

Disciplinary Action Summary Assignment

Instructional Module 2

Caroline Abeyta

October 20th, 2020

DAS Assignment #4

Defendant: Julio Ato Asilador

Registered Nurse License Number: 610635

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

Type of action taken against the license: Reprimand with Stipulations

On or around April 17th, 2008 Mr. Julio Asilador was working as an RN and inappropriately delegated communication of discharge instructions to a LVN for a patient who was postoperative for a cystoscopy, urethral dilation and electrocision of the bladder. The instructions were incomplete, and documentation was not adequately finished in that Mr. Asilador did not note that the patient was discharged with a foley catheter that was to be left in place or care of the catheter. Therefore, without proper communication to the LVN that the foley catheter was to be left in place, it was removed, consequently resulting in the patient undergoing an additional surgical procedure for re-insertion of the foley catheter. The physician was not notified of any of this occurring resulting in the patient undergoing unnecessary stress and pain due to improper communication and delegation of tasks. Mr. Asilador states that he documented the care of the catheter and signs and symptoms to watch out for and that he was surprised when he was notified that the catheter was removed. He also stated that the primary care nurse was responsible for notifying the physician because she removed the catheter without checking the orders. He says that the primary nurse requested his help with reinserting the catheter, but he was not aware that he/she had not notified the physician. Mr. Asilador states that the primary nurse requested him to help reinsert the catheter but received no urine backflow, never inflated the balloon, and removed the catheter, he noted a small amount of blood and that the procedure only lasted a few minutes.

Mr. Asilador unfortunately dealt with the consequences of improper delegation and communication. He should have never delegated patient teaching to someone other than himself. He should have looked over the orders and documentation from prior physicians and nurses, then done the appropriate discharge patient teaching himself. The patient might not have been exposed to unnecessary risk associated with extra surgical procedures had Mr. Asilador done the patient teaching himself, instead of delegating out the task. Also, when realizing that the catheter had been removed, he should of checked to see if the physician had been notified instead of assuming that it had been done.

If I were the nurse that found the error with the patient, I would have made sure the patient was stable then notified the primary care physician or surgeon.