

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student name: Hanna Wells
Date: 10/26/2024
DAS Assignment: #2

NOTICE OF DISCIPLINARY ACTION – 06/2019

Name of defendant: Richard Bradley Calhoun
License number of the defendant: 686551

Date action was taken against the license: 09/2019

Type of action against the license: warning with stipulations and fine

On June 6th, 2019 Richard Calhoun took 12 tablets of cozaar from Baylor st. Luke's Medical hospital. He admitted to taking 7 of them for himself. While this was a warning, Calhoun diverted drugs from the patient and left the patient without their meds. Which could have led to numerous other issues such as the declination of patient health, insurance issues for the patient, harm to himself, and could have led to the revoking of his license

There are a few actions that could have been taken in order to prevent this misappropriation of medication. For starters, if he had not diverted medications in the first place, that would have prevented the warning and fines Calhoun had to pay. Also, proper documentation is something that helped this situation and allowed for the higher ups to find out about this med diversion. Finally, I think someone needs to be overseeing Calhoun when he is in the med room and with his patients, in order to ensure that no diversion is occurring. This way, both the patient and respondent are safe.

Universal competencies violated: Safety and Security (physical), Communication, documentation

Safety and Security (Physical) was violated when the respondent decided to take medications from the patient med room. This could have led to the delineation of multiple patients' health if they happened to be in need of the Cozaar that was diverted.

Communication was violated by the RN by hiding his decision to divert medicine. This secrecy led to more harm than good for Calhoun and his patients in the hospital.

Documentation was violated by the respondent when he decided to take meds from the med room and improperly document how many had been taken. The incorrect number of tablets in the med room were eventually noticed, and tracked down thankfully. This easily could have led to patient harm.

If I had been the nurse who discovered the incorrect number of tablets in the Pyxis, I would immediately ask my charge nurse and pharmacy to see if there was an accident. After I went to them, I would work with my charge nurse to see who could have been responsible for this med diversion. Once I learned who diverted the meds, I would suggest different ways for the respondent to get help, and find a means to help him and allow him to work, while keeping myself, my patients, and him safe.