was violated, as the RN did not prioritize his actions correctly when he left for a Rapid response for another patient, while simultaneously leaving a patient to administer his medication himself. RN should have waited till after the situation was handled, so he could give his full attention to the patient needing the medication administration. This was not only to ensure the meds were delivered properly, but to be available in case an adverse reaction occurred.

*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.*

If I was the first person to discover these events, I would first report this to the charge nurse and verify no other damage has occurred and ensure the patients needs were met. I would do this by calling a patient to return after an unauthorized discharge, and have them wait to receive their labs to ensure safety. I would also run labs on the two medication administrations to see how each patient was faring. I would then go over the situations with the RN Young to communicate the discrepancies and see where their train of thought was and what I may be due to help. Afterwards, I would advise or recommend training with the charge nurse to help avoid problems in the future.