Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Vanette Martinez Date: 02/09/2023 DAS Assignment # 4 (1-4)

Name of the defendant: Krystina Mcihelle Bruner License number of the defendant: 823596

Date action was taken against the license: 27th day of October 2014

Type of action taken against the license: Warning with stipulations

Krystina Mcihelle Bruner was employed with Hendrick Medical Center, Abilene, TX when the incident took plac. During a surgical procedure there are responsible for doing an instruments, sponges, and sharp counts before the procedure and after the procedure to make sure nothing was left inside the patient. Krystina Mcihelle Bruner was in charge to document everything, but she mistakenly counted the sponges at the end of the procedure which it turned out they left a sponge inside the patient. The patient needed a second surgical procedure for the removal of the sponge which the patient was exposed to obtaining an infection or serious health problems

If Krystina Mcihelle Bruner would have had taken the time to count every instrument, sponge and sharps used before and after the procedure the patient would of have not gone through a second procedure. Documentation was not done correctly which led the patient to be exposed for attaining an abscess, sepsis, or a possible demise. Krystina Mcihelle Bruner needed to re-count everything before the patient's procedure was over to prevent opening the patient for the removal of the sponge left inside the patient.

Krystina Mcihelle Bruner failed to fallow the universal competencies such as safety and security, standard precaution, communication, critical thinking, documentation, and human caring. The patient's safety and security were put at risk because the patient needed a second procedure, and the patient did not have to go through it. Standard precautions were not fallowed when Krystina Mcihelle Bruner forgot to accurately count all the equipment after the patient's procedure. Krystina Mcihelle Bruner failed to fallow the decision making while counting the equipment. Communication could have prevented the patients second procedure for the removal of the sponge if she would have said something before, they finished the first procedure. Human caring was not taken into consideration because the patient was not treated with respect which led the patient to come back for a second procedure.

This incident could of have been prevented before they started closing back up the patient. If I would have discovered this incident or if I was doubting myself about the count of the equipment, I would had let the physician know and I would count look at the documentation before the procedure started to make sure everything look the same after the procedure so the patient does not have to go through any harm.