Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Andrea Fabela Date: 10/24/2024 DAS Assignment # 1

NOTICE OF DISCIPLINARY ACTION – 10/2021

Name of the defendant: Oliver Daleno Bravo, RN License number of the defendant: 874193

Date action was taken against the license: 6/8/2021

Type of action taken against the license: Probated Suspension

Oliver Daleno Bravo had multiple occurrences of unprofessional actions while in the clinical setting, which led to these disciplinary actions. These unprofessional actions included failing to perform complete and correct documentation for a pain assessment on the patient, not recording the removal of Tylenol from the medication dispensing system and failing to document the dose of Tylenol administered. These poor actions resulted in incomplete medical records, increasing the risk of injuring the patient, especially while other caregivers are providing care since they are relying on their decisions with the medical information provided.

Performing a pain assessment has to be one of the most accessible assessments for a patient. It should take no more than 15 seconds to be done, including documentation. Nurse Oliver decided to do neither of these things. When assessing for pain, you are listening to the patient's comments about the site of pain, and as a nurse, it is your job to evaluate the site and look for any abnormal signs. Once done with the assessment, it is essential to document the site location and the patient's pain rank. Which Nurse Oliver also failed to do. These failures could have led to the patient getting injured since no one who has access to this patient report had an idea of the pain

this patient has been going through. Say the patient needed to go to the restroom, and the CNA came in to help, but the pain was in their left leg, and the patient fell once the CNA got them out of bed and severely got injured. The CNA had no idea about the patient's pain, which led to more consequences that should have been avoided by completing the correct documentation.

Nurse Oliver documented that Tylenol was given to the patient at the time of administration. However, no record of Tylenol being removed from the medication dispensing system exists. From this point of view, it seems like Nurse Oliver gave the patient the wrong medication. When preparing to dispense a medication in the med room, on the screen, there should be a button next to the medication you need to "select to dispense" to click on. Once you click that button, the dispensing cart opens a drawer, and on the screen, it localizes precisely where the medication is for you to grab. The possibility could have been that Nurse Oliver clicked on the wrong medication thinking it was Tylenol and did not verify it once grabbed. It was Nurse Oliver's job to verify the medication with the three checks before giving it to the patient and worked slowly. Nurse Oliver could have harmed his patient severely because you do not know what kind of reaction the patient can have towards the wrong medication, which can lead to death.

Adding to the category of many documentation errors, Nurse Oliver also failed to complete the documentation for administering the dose of Tylenol. This could have caused inappropriate clinical decision-making for the patient in future events. The Provider could have ordered another dose for the patient, thinking they ordered too little when the patient needed more. Possibly, that added dose could severely injure the patient since the Provider believes that the reported dose was correct. Doing correct documentation is for your patients, coworkers, and safety; it is vital to be aware of it.

In conclusion, Nurse Oliver’s poor actions resulted in an incomplete medical record, which could have led to injuring the patient and caused inappropriate clinical decisions from all the caregivers in future events to the patient.

Every failure action Nurse Oliver performed could have been avoided, and this would have been a completely different story. For starters, the poor decisions he made of not assessing patients' pain and not documenting correctly could have been avoided by taking the time to ask and listen to what the patients had to say about their pain. As for documentation, it

should have been done at the bedside to avoid forgetting the information and knowing the correct documentation for pain. This would have avoided injuring the patient in future events.

There is no record of medication being dispensed. However, there is a record of medication being given at the scheduled time. This could have been avoided by verifying the medication and paying attention to what is clicked on the screen. Nurse Oliver seems to have been rushing and not aware of what medication he was grabbing from the dispensing cart. By committing this kind of error, Nurse Oliver could have seriously harmed his patient. He should have been more orientated and alerted to what he was doing.

Incomplete documentation of medication dose could have easily been avoided by documenting and verifying medication at the bedside. Nurse Oliver was possibly documented at the nurses' station, forgetting the exact dose given and assuming the dose he reported was given.

If the RN had a proper and completed medical record, the RN could have avoided many complications. These are the little things that can take away our license. The RN should have been more alert and organized with their performance. There are no excuses for this kind of behavior.

Competencies that were violated were Safety and security, communication, critical thinking, documentation, and professional role.

Safety and security were violated when the RN did not verify medication using the three checks starting once it was removed from the cart. This would have prevented the patient from being administered the wrong medication.

Documentation was violated regarding the incomplete medical record the RN had due to not correctly documenting pain assessment, not documenting that medication was given but not dispensed, and documenting an inaccurate dose of medication.

Communication was violated when the RN did not communicate properly with the patient when assessing for pain. The RN should have asked the patient to rank their pain and asked where the site of pain was located.

Critical thinking was violated multiple times. The RN made poor decisions about whether they gave medication and did not prioritize their tasks and procedures with the med admin.

Professional Role was violated by RNs' lack of proper appearance. They committed too many errors that could have harmed the patient.

If I were the first person to discover these events, I would immediately stop the RN from committing any more mistakes to harm the patient; then I would inform the charge nurse right away about the current events that have happened. Then, my second action would be to check up on the patient and assess a full set of vital signs, a head-to-toe assessment, and any abnormal signs and symptoms to see if any harm has occurred to the patient. Then, I would notify the provider about what has happened, give an update on a patient with a new assessment and vital signs, and wait for further orders.