Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Alexis Wilkinson Date: 04/11/2025 DAS Assignment # 2

NOTICE OF DISCIPLINARY ACTION- 04/2020

Name of the defendant: Zachary Watson, RN License number of the defendant: 881330

Date(s) and BON decision(s) taken against the license: December 10, 2019

Type of action 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, forfeiture on student loans, etc.

Zachary Watson worked as a RN in the Emergency Department of Huntsville Memorial Hospital, Huntsville, Tx. Watson was charged with six counts involving medication diversion, possession, fraud, theft, substance abuse and misappropriation of medications. His first and second charge, he lacked fitness to practice. Profusely sweating, appeared disheveled, and had impaired behavior while on duty. Third charge, he withdrew Fentanyl 250 mcg/ 5 mL ampule from the medication dispensing system and failed to document in the Medication Administration Record. Fourth charge, he withdrew (3) Fentanyl 250 mcg/ 5 mL ampules and (1) Diazepam 5mg tab and failed to follow proper policy and procedure by having a second nurse witness and document the wastage. Charge five, he misappropriated the medications that he withdrew. A different nurse documented the patient took 50 mcg of Fentanyl IVP when Watson withdrew 250 mcg. A different patient took 2.5 mg of Diazepam instead of 5 mg that nurse Watson took from the medication dispensing system. Charge six, Possession. When Watson was asked to empty his pockets, he took out (1) 10cc syringe containing 2.5 mL of Fentanyl and at his workstation he had (1) syringe labeled Demerol 37.5mg, (1) syringe labeled Fentanyl, (1) unopened Bactrim tablet in a med cup, (1) partially used vial of Labetalol, and (1) Cardizem pill. He denied submitting a drug test.

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.

I can understand that the emergency department can get chaotic at times but it's the job of the nurse to take proper procedures seriously and while a life is important, you can no longer save lives if you do not have a license. There is always someone that can witness medication procedures involving wastage. It does not take that long out of a fellow nurse's day to watch and document the witness knowing what the policy contains. Having medications at the nurse's station is also a violation because anybody can walk up and ingest it not caring what it is or what it can do. That is careless of Nurse Watson and the fact nobody saw it until it was accumulated to that extent is mind boggling. Not documenting the meds properly causes overdoses and or

lack of dosage leading to patient's feeling pain or not healing in a timelier manner. Another nurse should have seen him and asked him questions or told him to go home. Having another body their to help keep the ratios means nothing when there is an impaired nurse. Another nurse could come in for him or the ED could have had another nurse from a different department. There are always options that can be made. Someone from administration could fill in if truly needed. Patients could have been diverted to other nearby hospitals, worst case scenario. It's not an episode of Grey's Anatomy where there's zero control over a department. Houston is a big area and has plenty of resources to avoid an impaired nurse from coming into work.

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

1. SAFETY AND SECURITY (PHYSICAL)- failed to give the 7 rights for medication administration by not documenting and failing to give proper dosage to patient. He gave his patients the wrong dosage and lacked documentation of the Fentanyl he withdrew. He or another nurse could easily mis-judge what was and was not documented that could have potentially put the patient at an even greater risk than what they came in for.
2. SAFETY AND SECURITY (EMOTIONAL)- failed to promote trust and respect. He violated the trust and respect of the patient because the patient's trust that their nurse is giving them the accurate dosage of meds to ease their pain and disrespecting them by not doing so.
3. STANDARD PRECAUTION- failing to properly dispose of medications, that anyone could have taken and possibly over-dosing. Exhibiting signs of impairment, could have easily lacked aseptic precautions due to lack of judgment.
4. COMMUNICATION- lacking proper communication skills to inform the patients of their medications and making sure the patients understand what they are giving consent to.
5. CRITICAL THINKING- his impaired judgment, decision making (medication diversion), evaluating and assessing is compromised due to looking disheveled and being neglectful in his duties.
6. DOCUMENTATION- failed to document the medications and failed to document the appropriate amount the patient was to receive.
7. HUMAN CARING- putting his patients lives at risk by being neglectful in his duties.
8. PROFESSIONAL ROLE- lack of appearance, maintaining a clean work environment, manage equipment, supplies, and human resources. Drug seekers could have seen his workstation and could have ingested the meds, kids could have stopped on their way to the bathroom thinking they were candy and ingest them, a patient with Alzheimer's or dementia could have wondered and mistaken the pills as their own. So many things could have gone wrong.

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.

I would immediately report the nurse to the TPCN and cops for putting patient's lives at risk. There are many options Watson could have and should have taken before showing up to work the way he did. Calling in, having someone take his shift, anything that did not involve him showing up to work and working with patients. There is not a single patient that would want their nurse looking worse than themselves and being looked after by someone in that state of appearance and mindset. Watson could have caused severe problems to patient, if he did it was not listed in his report. His lack of judgment due to impairment he could have missed many signs and symptoms that we as nurses are trained to look out for. Whether it was due to alcohol or drugs he was irresponsible of his own actions and had zero business being in the emergency room tending to cases that involve a sound and rational mind. There is a reason why there are policies and procedures. They are to be strictly upheld for a reason. While the medical field is gray, when it comes to lives it's very black and white.