Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Hannah Holland Date: 04/01/2024 DAS Assignment # ___2____

Name of the defendant: Russell Eugene Thomas License number of the defendant: 953432

Date action was taken against the license: 12/10/2019

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.*

Russell Thomas had multiple incidences of unprofessional and unethical actions that led to disciplinary actions against his license. These actions include: failing to ensure that the intravenous catheter of a patient was functioning properly and patent, and incorrectly documenting that the catheter was patent, he failed to administer time-critical intravenous antibiotics and failed to assess the patient's vital signs, he administered a rectal suppository vaginally, he failed to complete the National Institute of Health Stroke Score (NIHSS) on a patient and falsely documented that he performed the NIHSS. These occurrences led to inaccurate medical records and put the patients at risk for harm due to the inaccurate medical records, which lead to action being taken against his license.

The first incident occurred on November 11, 2018, when Russell Thomas failed to ensure the intravenous catheter of a patient was properly functioning and patent. He also incorrectly documented that the catheter was patent. The RN also failed to administer intravenous antibiotics to the patient at 1600 and failed to assess the patient's vital signs. These actions created an inaccurate medical record and put the patient at risk for ineffective treatment of a time-critical antibiotic. He stated that he reported that he did not have time to address the nonfunctioning intravenous catheter of the patient to the oncoming nurse at shift change.

Next, Russell Thomas incorrectly administered a suppository to a patient, and instead administered it vaginally. This suppository was ordered to be administered rectally. This could have led to non-efficacious treatment since the patient did not receive the suppository in the correct route it was ordered. The nurse stated that this patient refused all oral medications, and he felt rushed to complete the task and during administration the lights were dimmed in the patient's room. This led him to administer the suppository vaginally instead of rectally. He states that this action was corrected and the patient received a new suppository as ordered.

Lastly, Russell Thomas failed to complete the National Institute of Health Stroke Score (NIHSS) for a patient. He had previously told a charge nurse that the patient was having difficulty communicating and appeared weaker than the previous day. He falsely documented that he performed the NIHSS at 0830, when he in fact, had not completed the assessment. This caused an inaccurate medical record and put the patient at risk for

possible undetected changes of condition. He states that the patient answered all the assessment questions appropriately, but that he only completed 9 out of the 11 items on the stroke scale. He said that the other two items needed flashcards, and that these were not available on the unit until later in the day.

In conclusion, Russell Thomas provided inaccurate medical records and showed negligence by not checking the intravenous catheter and administering the suppository by the wrong route. He put his patients at risk for injury in all of these instances.

- *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 many ways the nurse could have prevented harm to his patients and action being taken against his license.

First, he should have checked that the intravenous catheter on his patient was properly functioning and patent. He should not have documented that the catheter was patent without checking first, and this would have prevented action from being taken against his license and prevented any possible injury to the patient. He also should have administered the patient's intravenous antibiotics at 1600 since they were time-sensitive. He should have managed his time better and known which tasks were of utmost importance. He also should have assessed the patient's vital signs to ensure that there were no abnormalities.

Next, RN Russell Thomas put a suppository in vaginally when it was ordered to be a rectal suppository. He stated he was rushing and the lights were dim in the room. To avoid this, he should have turned the lights on fully so that he could see what he was doing. There is no reason for the lights to be dim in a patient's room when the nurse is going in to take vitals, do an assessment, or administer medications. He should have slowed down and taken his time to ensure he was administering the suppository correctly and created a safe working environment by turning the lights on.

Finally, Russell Thomas failed to complete the National Institute of Health Stroke Score for a patient. He stated that he completed 9 of the 11 tasks because he did not have all of the needed equipment for the assessment. To prevent a false medical record and action being taken against his license, he should have gone into the patient's room fully prepared with everything he needed to do the assessment. He also should not have documented that he had completed the assessment when he had not.

Overall, all of these occurrences could have been avoided if the nurse had taken his time, followed hospital protocol when documenting and assessing, and double-checked his work. I believe this nurse needs to focus on his time management skills to ensure that all patient's are receiving the highest level of care.

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

Safety and Security were violated when the nurse failed to follow the 7 rights for medication administration and failed to give the rectal suppository by the right route. He also violated the 7 rights for medication administration by failing to give a patient their intravenous antibiotics at the right time. He further violated the 7 rights of medication administration by falsely documenting that the patient's intravenous catheter was patent.

Communication was violated when the nurse failed to communicate with his unit that he needed flashcards to complete the National Institute of Health Stroke Score (NIHSS).

Critical Thinking was violated when Russell Thomas failed to provide his patient with a proper assessment when they were showing signs of weakness and decreased communication. This was further violated by his inability to prioritize tasks and procedures by failing to ensure the intravenous catheter was properly functioning and patent, failing to administer the patient's time-critical IV antibiotics, and failing to assess vital signs, failing to complete a stroke score on his patient.

Documentation was violated when the RN falsely documented that his patient's intravenous catheter was patent. He further violated documentation by falsely documenting that he had completed the NIHSS at 0830, when he did not complete the stroke scale until later in the day.

Human Caring was violated when the nurse rushed through medication administration and incorrectly gave a vaginal suppository. He should have taken his time with the patient to ensure that he was administering the medication correctly.

Overall, Russell Thomas violated many of the universal competencies and failed to provide appropriate nursing behaviors when managing patient care.

- *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 were to discover these events, I would immediately report everything I found to the charge nurse and ensure that all of the patients were unharmed. I would check vitals on the patients and ensure that no other damage had been done, and recheck the NIHSS to ensure that the patient's chart was correct. I would then go over each situation with the nurse and remind him to take his time and go over time-management skills with him. I would give him resources for support to ensure that these occurrences do not happen again.