

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Jeffrey Goodman

Date: 05-06-2022

DAS Assignment #: 1 (1-4)

Name of the defendant: Kellye Harbin Burrill

License number of the defendant: 792230

Date action was taken against the license: January 8, 2018

Type of action taken against the license: Warning with Stipulations and Fine

*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.*

Three charges were filed against Ms. Burrill. The first charge was failing to administer a medication in a timely manner. The second charge was failure to re-assess. The third charge was failing to document completely. All of these incidents were in regard to the same patient (Medical Record Number 005251516).

Ms. Burrill clocked into work at 0649. Patient had a blood glucose of 69 mg/dL at 0629, before the start of her shift. Blood glucose was rechecked at 0941, and Dextrose 50% was administered at 0945. The delay in care was a total of three hours and 16 minutes after the initial low reading. After administration of Dextrose 50%, blood glucose was not reassessed for six hours. Furthermore, the medication of Tylenol 3 was administered to the patient without proper documentation. Ms. Burrill added a note in the chart that documentation was pending.

*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.*

Better communication and teamwork were needed to ensure the patient's safety. Although the low blood glucose reading was taken during the previous shift, Ms. Burrill's assumed responsibility for the patient at the start of her shift. If Ms. Burrill was immediately busy upon the start of her shift, she should have notified the charge nurse or asked the night nurse to complete this task before leaving. Both measures could have prevented the delay in patient care and the need for disciplinary action. Unfortunately, the patient was neglected for about 3 hours, while the nurse was busy. Several universal competencies were violated, such as right medication time, right medication documentation, proper SBAR, correct prioritization, and evaluation of interventions. Ms. Burrill stated many excuses for the delay and poor documentation, but, ultimately, none of these excuses prevented action from being taken against her by the Board of Nursing.

*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.*

This case seems like it would be relatable to many nurses, and no direct harm occurred to the patient. Also, Ms. Burrill had some reasonable excuses for the delay, such as her other patient bleeding from a post-operative surgical site. As such, I feel that many nurses might confront Ms. Burrill as opposed to reporting her. Sometimes, a remediation can take place without escalating to a higher authority. However, reporting her is probably the more correct response, as the “near misses” are still serious and could have resulted in injury to the patient. Reporting ensures that the issues are addressed properly and avoids direct confrontation with a co-worker.