

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Lyndee Gilmore
(1-4)

Date: 10/1/2021

DAS Assignment # 1

Name of the defendant: Rhonda Jeanine Ransom

License number of the defendant: 563598

Date action was taken against the license: December 23, 2015

Type of action taken against the license: Suspend/Probate

Use the space below to describe the events which led to action 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.

At the time of the initial incident, Ransom was employed as a RN at Terrell State Hospital. Prior to the incident, she held that position for almost 16 years. This incident consisted of failing to ensure that there was a current and valid PO for a patient to remain in soft wrist restraints and a Vest Restraint Mesh Posey Houdini Suit (VRMPHS). The patient later died, and the autopsy brought back disturbing results. The patient ultimately died from a pulmonary thromboembolism due to deep venous thromboses due to a lack of immobility. Ransom later stated that she documented the order for the restraints and suit by her physician in the medical chart later that day "when she had the opportunity to do so." She also stated that the physician agreed the order was necessary, and that she had an abundance of patients to care for that day, and that she considered that it was a huge obligation. She then continued to state that it was Dr. Kranti Purmetla's job (who was the treating physician) to document the use of restraints in the chart, and failed to do so.

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. Consider which universal competencies were violated.

As nurses, we are going to make mistakes, however, I believe it is crucial that we are honest with ourselves and others, and are able to admit to those mistakes. In this situation, and from background information I have learned with the associated risks of utilizing restraints, it was crucial for this nurse to know whether or not these actions were necessary. With bed rest, risk of DVT's are very high due to a lack of mobility, and it is important to move patients as much as we can to prevent these types of incidents. It seems to me that this nurse was not practicing to the best of her ability, and although I don't believe she did these things with a negative intent, it happened. I also find it troubling that the nurse continued to place blame on everyone else but her, and that she truly believes she didn't do anything wrong. She should have communicated better with her patient and the physician, and by just doing that, this death could have been very avoidable.

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.

If I had any suspicion or had any doubt that a patient was experiencing mistreatment, I would follow up with that patient's nurse initially. After that, if the problem is still present, I would then turn to someone of higher authority such as a nurse manager or even that patient's physician. It is our responsibility as healthcare workers to hold each other to the highest extent, and to keep each other accountable.