Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Marco Godino Date: 08/23/2024. DAS Assignment #1

Name of the defendant: Martin Ruiz Alaniz. License number of the defendant: 676510

Date action was taken against the license: 04/20/2020
Type of action taken against the license: Voluntary Surrender

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.

Martin Ruiz Alaniz had numerous negligent actions in his years as being a Registered Nurse. These negligent actions are followed: administering IV Dilantin rapidly, failure to accurately document a skin assessment, failure to document and/or an intake/output assessment, failure to document an incentive spirometry assessment, failure to complete and/or document a physical assessment, and failed to document the administration of Synthroid.

Martin Ruiz Alaniz administered Dilantin 1GM IVP after receiving a verbal order to administer 1000mg IV. After Martin IVP 1GM of Dilantin the patient then went into cardiac arrest and was in need of CPR. It is unknown if the patient survived or not. Dilantin can't exceed the administration of 50mg/minute. Lack of communication between the provider and Martin played a big factor for this patient to go into cardiac arrest. Martin never asked the provider the dilution of the dose or a rate to administer the dose. Knowing to ask for the dilution and rate from a verbal order is something we are taught in nursing school. If Martin would've double-checked with the provider about his verbal order, it could've prevented the patient to go into cardiac arrest. Administering at the wrong rate and wrong route caused serious harm to the patient due to lack of knowledge from Martin.

Failing to accurately document a skin assessment is one way to show laziness. Martin documented "Within Normal Limits" under this patient's chart. This patient's skin was in fact, not within normal limits. The patient was admitted with a left toe amputation. Because of Martin's laziness and inaccurate documentation, it could've caused this patient medical harm.

Martin failed to complete and/or document an intake and output on a patient. On this same patient Martin failed to complete and/or document an incentive spirometer assessment. Failing to do so could've caused medical harm to this patient. Without the documentation, care givers had nothing to determine their future care for this patient.

Martin failed to do and/or document a physical assessment on a patient. A physical assessment should have been Martin's main priority. Since they are done upon every admission. Failing to do so lead future care givers caring for this patient to not know the patient's physical baseline upon admission.

Martin failed to document the administration of Synthroid for a patient. Failing to document the administration of a medicine can result in major harm for a patient. If this medicine was given again by another caregiver due to lack of documentation. It could've resulted in numerous side effects for this patient.

· *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.*

Martin could have done his job totally different to prevent the surrender of his license. Failing to document the right information on many patients played a big factor in the surrender of his license. Martin failed to document the administration of medication, intake/output assessment, the use of an incentive spirometer, skin assessment, and a physical assessment. If Martin's documentation would've been true and correct, he still could be practicing as an RN till this day.

Receiving the right information for a verbal order from a provider would have prevented a patient to go into cardiac arrest. If Martin did not know how to properly administer Dilantin the first thing, he should have done was hold off on administering it. The second thing he could have done would be to call the provider and get all the information he needed to safely and effectively administer Dilantin.

Identify ALL universal competencies were violated and explain how.

Safety and Security (physical) was violated when Martin administered Dilantin. Martin violated two of the seven rights being, right dose and route.

Safety and Security (emotional) was violated when Martin failed to accurately and correctly document. Leaving patients and care givers to not trust him.

Critical Thinking was violated when Martin had lack of decision making. And administered the wrong dose and route for Dilantin.

Documentation: Martin failed to document the administration of medication. Which violated eMAR medication scan.

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.

There are numerous things I would have done if I were the nurse. That discovered the improper documentation on patients. Depending on how serious the side effect could be would determine the action I would take. I would first start by asking Martin if he needed help on how to document in the eMAR. If he said no and still failed to document accurately, I would follow

my chain of command until action was taken on Martin. If I noticed Martin was about to IVP Dilantin without knowing all the seven rights of medication administration. I would've asked him to not administer the medicine. Then go and ask the provider what route and dose he was wanting for the patient.