

Covenant School of Nursing  
Disciplinary Action Summary Assignment  
Instructional Module 2

Student Name: Jailene Gonzalez      Date: August 23, 2024

DAS Assignment # 1

Name of the defendant: Zachary James Watson

License number of the defendant: RN 881330

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

Type of action taken against the license: Revoked

Zachary James Watson committed various unprofessional actions while employed in the Emergency Department of Huntsville Memorial Hospital that led to the revocation of his nursing license. The respondent lacked fitness to practice as a nurse, failed to document administration of Fentanyl, did not follow wastage of unused portions of Fentanyl and Diazepam, misappropriated Fentanyl and Diazepam, and did not secure Fentanyl and Diazepam that belonged to the hospital. The actions that Zachary did significantly compromised patient safety

The nurse presented to their shift in a disordered manner, appearing to be sweating significantly, having weakened physical responses. This was recognized not only once, but on three subsequent different dates, March 15, 2018, March 19-20, 2018. This rise worries towards the well-being of the nurse, and in result making the judgment that they are not fit to properly care of the patient since they may miss important observations of the patient's condition to conclude patient's treatment, eventually compromising the patient's safety.

Nurse Zachary failed to complete the documentation of the withdrawn medication (Fentanyl) in March 20, 2018. This drug is known to be a potent opioid with high risks of severe side effects, the documentation provides healthcare workers prevent overdoses/ drug interactions. Since this is a controlled substance, proper documentation would've prevented the violation of the Controlled Substance Act.

Fentanyl and Diazepam were both not discarded on March 20-21, 2018 by following the hospital's policy for wastage of these two controlled substances with high potential of abuse. The proper discard policy helps ensure that medications are not diverted for unauthorized use, prevent med errors from leftover medication from other staff, and not facilitate access to this medication to unauthorized personnel.

Several medications were found to be misappropriated by the nurse (in March 20-21, 2018) that could've compromised the state of legality of the hospital and the costs placed on the patient. This included a total of 650mcg of Fentanyl, and 2.5 mg of Diazepam.

In March 20-21, 2018 Various syringes filled controlled substances (Fentanyl and Demerol), a vial, tablet, and pill were left exposed in nurse's Zachary's workstation. These medications were not properly secured, this again compromised the nurse's accountability, unauthorized use, and legal repercussions of the nurse and hospital.

Nurse Zachary could've prevented the TBON to revoke his license in several manners, most importantly, by seeking help. This nurse was misusing medication, for their own use/ other reasons. This can be concluded based on his appearance (sweating/disordered). He had to become self-aware of his actions and decide if needed drug abuse counseling, to recover. He could've stepped away from his position for a momentarily period, as he fully recovered. At the minimum, the nurse should've considered another nurse to be near his when administering/ being near medication to keep him accountable. This is important to recognize, especially when dealing with the safety of patients, who are constantly receiving medications.

There are various measures the nurse could've done within the hospital such as; following the hospital's waste protocol, properly documenting medicine administration, and safely displacing medications. This significantly minimizes the patient being in life-threatening situation, the legal repercussions towards the hospital, and other healthcare works properly completing their role of the patient's care.

I believe this nurse violated all seven universal competencies: safety and security, standard precaution, communication, critical thinking, documentation human caring, professional role.

**Safety and Security:** The nurse compromised patient safety by not being physically adapt to be able to recognize patient's condition, complete nursing assessments, to be able to carry out proper judgments for the patient's care. Further safety and security violations were done through improper/non existing documentation and communication.

**Standard Precaution:** This was violated when he was found with a syringe containing 2.5mL of Fentanyl in his pocket, refusing to submit a drug test, various medications were found at his workstation (Demerol 37.5 mg, syringe labeled Fentanyl, a Bactrim tablet, one Cardizem pill, and a partially used vial of Labetalol. He also did not discard/waste unused portions medications as per hospital's protocol. He did not document withdrawn medication, information that is crucial for other caregivers to be aware of to ensure safe patient care.

**Communication:** Violated when he did not communicate that he was unfit to care of patient based on his impaired behavior. Also, when he did not meet facility's procedure on medicine wastage, documentation to communicate with other caregivers on patient's given medication to avoid dosage/ provide proper treatment.

**Critical Thinking:** The nurse should have documented medication withdrawn to avoid any severe patient overdoses.

**Documentation:** Did not complete medical administration documentation when withdrawing Fentanyl, other healthcare professionals rely on accurate information to further administer medications to the patient to ensure proper medical treatment.

**Human Caring:** The nurse prioritized his desires before putting the safety of the patient beforehand. He continuously jeopardized the well-being of the patient; this could've ended the patient's life.

**Professional Role:** He was recognized to be lacking fitness, he was sweating profusely, and was physically disordered (compromising his professional appearance and possible hygiene).

If I were to become aware of the events mentioned in this case, I would immediately inform the charge nurse, whom I would report back to ensure that their upper-level management have also become aware. This would be after assessing patient (taking vitals, observing for S/S, etc.), and informing their PCP to ensure the patient is safe. Lab test must be completed to monitor how the patient is reacting to the medications given, have a caregiver be always present with patient to act for any worse case scenario (overdose). I would then communicate with nurse Zachary to check their vitals, see any way I could help them for that moment, since he could've been under the influence of the medications mentioned.