Disciplinary Action Summary Assignment

Instructional Module 2

Caroline Abeyta **October 3, 2020** **DAS Assignment #2**

Defendant: Eileen Patricia Betts **Registered Nurse License Number:** 524562

Date action was taken against the license: September 21, 2010

Type of action taken against the license: Warning with Stipulations then Revoked

On February 12th through 13th, 2009 Eileen Betts failed to adequately care for a patient assigned to her. Ms. Betts failed to document her interventions related to a patient's critically low blood glucose of 29 mg/dl, failed to notify the physician of this lab value. She documented withdrawing 1 amp of D50 at 0400 but failed to document administering the medication. Ms. Betts neglected to document a complete neuro assessment and recheck of the patient's blood glucose level after the administration of the D50. The on-coming staff were not notified of the patient's glucose levels. At 1027 the patient's glucose level was "20". Ms. Betts was ordered to complete a course in Texas nursing jurisprudence and ethics at a minimum of 6 hours in length, a course in documentation at a minimum of 6 hours and a course in "Sharpening Critical Thinking skills" at 3.5hrs online. She was required to be supervised by another registered nurse while working. Ms. Betts had one year to complete these stipulations, but failed to do so, therefore on December 18th, 2012 her licensure as a registered nurse was revoked.

Documentation is a lesson that is strongly taught in nursing school. We are taught that documentation can literally mean the difference between life and death for a patient. In this situation, this nurse didn't document vital information such as blood sugar levels and interventions related to treating dangerously low levels. The oncoming shift could have understood the EMR of the patient's blood glucose levels as fine because Ms. Betts neglected to document anything different. Ms. Betts acknowledged that she failed to adequately document for her patient but blamed having computer troubles as the reason for the lack of documentation. Even if she were having trouble with the computer systems, there are a few routes she could have taken instead of flat out not documenting. There was never a mention of if she had tried to get ahold of IT to see if there was a fix to her problems. She also could have properly documented on paper until she was able to get the computer to work, or until the next shift came on. There is never a reason to not have full adequate documentation of care for a patient.

If I were the oncoming shift taking over care for the patient for Ms. Betts and I discovered the patient's blood glucose levels to be "20" (as stated in the legal order), I would first take care of my patient by notifying the physician and enacting the hypoglycemia protocol. Once the patient was stable and out of the danger zone for blood glucose levels, I would notify the charge nurse and supervisors that there was minimal to no documentation about the care for the patient during the shift prior to mine, and of the condition I received the patient in.