Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Kimbra Rodriguez 1/23/2024 DAS Assignment: 1

Name of Defendant: Martin Ruiz Alaniz, RN License Number of Defendant: 676510

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

Type of action taken against the license: Voluntary surrender

The disciplinary actions against Martin Ruiz Alaniz were the result of various instances of his lack of awareness in the clinical setting. These actions included: *Incorrect medication dosage given to his patient, failure to document a skin assessment, failure to document intake and output, failure to document incentive spirometry, failure to document a physical assessment, and failure to document medication administration of Synthroid to his patient.*

The first offense (June 19th, 2013) dealt with medication dosage. Mr. Alaniz was given a verbal order to administer Dilantin 1GM IV to his patient. His error occurred when he administered 1000mg through IV push, rather than through IV infusion. Dilantin is to be given at a rate that does not exceed 50 mg per minute, which Mr. Alaniz exceeded well over. Consequently, Mr. Alaniz's patient needed cardiopulmonary resuscitation after suffering a sudden cardiac arrest. The patient was put in unnecessary danger from the quick IV administration of Dilantin. Using SBAR, Mr. Alaniz could have written down the verbal order and confirmed it with the physician. If he had researched the medication, he would have learned the proper rate of administration as well.

Mr. Alaniz's next offense (June 14th, 2017) included the failure to accurately document a skin assessment of his patient with a left toe amputation. He documented the skin assessment as “Within Normal Limits,” resulting in an inaccurate medical record. He should have thoroughly assessed the patient, as this would have revealed the amputation and avoided any risk of harm caused by misleading medical records.

Another offense (June 15th, 2017) involved Mr. Alaniz's failure to document intake and output and incentive spirometry assessment in the patient's medical record before leaving his shift. He also failed to document a physical assessment during another shift (June 20th, 2017). Mr. Alaniz should have taken the time to slow down and document as soon as these actions were complete. Both actions resulted

in an inaccurate medical record, which could have harmed the patient as future caregivers would lack crucial information needed for treatment decisions.

Lastly, (June 24th, 2017) Mr. Alaniz failed to document the administration of Synthroid in the Medication Administration Record, resulting in an inaccurate medical record. He should have performed the three checks of medication administration to avoid this crucial mistake. Failing to document vital information, especially medication administration, could have resulted in patient harm due to incomplete information available to caregivers.

Universal competencies that were violated:

Safety and Security (Physical): The RN gave the wrong route of the medication Dilantin and administered it too quickly.

Safety and Security (Emotional): The RN failed to promote trust and respect to his patients by missing documentation and incorrectly administering medication.

Documentation: The RN failed to document the administration of Synthroid, the patient's left toe amputation, physical assessments, intake and output, and incentive spirometry.

Critical Thinking: The RN failed to confirm verbal orders and make correct decisions regarding medication administration.

Communication: The RN did not document or communicate with staff about patient assessment and medication administration.

Human Caring: The RN failed to spend enough time with the patient to notice the amputated toe.

If I were the first person to notice this RN’s mistakes, I would first check on the patients to confirm they were in good health. Next, I would notify the charge nurse of the RN's mistakes. I would then perform a physical examination of each patient to ensure nothing was missed during Mr. Alaniz’s shift. Finally, I would speak to Mr. Alaniz about his actions and help him understand what he did wrong. If I were to see him practicing this profession again, I would report it immediately to the Board of Nursing.