

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Mercedes Villalovos

Date: January 27<sup>th</sup>, 2023

DAS Assignment # 2 (1-4)

Name of the defendant: Tina Dawn Hudson Baggett

License number of the defendant: 577672

Date action was taken against the license: January 4<sup>th</sup>, 2011

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

*Use the space below to describe the events which led to the action(s) 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.*

Around September 10, 2009, Tina Baggett at the time was employed with Doctors Diagnostic Hospital as the Chief Nurse Officer. Tina was working as a Circulating Operating Room Registered Nurse and failed to report the accurate number of sponges accounted for a patient, leading to the surgeon closing the surgical wound and leaving a sponge inside the patient. Two days after the patients surgery, they went in to get an X-Ray and it showed a foreign object within the patient. Despite the X-Ray technicians recommendation to take more diagnostic X-Rays, the patient was released. The patient was then admitted again three weeks later due to a 7cm abscess due to a foreign object left in the body. The patient then had to undergo a second surgery to remove the sponge. Post-surgery, the patient had complications of a blood clot, which lead the patient to have blood thinners administered. The nurse's failure to properly document the number of sponges led to unnecessary problems for the patient. Come October 27<sup>th</sup>, 2009, Tina Baggett documented she informed the surgeon of an accurate count of sponges, and did not note that the documentation was a late entry. Tina Baggett insisted she documented the correct number of sponges and admitted to when the patient came in for a X-Ray, she altered the documentation due to it be uncompleted. Tina Baggett however failed to note it was a late entry and admitted to not documenting it was a late entry.

*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.*

The nurse could have been better at counting how many sponges were used during the surgery and had someone double check her number after counting to be sure all equipment was accounted for. Also, if the nurse was aware of her mistake, she should have spoken up to have necessary measures taken for that patient as soon as possible.

*Identify which universal competencies were violated and explain how.*

-Critical Thinking: Decision Making

Baggett failed to count the correct number of sponges used within a patient and could have double checked her count along with having someone count the number of sponges as well.

-Documentation: Any narrative or Exception Charting of Findings

The nurse altered the patients documentation and failed to report her record of documentation was a late entry leading to complications for the patient.

-Human Caring: Treat Patient with Respect and Dignity

Baggett failed to treat her patient with respect when she knowingly altered the patients documentation for her sake.

*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.*

I as a prudent nurse would first notify the surgeon that the sponges/equipment used for the patient was miscounted. I would then inform my charge nurse of that nurses mistake and take any necessary means to prevent further harm for that patient or any other patients.