Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Amaya Jones Date: 10/18/2024 DAS Assignment # ____1____

Name of the defendant: Martin Ruiz Alaniz License number of the defendant: RN #676510

Date action was taken against the license: 4/22/2020

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.*

Mr. Alaniz has conducted one instance of a medication error and failed to appropriately document various instances of care. In 2013, Mr. Alaniz failed to clarify a verbal order for Dilantin to be given via Intravenous Push and delivered the dose to a patient at a rapid rate. This action resulted in the patient going into cardiac arrest and resuscitation. After being ordered a reprimand with stipulations, Mr. Alaniz was placed under review again years later for failing to document care. In 2017, he inaccurately documented a patient's skin assessment, failed to document a patient's intake and output as well as an incentive spirometer assessment, failed to document a patient's physical assessment, and failed to document the administration of Synthroid in the eMAR.

- *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.*

During Mr. Alaniz's initial infraction, asking for clarification about the verbal order and reading it back to the physician would have prevented the rapid administration of Dilantin. The nurse should always clarify an order they receive to ensure that have the correct information and to potentially halt any medication errors for occurring. Reading back the order would relay back to the physician what Mr. Alaniz heard and provide room for correction on the appropriate rate to administer Dilantin. Mr. Alaniz should have made sure to properly document the care for all of his patients. For instance, he documented a patient as having a skin assessment within normal limits, but that patient was admitted with a toe amputated. He also failed to document a patient's intake and output throughout the day as well as their ability to use the incentive spirometer. Documenting all care provided and the administration of medication is crucial to ensure that care has been performed efficiently. Failing to document properly could cause patient harm and means in the legal world that care did not happen.

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

Mr. Alaniz violated safety and security (physical) by failing to clarify the verbal order he received and reading back what he heard to the physician. The seven rights of medication administration include clarifying the right patient, right medication, right dose, right time, right route, right reason, and right documentation. The nurse needs to inquire about all of the information relating to those rights to make sure that they have all of the correct information. The physician could have clarified or reminded Mr. Alaniz of the appropriate rate to administer Dilantin to avoid the medication error.

Mr. Alaniz also violated documentation by failing to appropriately document the care provided to multiple patients. He did not appropriately document one patient's skin assessment and failed to document the care of other patients such as intake and output and the administration of Synthroid. Failing to document correctly does not guarantee that he has performed the care and puts the patient at risk if they show signs of deteriorating due to the absence of a prior log of what has been performed and any potential changes that could have been observed during an assessment.

- *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.*

The first thing I would do is report to the charge nurse in privacy about the events that took place and follow policy and procedure on who else I would need to contact regarding the incident(s). I would keep a close eye on the patient that had to be resuscitated after being administered Dilantin and conduct a focused assessment on them to ensure they are displaying any symptoms that could give alarm. I would also conduct physical assessments and appropriately document my findings immediately afterwards. I would be willing to supervise Mr. Alaniz while he continued to provide care on the floor and remind on the importance of documenting everything.