

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Marcela Guevara

Date: 08/30/24

DAS Assignment # 2

Advisor: Karvas

Name of the defendant: Andrew Scott Voland

License number of the defendant: 913521

Date action was taken against the license: 8/21/2018

Type of action taken against the license: Warning 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.*

Andrew Scott Voland graduated from CSON on December 16, 2016, and got his professional license from the State on January 10, 2017. During this time, Andrew was hired as a day surgery staffing nurse at Covenant Children's Hospital from January 2017 through January 2018. After being hired there for 7 months, Andrew Voland started to have multiple issues leading to disciplinary action against his license. On August 28, 2017, Voland failed to label a catheterized urine specimen, and the lab wouldn't accept it. This increases the patient risk of spreading their infection even further because the urine results could've helped the patient get on medication they needed as soon as possible and helped with fast recovery. On September 21, 2017, Voland failed to label an emergency blood specimen that was ordered from the anesthesiologist. This blood work was needed so they could receive the units of the right blood type before the surgery began. During this was occurring, Voland failed to insert a catheter far enough into a 4-year-old patient and inflated the balloon in the patient's urethra causing damage and bleeding. This injured the patient and delayed the patient's surgery. The last event was on December 28, 2017, when Voland removed the IV line with Potassium Chloride from the Infusion pump and let it infuse freely in a 7-month-old patient. This could've harmed the patient by the excess amount that was given which could've led to cardiac arrest. During this time, he encountered another situation where he left his patient unattended and sitting on the edge of the OR table while the patient was under the influence of benzodiazepine making the patient a high- fall risk because of its side effects. This could've potentially harmed the patient which could have caused a severe fall injury. Failing to label blood specimens, label urine specimens, lack of appropriate nursing care, and creating an unsafe environment caused the Texas Board of Nursing to take disciplinary action against Andrew Voland.

- *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.*

Multiple opportunities could've avoided this situation. One is, to always label any specimens that are ordered. When you're gathering your supplies always gather your labels before going into the patient's room and label them in their room before leaving. Second, always double-check your lines and make sure

you have stopped your infusion. Double-checking your lines and dispose of solutions right away once the right dose is given. This will prevent giving the wrong dose with improper dilutions of the medication. The third will be when inserting a urinary catheter if you don't see urine return you are not far enough and if it's a male patient you should enter the whole catheter in. If you can't get any urine returned remove the catheter and call a urologist. The last would be keeping a close eye on fall-risk patients when they are on certain medications. If the patient was in the OR table the nurse could've stayed in the room with the patient before the surgeons arrived avoiding any falls or injuries.

Identify ALL universal competencies were violated and explain how.

Safety and security, documentation, and critical thinking were the universal competencies that were violated during this time.

- Safety and Security: The nurse violated this by not using the fall bundle and leaving the patient alone in the OR knowing the side effects of benzodiazepine. This resulted in the patient being found sitting on the side of the OR table causing the patient a high risk of falling and potentially harming themselves with a fall or something worse. The nurse also failed to give the patient the wrong dose of Potassium Chloride to the patient while taking off the IV solution and did not stop the Potassium Chloride. This caused the patient to receive more Potassium Chloride than was needed which could've injured the patient leading them to go into cardiac arrest.*
- Critical thinking: The nurse didn't make good decision skills when he was inserting the 4-year-old patient's catheter. When the nurse saw signs of pain and blood the nurse should've stopped and removed the catheter immediately. The nurse left the catheter in the patient causing injury to the patient from lack of nursing care.*
- Documentation: The nurse failed to label a catheterized urine specimen which caused a delay in the patient treatment and recovery time. The nurse also failed to label an emergency type and cross-blood specimen that was needed by the anesthesiologist. Units of blood were needed before the surgery began and was delayed because of improper labeling.*
- 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 the first person to discover these events, I would explain to the nurse that he wasn't doing appropriate nursing care and risking the patient getting injured causing irreversible effects. I would ask what the reason behind the improper care was. Then I would contact the charge nurse and notify them of the lack of improper care that is occurring and improper documentation. Then I would ask the charge nurse to make a proper report to the State Board of Nursing because these incidents are harming and risking the patients well beings.