

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Amber Freeman

Date: 8/30/24

DAS Assignment # 2

Name of the defendant: James Ross

License number of the defendant: 548380

Date action was taken against the license: 01/05/23

Type of action taken against the license: Voluntary Surrender

- *James Ross had several occurrences of unprofessional behavior that led to his license being voluntarily surrendered. Those occurrences include falsely documenting and failing to intervene to a code in a timely manner.*

On or about June 2, 2019, through June 3, 2019, while employed as a charge nurse with the University of Texas Health Tyler North Campus, James Ross falsely documented the times assessments were completed on ten patients, when instead James was logged into streaming video websites in the nurse's station. James states that he did not falsify any assessment records. He states that he always comes in early prior to actual shift change and performed a walk around and saw all the patients under his charge. James states he performed assessments on each patient. He states he came back later and entered the assessments in the electronic medical record. James states this has always been his practice.

On or about June 3, 2019, while employed as a charge nurse with the University of Texas Health Tyler North Campus James Ross failed to timely intervene and call a code when one patient choked another patient in direct view of the nurse's station. The patient was found unresponsive with facial cyanosis, had voided herself, reddened fingerprint ecchymosis on her neck, and had pinpoint petechiae around her eyes. During this incident, James was logged into streaming video websites at the nurse's station. James states that the medication nurse was next to the patient on the other side of the desk, passing medications to other patients. James states that he was at the desk putting in updates for upcoming shift report when he heard the medication nurse call for help. He stated he looked up immediately and went to help. James states that he assisted in getting the patient off the other patient, and the other nurse left to go call for a code bert and rapid response. He remained at the side of the patient checking her pulse and breathing. He states he called for vital signs and pulse os and both were stable. He said other personnel arrived, and he called the emergency room resident to see the patient but noticed he was there already. He states he informed the resident of the vital signs and the situation. James states the patient was seen and was stable afterwards.

On September 11, 2019, James Ross was reprimanded with stipulations and fined. James Ross failed to comply with the orders and on January 5, 2023, he voluntarily surrendered his license.

- *Measures I think that could have prevented James Ross from losing his license 1st and foremost is not to be on computers for leisure or phones while you are on duty. He would have been way more focused and concerned about his work if he had his priorities straight. It is also good practice to document right then or soon after to when you provide any type of care. Also, if he would just have followed through with the courses and stipulations that were given to him, he would still have his license.*
- *Universal competencies compromised here are safety and security, communication, critical thinking, documentation, and professional role.*

Safety and security were compromised by not being more alert to why another patient was in one patient's room. This may have been prevented if James had been more aware of what was going on in the rooms/halls by not being on the computer watching videos. He definitely was not engaged with the situation. Also, he was assuming the medication nurse was able to pass meds and be more aware of where each patient was. Again, if he was more alert to where everyone was instead of being involved in the computer. Him being on the computer could have injured the patient from delayed treatment of her injuries.

Communication was compromised by not communicating more with each patient about problems. I would think that if patients were fighting, there would have been a situation or situations prior to the fight. If he would have communicated with his nurses about problems with patients maybe he could have intervened and came up with a resolution.

Critical thinking was compromised by not documenting findings when the assessment was done. By not documenting right then, injury could have happened to a patient by not noting changes within a patient. Also, by being on the computer he was not supervising the nurses he had under him. He was not readily available for help when he was engaged in other things.

Documentation was compromised by not documenting findings on all 10 patients when the assessment was performed. Late documentation is not acceptable when he clearly states this is something he always does by coming in early before his shift starts. This is unfair to the patient and puts the patients at risk of something being missed. Timely documentation is so important so if a patient is to decline, it can be caught based on prior assessments.

Professional role was compromised by not following policies and procedures set by the hospital. It is very unprofessional to be on a computer watching video streaming instead of being focused on the patients and the nurses that are under you. Also giving delayed care to patients because you are watching videos is not professional. Professionally in nursing you are to document after the assessment and not way later. Also, he was not following the RN scope of practice.

- *If I was the first person to discover that a nurse was coming in early to assess patients and then discover that these assessments were not documented or time was documented differently, I would go to the director of that unit since this was a charge nurse doing this. I would also maybe bring it to the*

attention of the charge nurse about watching videos at work. I would definitely let someone know because an ongoing problem of watching videos means that he is not in charge and overseeing what is going on with that floor. This not only puts the patients in situation where something could go wrong but for the nurses under his care as well.