Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Binjay Kabua Date: 01/30/2024 DAS Assignment # 2

Name of the defendant: Jason Ray Harris, RN License number of the defendant: 674688

Date action was taken against the license: 07/28/2016

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.*

While working with Houston Methodist Hospital and Ben Taub Hospital, RN Jason Ray Harris was involved in several unprofessional incidents. Harris withdrew Fentanyl from the dispensing system for a patient without a physician's order. That same day, he withdrew 4 mg of Morphine more frequently than prescribed. Administering medication without a physician's order could result in the patient suffering from adverse reactions. Additionally, he neglected to assess and document the patient's pain scores before giving Morphine. Further discrepancies were found in his documentation, as he falsely recorded the administration of Morphine without corresponding withdrawals from the dispensing system. Similarly, he withdrew both Fentanyl and Morphine but failed to document their administration in the patient's MAR. Harris also violated the Controlled Substances Act by not adhering to the facility's required procedures for wasting unused portions of Morphine, Fentanyl, and Lorazepam.

While in the clinical setting, RN Harris exhibited signs of impaired behavior including passing out in a chair, having slurred, rambling and incoherent speech, walking with a swaying gait, having glassy and bloodshot eyes, and not being able to carry his tray of food back to his unit. He refused to submit a urine specimen when he was taken to the employee health clinic for probable cause drug screen. While there, an empty vial of Fentanyl dropped out of his pocket. These actions could have affected his ability to make rational, accurate, and appropriate assessments regarding patient care, thereby placing the patient in potential danger.

- *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 prevent any action against the license and to avoid harm to patients, several measures could have been implemented. Strict medication access controls, such as biometric authentication and real-time verification by another healthcare professional, could have prevented unauthorized withdrawals of controlled substances. Enhanced documentation and monitoring through electronic systems with real-time alerts would have ensured accurate record-keeping and prevented discrepancies. Regular audits and compliance

checks on medication administration records and patient charts could have detected irregularities early. Additionally, mandatory and random drug screenings, coupled with strict policies on impairment, would have helped identify and address substance abuse among staff. Education and training on substance abuse awareness, recognizing impaired behavior, and encouraging a culture of reporting suspicious activities without fear of retaliation would have promoted accountability. Stronger waste management policies, requiring proper documentation and witnessed disposal of unused medications, would have minimized drug diversion risks. Confidential support programs for healthcare workers struggling with substance abuse, along with rehabilitation opportunities, could have aided before patient safety was compromised. Lastly, enforcing strict reporting procedures and disciplinary actions for impaired behavior would have ensured that affected nurses received necessary intervention before endangering patients. Implementing these measures would have significantly reduced risks to public health and maintained the integrity of patient care.

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

All universal competencies were violated in the incidents described, including safety and security, standard precautions, communication, critical thinking, documentation, human caring, and professional role Below is an explanation of how each was violated:

Safety and Security: The RN compromised patient safety by administering medications without proper authorization, withdrawing excessive doses, and failing to document medication administration accurately. This increased the risk of overdose, adverse reactions, and patient harm. Additionally, the RN's own impaired behavior, including signs of drug use, placed both patients and colleagues at risk.

Standard Precautions: Standard protocols for medication management and waste disposal were not followed. The RN failed to document medication withdrawals, leaving controlled substances unaccounted for. Proper precautions for handling narcotics, such as verifying prescriptions and ensuring proper dosages, were disregarded, increasing the risk of drug diversion and patient harm.

Communication: Effective communication between healthcare providers is essential for patient care. By falsifying medication administration records and failing to document pain assessments, Harris deprived other caregivers of critical information needed to make informed decisions about the patient's treatment. This lack of communication could have led to improper dosing, non-efficacious treatment, or overdosing if another nurse administered additional medication without knowing the patient had already received a dose.

Critical Thinking: The RN failed to exercise sound judgment in medication administration and patient care. Administering excessive doses, withdrawing medications without physician authorization, and failing to document properly indicate a lack of critical thinking. Additionally, the RN's impaired state further diminished his ability to recognize subtle signs of patient distress or adverse reactions.

Documentation: Accurate and timely documentation is essential in nursing practice. The RN falsified records, failed to document medication withdrawals, and provided inaccurate medication administration details. This not only violated hospital policies but also created serious risks for patient care, as future healthcare providers relied on incorrect records to make treatment decisions.

Human Caring: Nursing is built on compassion and patient advocacy. The RN's actions demonstrated a disregard for patient well-being, as unauthorized medication administration and failure to assess pain levels before administering narcotics could have led to serious harm. Additionally, impaired behavior, including slurred speech and difficulty walking, suggested that the respondent was not in a state to provide safe and compassionate care to patients.

Professional Role: Nurses are held to high ethical and professional standards. Harris' behavior, including drug diversion, falsification of medical records, and working while impaired, violated the fundamental principles of nursing professionalism. Additionally, the refusal to submit a drug screening after exhibiting signs of impairment further demonstrated a lack of accountability and professionalism.

In summary, the respondent violated all universal competencies, leading to compromised patient safety, professional misconduct, and ethical breaches. These violations not only endangered patients but also placed the healthcare institution at legal and regulatory risk.

- *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.*

A prudent nurse who first discovers the harm to a patient, the impairment of a colleague, or criminal activity such as drug diversion would take immediate and appropriate action to ensure patient safety and uphold professional and ethical standards. The first thing I would do if I discovered these incidents is to assess the patient's condition immediately, checking for signs of overdose, adverse reactions, or distress. If necessary, I would initiate emergency interventions, such as administering naloxone for opioid overdose or alerting the rapid response team. The physician and charge nurse would be notified immediately, and I would document the patient's condition and any interventions taken.

If impairment is observed in the colleague (such as slurred speech, unsteady gait, or erratic behavior), I would immediately remove the impaired nurse from patient care duties to prevent further harm. The incident should be reported to the charge nurse, nursing supervisor, or hospital administration following facility policies. If the impaired nurse refuses a drug screening, further action may be required, such as notifying hospital security or administration. If the criminal activity, such as drug diversion or falsified documentation, is discovered, I would report the findings to hospital leadership, risk management, and the pharmacy department to investigate and secure the medication supply. Any missing or misused controlled substances should be reported according to hospital policy and possibly to law enforcement or the appropriate regulatory board if required.

Throughout this process, I would document all observations factually and objectively, ensuring that all actions taken are in compliance with institutional policies and legal obligations. The primary goal is to prioritize patient safety, uphold professional integrity, and ensure that corrective measures are taken to prevent future occurrences.