# Covenant School of Nursing

## Disciplinary Action Summary Assignment

## Instructional Module 2

Student Name: Logan Rundell Date: 8/30/2022 DAS Assignment #1

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Name of the defendant: Debbora Blakesley License number of the defendant: 772581

Date action was taken against the license: May 20, 2011

Type of action taken against the license: Warning with Stipulations

On July 19, 2009, Debbora Blakesley made her first of many medical errors. Her medical errors consist of non effacious treatment, inaccurate assessment information, and negligence. She blatantly ignores the doctors' orders on more than one occasion and does not do what is asked of her. In her first medical error, Blakesley, failed to administer oxygen per nasal cannula as ordered by the physician. On July 20, 2009, just one day later, Blakesley failed to accurately report the correct dose that was administered to her patient. She told the Physician that 97mcg/kg/min was administered when in reality she administered 7mcg/kg/min. On November 18, 2009, nurse Blakesley failed to follow the physicians orders for titration of insulin drip. The result of this medical error caused the patients' blood sugar to go from an already high 191 to 479 by the end of her shift.

*If nurse Blakesley would have followed protocol and done all of her checks in the first place, all of these infarctions could have been avoided. With her first error regarding the oxygen, this should have been a simple fix that would have benefitted the patient quickly. This, in my opinion, is just sloppy nursing. It is a nurse who was rushing through things and as a result she ended up missing an order. In the report it states that the nurse placed the nasal cannula on the patient but just never turned it on. There are so many checks in place, and this should not have been missed. When administering oxygen, you always want to go back into the room to reassess the patient. If she had done this, she would have noticed that the oxygen was not turned on. Her next medical error regarding the inaccurate report of the dose administered should have never happened. This showed carelessness, unprofessionalism, and lack of preparation and readiness on her part. If she would have had her information together before speaking to the physician, this would not have happened. Although the patient was not injured, in the physicians eyes the nurse lacks knowledge of dosage calculation and reading orders. In the finial medical error, Blakesley blatantly ignored the physicians order regarding a titration insulin drip. This is just plain negligence in my eyes. This error left the patient with an extremely high blood sugar of 479. Just like every other patient, there are checks in place with every single medication. There is absolutely no reason for this to have ever happened. Blakesley put this patient at risk and absolutely did not give the best care that she could have. This not only jeopardized the safety of her patient but also showed lack of care. This error could have been easily avoided if she would have checked her orders the way that she should have.*

*If I was the nurse to discover Blakesleys many medical errors, I would first start by making sure that the patient is stable. Regarding the oxygen error the first thing I would do is a respiratory assessment, get a full set of vitals making sure to count respirations for an entire minute and getting an accurate pulse ox reading. Since the heart and lungs are so closely related, I would make sure the rest of the patients' vital signs are within normal range. Depending on the verdict of my assessment I would then administer the oxygen that the patient needs. Once the patient is stable, I would go and find Blakesley and inform her of the state of her patient and her error. In conclusion of this error, I would document what I did and what the current nurse neglected to do. For error number two, the nurse reported the wrong dose to the doctor. This one is a bit tricky because from what I understood this was a two people conversation. If Blakesley had said aloud how much she had administered that might raise some red flags for me. If I had any questions about the dosing of someone else's medications for their patient I would encourage the nurse to go back through her eMAR and double check to make sure that she read her orders correctly. Finally, the blatant lack of acknowledgement for the titration of insulin drip. The prudent nurse would immediately check on the patient. I would check a blood sugar as soon as the error was discovered and then immediately correct the blood sugar based on the sliding scale that is in place. I would then notify the charge nurse and ask how to proceed. I would then call the physician with the high blood sugar and explain the situation. I would document all my findings and interventions at the precise time they occurred.*