

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Rafaella Colmenero

Date: 8/23/2024

DAS Assignment #1

Name of the defendant: Jonathan Harraid, RN

License number of the defendant: 678146

Date action was taken against the license: 1/5/2019

Type of action taken against the license: Enforced Suspension

- *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.*

Jonathan Harraid had many events that led to the actions taken by the Board of Nursing (BON) against his nursing license. The charges filed against him range from potential drug diversion to lacking documentation in the clinical setting. The charges taken against him are listed below:

- Did not document/document accurately a performed pain assessment for the administration of morphine.
- Did not document/document accurately the administration of hydromorphone to a patient.
- Documenting that he gave a patient pain medication, Oxycodone, when supporting evidence showed that he did not.
- Incorrectly wasted the unused hydromorphone medication based on the hospital policy and procedure put in place.
- Accessed medical records of patients who were not in his care.
- Administered Oxycodone to a patient who was not under his specified care.
- Administered Morphine to a patient who was not under his specified care.

Jonathan Harraid had a previous history of disciplinary action taken against him by the BON. The incidents brought into evidence that led to the enforced suspension of his license stated above, all follow incidents of the same matter in previous cases.

Harraid did not document that he performed a pain assessment in the electronic medical record (EMR) before he administered the Morphine pain medication to a patient. This failure to accurately obtain a pain assessment fails to provide the nurse with the information to determine if the patient's pain scale was within the parameters to safely administer the medication. This lack of care could result in the patient receiving a dose of Morphine that would alter the patient's mental and physical status in a way that was not necessary. In addition to this violation of care, Harraid also did not document an administration of hydromorphone given to a patient. This lack

of documentation could potentially cause major harm to the patient as the EMR would not provide an accurate detail to following nurses of the amount of medication given and therefore allow for the risk of the patient becoming overdosed by the medication. On the opposite end from these events, Harraid also did document actions that he did not take. Harraid documented that he administered a pain medication, Oxycodone, to a patient under his care; however, after investigation, supporting evidence revealed that Harraid was not shown in the patient's room at the time that the medication was given per the documentation entered by him. Other evidence also showed that the patient did not interact with Harraid during the time, which would ultimately reveal the patient did not communicate that a pain medication was needed. Next, the incorrect wasting of hydromorphone according to the hospital's policies and procedures put in place, brought forth inaccurate data for hydrocodone in the pyxis. Being that hydromorphone is an opioid, this action could very well open up a case in investigating a potential crime of drug diversion for Jonathan Harris. It could also bring forth the danger of following nurses being accused of narcotic diversion or tampering if they were not careful when pulling the medication.

When asked about the medical records that were accessed of patients who were not under his care, Harraid explained that the EMR that he was working with was unfamiliar and new to him. He stated that the only way he knew to get to his patient was to go through a list of all of the patients in order to get to those who were assigned to him. Despite his explanation, it still reveals that he was accessing patients' records that he did not have authorization to. This is a violation of patient confidentiality, violating HIPAA, and is a breach of the patient's personal information.

Lastly, Harraid was noted to have administered medications to patients not under his specified care in two instances. The first one was administering Oxycodone and the second while administering Morphine. When asked about the event, Harraid stated that he was working in an environment that involved a lot of teamwork and helping each other out. Although nurses can delegate medication administration to other nurses, these instances would have needed to have supporting documentation as well as why it was appropriate for Harraid to be delegated the task. It was not brought into evidence that this supporting documentation was written, so ultimately it is a violation of the patients' privacy as the patients were not specifically assigned to be under the care of Jonathan.

- *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.*

Each of the findings that brought action taken against Jonathan Harraid could have been avoided if the time to do things thoroughly was taken. Harraid did agree that there was an issue of poor documentation and a need for remediation.

Initially, a nursing pain assessment should have been performed to ensure that the findings were within the parameters to safely give the medication. Now, if the assessment was done and documentation was just forgotten, the simple way to prevent this issue is not to rush and to document as closely as possible to the time tasks were performed. This same fix could have been implemented when he failed to document the hydromorphone administration. Although Harraid testified that these nursing actions were taken, it is important to remember the saying, "If you didn't document it then you didn't do it." This same principle can be applied to not correctly wasting a drug based on hospital policy. You have to take the time to do things properly and document it correctly so that you correctly reflect your actions, especially with tasks like pulling drugs from the pyxis.

Another measure that could have been taken would be to advocate for yourself. In the finding that Jonathan Harraid was accessing medical records of patients who were not in his care was, he testified it was due to not knowing how to correctly navigate the EMR system. In that case, Harraid should have communicated with someone such as a charge nurse to ask questions and get proper clarification on how to correctly use the EMR. This would have prevented him from violating patient confidentiality.

Harraid also should have taken the measures of protecting his license by following up with the nurse who delegated medication administration to make sure that the proper documentation on their end was written. Now, had Harraid passed the medications without the delegation from the patients' nurse then Harraid should have not done any nursing intervention at all even if he was trying to just trying to be a helper in the situation.

Lastly, Harraid should have not falsely documented the medication administration to a patient. If it was a dose that was missed, it is ultimately safer to accept the medication error and take accountability for it. It was not stated whether the patient was harmed, but in this case it would have affected the patient in some way due to the documentation containing false information. Had Harraid just made the error, safety precautions could have been put in place such as monitoring the patient for a time frame after the medication error was made.

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

The universal competencies violated were:

Safety and Security (Physical) – Failure to perform a pain assessment prior to administering Morphine to a patient violates the 7 rights for medication administration because there was not a reason that supported giving the medication. Failure to document medication administration directly violates the documentation point in the 7 rights for medication administration. Lastly, administering medications to patients that were not assigned to him also falls into the category of him not keeping patient confidentiality, as he would have had to access patient records without in order to document that he gave the medication. Now, if he did have permission to complete the nursing intervention, it should have been documented by the person who delegated the task to him.

Safety and Security (Emotional) – Accessing patient medical records that he was not caring for violates patient confidentiality under HIPPA. Whether or not he did not intentionally access the records, it is still a violation of their privacy.

Documentation – Documentation was violated because of the pain assessment being excluded from the documentation. Another direct infraction that violates the universal competency of documentation was the false documentation that was written by Harraid.

Standard Precautions – Failure to dispose of unused hydromorphone correctly, disrupts the information in the electronic medical record (eMAR) and creates a safety issue for others when not disposed of properly.

- *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.*

Immediately after discovering the events that occurred, I would have followed the chain of command and first reported it to my charge nurse what I found. If the events that occurred where a patient could have potentially been harmed by the faults during medication administration by Harraid, I would have immediately gone to check on the patient's status and then go to the charge nurse to address my concern. From there I would participate in any deliberation to come up with a care plan for the patient with all things considered. After the plan is in place, I would then express my concern for Harraid and do as I was told by those above me in the chain of command.