

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: **Meghan Schmitt**      Date: **05/20/2022**

DAS Assignment #   **3**   (1-4)

Name of the defendant: **Yushema Yunique Simon**

License number of the defendant: **676247**

Date action was taken against the license: **December 18<sup>th</sup>, 2012**

Type of action taken against the license: **Warning with Stipulations**

On or about April 11, 2011, the defendant failed to re-identify Patient Medical Record 8051459, by armband or by the patient's chart, prior to escorting the patient to the operating room (this is required per facility policy). Since the defendant did not check the orders of the patient, the defendant did not know that another patient had been brought to the pre-op area and the order of patients had changed. Due to the defendant not re-identifying the patient, the wrong intraocular lens was implanted in the patient's eye and required additional surgery to implant the correct lens. It was noted by the board, that the defendant's conduct was likely to injure the patient from complications due to additional surgery. To the board, the defendant admitted to the allegation, adding that "nothing takes the place of an armband and chart for identification."

Before taking the patient to the operating room, not only should the defendant look at the patient eMAR at the nurses station, but should have scanned the patient at the bedside as well. By doing this, the defendant would have seen a change in the patient's orders at that time. When looking at this situation, you could argue that a few of the universal competencies were violated. First, safety and security, this includes any action or inaction on the part of the nurse that threatens the patient's well-being or violates the patient's physical security. The defendant did not verify patient orders before taking said patient to the operation room, this is in violation of the patient physically. Second, critical thinking, one could argue that the defendant did not make decisions based on legal, ethical and professional standards. When doing a variety of administrative practices for patients, we check and verify three times against the patient eMAR, the defendant should have scanned the patient's armband or chart previous to moving the patient. Last, documentation, the recording of data required by, or pertinent to, the designated situation. Like a medication, the eMAR will state a date and time on when the patient needs to be relocated for surgery. The defendant should have reviewed the eMAR, to verify the date and time, to keep track of the patients updating information, but also make sure that once dropped off, the defendant's documentation of the relocation would have been accurate against the eMAR.

A prudent nurse would notify the charge nurse and physician immediately. Considering this patient underwent a procedure not meant for them, it severely put the patient at risk for complications, but then the patient needed to undergo another surgery to 1) remove the previous lens given and 2) surgically implant the lens meant for the patient originally. A prudent nurse would make sure that action was taken against the defendant and that moving forward, the defendant was aware of their breach in care, but also to keep future patients safe from the same situation.