

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Dova Keeling

Date: 3/29/2024

DAS Assignment # 1

Name of the defendant: Michael John Barnes

License number of the defendant: 866534

Date action was taken against the license: August 3, 2018 & June 24, 2020

Type of action taken against the license: Warning with stipulations, deferred

- *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.*

Michael John Barnes was a nurse at North Texas State Hospital in Wichita Falls, Texas. He originally had one incident or charge against him but a few years later received a couple more charges. These incidents include Respondent exceeded his scope of practice in the physical examination of a female patient where respondent's conduct could have resulted in injury to the patient. The respondent was informed that the patient was hemorrhaging, and he responded to the patient. She stated that she believed she had forgotten to remove her tampon and that it had been inside of her for five (5) days, and she wanted him to remove it. He advised her that a female nurse wasn't available to remove it. He states that she was persistent and insisted that he remove it himself. He suspected that she might be experiencing the beginnings of toxic shock. He also thought that assessing and/or removing said object was within his scope of practice. He asked for a nurse assistant to be present while he did the examination. He states that at the time of the examination, he was unaware of any policy the hospital had stating that only a physician could do a physical examination of the body cavities.

A couple years later, the respondent, for several days failed to administer a medication (Lyrica 75mg PO BID) to a patient, as ordered by a physician. The respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by a physician could have resulted in non-efficacious treatment. Several days later, he failed to correctly identify a patient and consequently, wrongfully administered medication (Seroquel 500mg, Risperdal 1mg and Gabapentin 600mg) to the said patient without an order by a physician. The conduct of the respondent was likely to cause injury to the patient and cause adverse effects from the administration of the medications. The respondent states that the medication mistakes were made due to his own medical condition.

For the first offense, the respondent was ordered to take two Board approved classes, one in Sharpening Critical Thinking Skills and the second in Texas Nursing Jurisprudence and Ethics, which he successfully fulfilled the requirements of this order. For the second offenses, he received the sanction of REPRIMAND WITH STIPULATIONS and the respondent's license was placed in INACTIVE status. The respondent will have to petition the Board for reactivation if he ever wants to work in the nursing industry again. If the Board was to

reactivate his license it would also require him to be subject to remedial education courses, work restrictions, supervised practice, and employer reporting. The respondent chose to have an inactive license at this time.

- *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 measures that could have been taken to prevent the actions that were taken. I think in the first instance, he should have consulted with the charge nurse and/or the physician before deciding to proceed with what he had decided to do. At that point he would have known the policies and procedures. He could have taken different measures at that point to ensure the patients' safety as well as his own. For the incidents later on, he could have taken several preventative measures. He could have verified the physician's order in the medication room while he was drawing up the medication, and again at the patient's bedside, and again when he had to document what medication was to be given. (7-rights) As far as the last incident, he shouldn't have not given the medication period. He didn't have an order to give it, nor did he properly identify the patient. I'm not sure what made him think he could give any of the medications to that patient.

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

Safety and Security: by not identifying the patient or verifying the 7 rights.

Communication: Utilize resources to enable communication consistent with agency protocols.

Critical Thinking: Decision making, Evaluation and revision of interventions, Prioritization of tasks/procedures.

Documentation: Emar medication scan.

Professional Role: Not knowing and adhering to hospital policies and procedures and practicing outside of their scope of practice.

- *Use the space below to describe what action you think a prudent nurse would take as the first 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 have first gone to speak with the charge nurse or physician. I would have let them know what the respondent was doing or had done. I would ask the physician what I could do to ensure that the patient was not in any harm from the wrong medications given or the wrongful examination. I would make sure the patient was ok. I would go over the situation with the nurse who made the mistakes and explain what mistakes were made and why it's important to follow hospital policies and procedures. I would then turn in the nurse to the state board.