

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Mendoza, Crystal

Date: October 20, 2024

DAS Assignment # 1

Name of the defendant: Matthew Clarke Aycock

License number of the defendant: 825850

Date action was taken against the license: 1/21/2016

Type of action taken against the license: Revoked

- *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.*

Within a clinical setting Matthew Clarke Aycock frequently displayed negligence and unprofessional actions. Due to the participation in frequent unethical actions, it led to disciplinary actions and ultimately the revoking of Mr. Aycock's nursing license. The following unethical actions that Matthew Clarke Aycock participated in are: failure to document a discharge summary resulting in an incomplete medical record, administration of incorrect dosage amount for medication therefore failing to administer medication as ordered, failure to document assessment or declining health status of a patient, failed to administer an ordered hepatitis vaccination at discharge, incorrectly administered insulin in 7 occurrences that were not in accordance with physician's order as well as administering insulin when blood sugar was below the value of 110mg/dL, lastly, failure to document condition and interventions taken for a patient presenting with unresponsiveness and clamminess.

Throughout the multiple unethical actions that Mr. Aycock displayed, failure to document was one of the most frequent actions that occurred. Mr. Aycock failed to document discharge summaries, assessments and changes in patient status. Failure to document a discharge summary put the patient in risk of an increase of medical errors because physicians would be unable to determine their plan of care based on the data that was failed to be documented. The patient was also not involved in their plan of care due to minimal documentation provided for their discharge. The patient's risk for safety increases due to the minimal knowledge taught by the nurse. Apart from failing to document discharge summary, the nurse failed in documenting an assessment on a patient whose health status later became critical and resulted in transferring to the ICU. Failing to document assessment put the patient as a greater risk to a decline in their health because of missing information from an assessment that could have caught any abnormalities in the patients' health.

Under Mr. Aycock's care, he failed to administer a diuretic medication to the patient as ordered by the physician and instead administered a higher dose of the diuretic medication.

Administering a higher dose than prescribed by the physician increased the risk for the patient to have a harmful reaction and impact on the patient's fluid and health status. Along with medication errors, Mr. Aycock ignored physician's order to withhold insulin if patient's blood sugar levels were below the value of 110, the nurse continued to administer insulin to a patient. This action increased the risk for the patient to become hypoglycemic and as a result did present with health concerns of hypoglycemia. Ultimately, Mr. Aycock's inability of documentation, and lack of precaution increased the risk of harm to many patients.

- *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.*

To have provided safe care to the patient and avoid any undesirable errors, it is essential to prioritize documentation, triple check medication when receiving the physicians order, when drawing the medication and at bedside before administration of the medication. First, prioritizing documentation could have prevented an error in how the patient was treated because physicians would have the necessary data to base their care plans. Along with successful documentation of patient's health history, documentation of assessments will also ensure that the patient's health status is being continuously monitored for any abnormalities, therefore Mr. Aycock could have detected any concerning health issues that could have arisen before the patient entered respiratory distress.

Medication Administration errors could have been avoided if Mr. Aycock performed his 3 checks before administration and informing the patient of their 7 rights before administering the ordered medication. By performing his 3 checks, Mr. Aycock could have caught the wrong dosage amount of the medication even before coming to the bedside. Once at the bedside, informing the patient of their 7 rights could have been another instance in which Mr. Aycock could have ensured that the proper dosage matched the medication he was going to administer to the patient. These factors could have also been a big contribution to preventing one of Mr. Aycock's patients from becoming hypoglycemic. If the nurse would have verified the physicians order, withholding medication for a value below 110 would have contributed to decreasing the chances of administering insulin when not appropriate. Another factor that could have prevented administering insulin would have been to verify that the blood glucose levels were within the parameters listed on the physician's order before preparing the medication.

Overall, the nurse could have avoided the many medication errors by taking the time to verify the orders and the medication that was to be administered, taking the time to fully assess and document could have also decreased the risk of a patient's health declining by having the necessary data to base the care of the patient.

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

The following universal competencies that were violated by Mr. Aycock were safety and security, critical thinking, documentation and professional role.

**Safety and Security** were breached when the nurse failed to perform the 7 rights of medication administration before administering a diuretic medication that ordered for 250mg but was given at 500mg.

**Critical Thinking** was breached when the nurse failed to withhold insulin on a patient whose blood sugar fell within the parameters to withhold. Another instance in which critical thinking was breached was when the nurse failed to prioritize assessments regarding the patient who experienced respiratory distress. The nurse also breached critical thinking when he failed to document change of health condition and interventions regarding a patient who became unresponsive under his care as a charge nurse. Despite the error being in documentation, critical thinking was breached due to the severity and importance that this information needed to be included in the health record.

**Documentation** was breached when the nurse failed to document assessments pertaining to a patient whose health was declining as well as the status of the patient's health, and failure to document discharge summary.

**Professional Role** was breached when the RN failed to document a change of condition a patient because by failing to do so, it prevents others involved in the care of the patient to base their care based on previous data. The nurse failed to be a good coworker to those around him and especially as a leader as the RN was the charge nurse at the time.

- *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.*

Upon encountering the events mentioned previously, I would notify the charge nurse immediately to prevent further harm from occurring to current/future patients. I would help ensure patient safety by participating in any plans to successfully care for the patients correctly and safely regarding what the charge nurse or physician order to do. I would also inform Mr. Aycock about the actions he has done that increased patient harm to help him acknowledge the unethical actions he is committing as well as seeing ways I could help him better care for the patient while still under his care by taking necessary labs to monitor patient health status, reminding the RN about the importance of documenting and continuously assessing patient for any adverse reactions. If I feel that the RN has no care about the harm he could have caused or drive to better care for the patients, I would inform the charge nurse or director of the unit, as well as the physician and I would contact the state board.