

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Vanette Martinez

Date: 11/2/22

DAS Assignment # 2 (1-4)

Name of the defendant: Angela Simpson Walker

License number of the defendant: 818808

Date action was taken against the license: 01/02/2015

Type of action taken against the license: Revoked

Angela S. Walker was employed as a staff nurse with Central Texas Medical Center, in San Marcos, Texas when she continuously failed to care for her patients under her supervision. The first event took place when she failed to report to the charge nurse about a positive stool sample and a low level of sugar. This patient condition deteriorated since no immediate assessment was done leading the patient to excrete blood clots the next day. Walker also failed to provide medication administration ordered by the physician and accu-checks to the same exact patient. Later, the response team was called with this patient due to Walker not reporting or assessing the patient. The second event took place when Walker failed to assess a different patient who required immediate restrains and sedation. This patient was on a CPAP machine and continued to remove this mask due to the patient's low level of conscious.

Angela S. Walker did not follow any procedures during her shift leading one of her patients to have the response team called and the other patient was put at risk for not having enough oxygen administration. Safety and security were not followed by Walker. One of her patients needed rapid assessment due to a positive occult blood sample and the patient was not treated which led the patient to deteriorate. The security was not done correctly because she had an order to put the patient on restrains and sedation on a confused patient. If Walker would have had reported the positive occult blood to the physician, this patient could have had the appropriate care and maybe the patient would have had not excrete blood clots the next day. If Walker would have had followed the physician's order as told, this patient would have been on restrains to appropriately have CPAP machine administration. Walker did not follow the seven rights of medication administration because she did not administer one of the patient's medications; therefore, her decision making was incorrect.

As a student nurse, discovering unsafe practices, would force me to try and assess the patient as soon as possible. If I would have had seen the patient deteriorating in such a short time, I would have had called the lab to check on the stool sample instead of waiting for the lab to call me. This patient was excreting blood clots and I could have had prevented by reporting the positive stool sample on this patient. Some patients have specific orders which as nurses we need to follow. Another patient had an order to for restrains to properly administer oxygen so the first thing I would do is assess this patient. The CPAP machine would be helping the patient once I would have had sedated this patient. The patient needs to be put first.