Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Brock Fitzgerald Date: 4/11/2025 DAS Assignment #2

Name of the defendant: Randall Keith Parish, RN License number of the defendant: 717509

Date(s) and BON decision(s) taken against the license: 6/9/2020

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 each of them, e.g. drug diversion, HIPAA violation, abandonment, etc.

Randall Parish committed several violations against both professional and state codes during his employment as a registered nurse at North Texas State Hospital located in Wichita Falls, Texas. The date(s) these offenses were committed was on or about May 11, 2019, through May 12, 2019, and on May 13, 2019. Three formal charges were accrued and implemented against Randall Parish. The charges go as follows: **Charge 1**, failed to assess or document on a patient, who sustained a fall causing an injury (bump on the back of the head) and had a history of a stroke, was actively on Plavix (blood thinner), and had a prior brain surgery; (this occurred on 05/11/2019-05/12/2019), **Charge 2**, failed to perform an assessment on the patient (who sustained the head injury) while they were experiencing adventitious vital signs while sleeping which led to respiratory distress and the patient to become unresponsive at 0853 (05/13/2019), and **Charge 3**, failed to notify the physician of the status change in vital signs and the neurological deficit, and did not properly document the findings (at 0853 05/13/2019), the patient declined further and had to be rushed to the hospital for an emergency surgery for a suspected brain hemorrhage. The accumulation of Randall Parish's grotesque negligence in this case led to the Board of Nursing justifiably revoking his licensure as a registered nurse.

Failing to assess the patient after falling and sustaining a head injury is completely reckless, especially with a history of a brain surgery, stroke and at the time on blood thinners. Since the patient was not assessed at the time of the incident, the fall could have been due to the patient suffering another stroke or stroke-like event. Randall Parish would not know that information since he did not perform an assessment. There is also the point of making the assessment to see if

the patient suffered a brain injury or further damage to the brain at the site of surgical repair. Being on blood thinners is yet another reason to inspect the patient due to the higher risk of bleeding and bruising. In addition, Randall Parish not only failed to assess the patient, but neglected to document the fall or the injury to the head. This excludes pertinent information that is essential to the patient's medical record for monitoring and care purposes and allowing other staff/providers to be aware of the status change. These failings by Randall Parish put the patient at an increased risk for hemorrhaging, severe injury and death. The negligence and omissions led the Board to believe this was an intentional decision.

Randall Parish failed to assess vital signs on the patient on the morning of 05/13/2019, even after recognizing abnormal findings while the patient was sleeping. The patient experienced an increased heart rate and number of respirations. These abnormalities paired with the injury to the head of the patient should have posed a significant indicator to Randall Parish that the patient could be hemorrhaging or other serious complications. The patient deteriorated to the point of respiratory distress (42 respirations/min), and was unresponsive to pain stimuli, which led to a rushed transport to the hospital (at 0835) for an emergency surgery for a brain hemorrhage. Randall Parish's failure allowed for substantial, unnecessary harm to fall upon the patient.

Not reporting an event like a fall, change in neurological status or out of range vital signs to the physician is deleterious to the patient and their plan of care. Not to mention this is an utter break in protocol/policy. The provider must be made aware of these findings to correctly and adequately order interventions to improve the patient's status. Once again, Randall Parish did not provide any further documentation as the patient was declining. As noted above, the patient went into respiratory distress, and became unresponsive, due to the underlying brain hemorrhage that required emergency surgery. These violations by Randall Parish allowed for delayed care to the point of a critical situation and consequential harm to the patient.

Overall, Randall Parish's multi-faceted situation filled with erroneous medical and professional decisions, put the patient in grave danger that could have been avoided by abiding by universal competencies.

- 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.

There was an abundance of measures that could have been taken to ensure the safety and health of the patient, maintenance of professional conduct and integrity, and prevent any unnecessary risk. The first measure that should have been implemented was immediately assessing the patient for injuries and performing focused physical/neurological assessments to measure the extent of the damage incurred from the fall and to determine if the patient possibly suffered another stroke. An incident report should have been filed, and the provider should have been notified at once.

Given the patient's history and being on blood thinners the nurse should assume to prep the patient for imaging as the physician is likely to place an order to check the severity of the injury. Had any of these interventions been done without haste by Randall Parish the hemorrhaging would have been detected considerably earlier.

When Randall Parish observed the adventitious vital signs (increased respirations and heart rate) while the patient was sleeping (05/13/2019), both a cardiac and respiratory focused assessment(s) should have been conducted. A pulse-ox should have been placed to assess the oxygen saturation of the patient. The site of the head injury should be reevaluated, and any changes should be documented and recorded. The provider should be quickly notified of all serious changes. These interventions could have prevented the patient slipping into respiratory distress and becoming unresponsive.

The omission of or failing to document are completely taboo in the nursing world and a universal competency violation. Randall Parish's repeated failures in documentation led to delayed recognition and care of a medical emergency. This also means the patient has an inaccurate medical record, which leaves the rest of staff and providers in the dark on the patient's current condition. The best way to prevent this is to document at the bedside after all interventions the nurse performs. In this case, Randall Parish did not provide any interventions, so following his own delusion there was no reason to document. This is lazy, unethical and dangerous nursing.

- Identify ALL universal competencies (4-5) that were violated and explain how in detail to reflect your understanding and importance of the universal competencies.

Communication was violated when Randall Parish did not notify the doctor or staff of the fall, head injury or atypical vital signs that occurred on his watch. Failure to communicate and excluding providers and other staff leads to confusion and hinders affective patient care. Protocol within the agency is broken at this point and disrupts the professional and ethical dynamic.

Documentation was breached when Randall Parish repeatedly failed to document abnormal vitals, the fall, and the head injury. The information could have allowed the provider to order patient specific interventions. Forgetting this crucial universal competency opens the nurse to malpractice and allows more harm to befall on the patient.

Professional Role was violated by Randall Parish when he failed to uphold his role under his license as a registered nurse. He did not make patient care a priority, broke protocol, failed his provider and patient, and displayed intentional actions of negligence.

Safety and Security in this case was ignored on several instances. Randall Parish failed to assess the physical and neurological status of his patient, failed to intervene after observing abnormal vital signs, and provided no documentation. Additionally, in the entirety of the incident Randall

Parish violated the patient's trust and respect. By not promoting these qualities, the patient's rights and level of care suffers.

Critical Thinking was not displayed on multiple occasions during this case involving Randall Parish. Every time an assessment was not conducted related to the injury or abnormalities, the patient suffered more each time. Had the symptoms such as the elevated rapid respirations and heart rate been addressed the patient could have avoided the catastrophe that followed.

- Use the space below to describe what actions 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.

The first action I would take if I found myself observing a situation like this, is to immediately report to the charge nurse on the floor and notify the provider of the patient. I would help the patient back to their bed with the assistance of staff after sustaining the fall. After denoting there were no issues with ABCs related to the head injury, I would then transition into a focused neurological assessment followed by a physical assessment of the head injury or other affected areas injured in the fall and record and document all findings. Once stable, I would diligently check the patient's vitals multiple times per hour to ensure there a no signs of hemorrhaging. If the staffing allows for it, I will have an aid assist me in monitoring the patient for any changes in vital signs or alterations to neurological/mentation status. I would find Randall Parish and see what his thought process was for neglecting his patient and question his reasoning for having no proper documentation over any of the incidents/findings involving his patient. I would file an incident report with the facility and turn Randall Parish into the Board of Nursing for his atrocious behavior, unprofessionalism, and countless violations against universal competencies.