Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Lisette Guerrero Date: March 25, 2024 DAS Assignment # 1

Name of the defendant: Colton Scott Woody License number of the defendant: 879063

Date action was taken against the license: April 17, 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.*

Colton Scott Woody had many unprofessional incidents that led to the reprimanding with stipulations of his license. Mr. Woody's unprofessional actions include failing to document many occasions, lowering a patient's oxygen level, and many more. Everything that failed to be missing is very crucial. Mr. Woody was a nurse in the ICU, which is a very life-threatening job. All the occurrences listed above and more led to the reprimanding with stipulations of his license.

Around November 4, 2017, Mr. Woody was working in the ICU as any other day. However, under his care, one of his patients' oxygen saturation would drop into the 80s. Mr. Woody did not know what he had done but only knew that the patient was at risk of suffering from a low oxygen saturation. Mr. Woody states that he was not aware of what he had accidentally done.

On the same day as above, Mr. Woody would fail to document vital signs on a patient until 1 am. The failure to document led to inaccurate and incomplete medical records as no one knows what occurred during that time. The failure to document could have led to many problems that could have been avoided with the patient's medical record.

Lastly, on the same day, he left the unit floor without notifying anyone. He failed to inform his patients, the charge nurse, his colleagues, or anyone around. His patients were left without care while he was gone. This was very life-threatening for the patients due to them being in the ICU without professional care.

Around December 30, 2017, Mr. Woody would fail to document once more. On this occasion, he failed to document a patient's vital signs up until 1 am. Mr. Woody also failed to document the input amount of the intravenous medications and fluids. This led to, once again, inaccurate and incomplete medical records. The lack of information would have put the patient in danger.

On the same day as above, Mr. Woody would repeat the same ignorance. Mr. Woody failed to document another patient's vital signs until midnight. He also failed to document the input amounts of a feeding tube and intravenous catheter. Once again, this led to incomplete and inaccurate medical records, which could have saved the patient's life.

Lastly, on the same day, Mr. Woody had a patient who was experiencing an increase in their anxiety. Mr. Woody failed to do a focused neurological assessment of the patient which then resulted in the delay of medical interventions. The medical interventions could have saved the patient's life as being in an ICU unit does cause anxiety.

Overall, Mr. Woody has committed multiple incidents that cost him in the end.

- *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.*

Many measures could be taken to prevent all that Mr. Woody has done. Since Mr. Woody is in an ICU unit, any mistake, big or small is life-threatening to the patient. If there was not a shortage of nurses, I believe that having two nurses per patient would greatly improve things. If one nurse does not catch a mistake, such as oxygen levels being low, there is hope the other nurse will catch the mistake.

When Mr. Woody left the unit, it was his job to make someone aware of where he was going and how long he would be gone. I understand that personal emergencies can happen while at work. However, leaving very critical patients without care is horrid. If he had to leave for personal matters, make the charge nurse aware so the nurse could lend a hand to his patients.

Lastly, failure to document on many occasions is very crucial as well. I believe that something that could help is for the hospital to have a system that would save automatically without having to be sure of pressing a save button. However, if such system does not exist, Mr. Woody should have made sure that all was documented and was documented correctly.

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

Safety and security were violated when Mr. Woody failed to complete the seven rights of medication administration in the sense of documentation. The patients now have inaccurate and incomplete medical records. It was violated once again when he failed to inform anyone that he was leaving the unit. His patients were left with no professional care.

Documentation was violated when Mr. Woody failed to document vital signs, input amounts of intravenous fluids and medications, and when he failed to document the input amounts of an intravenous catheter and feeding tube.

Human caring was violated when Mr. Woody failed to complete a focused neurological assessment on a patient who said their anxiety increased. This caused Mr. Woody to delay the medication that would have helped this patient.

- *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 nurse who discovered Mr. Woody causing all the harm to the patients, I would take measures. In the instance of the patient's oxygen saturation, I would have gone immediately to the patient's room taken an oxygen saturation, and applied oxygen. The charge nurse and the physician would have been notified. I would have told the physician to do further testing, and all needed to make sure the patient was not harmed. On all of the other occasions, Mr. Woody failed to do his job correctly, I would have notified the charge nurse, the physician, and the state board of nursing. I would have talked to Mr. Woody to see if there was anything I could help with to get him to do a better job.