Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Zachary Wiggins Date: 3-24-23 DAS Assignment # ____1____ (1-4)

Name of the defendant: Rose Marie M. Abel License number of the defendant: 230656

Date action was taken against the license: May 31, 2011

Type of action taken against the license: Remedial Education

The event that led to this nurse being sanctioned was unnecessarily exposing the patient undue harm that could have stemmed from a medical complication from incomplete lab specimens. The nurse internalized her want to prevent excess venapunctures on a patient who clearly expressed discomfort. This led to the nurse using forceps to extract a syringe from a sharps container that contained some of the patient's blood and proceeded to send the blood of to the lab for testing prior to an upcoming surgery. The blood was measured for potassium levels and had a significant enough change to proceed with patient surgery.

In this instance, the issue came out of compassion that caused the nurse to not follow protocol. By not taking the syringe out of the sharps container and instead just performing another accurate venapuncture, this problem could have been avoided. The patient would have had initial discomfort but significant patient teaching accompanying the final venapuncture would have alleviated patient concerns and would have successfully stopped action being taken on the nurse's license.

The universal competencies that were violated were standard precaution and critical thinking. Standard precaution was violated by not disposing of contaminated materials and an asepsis breach. The critical thinking competency was violated by making the decision to use of contaminated materials to send to the lab. This decision shows a lack of thinking critically to solve the dilemma when obtaining a fresh specimen along with some patient teaching would have been sufficient.

If I were to have been the one to catch this incident then my response would have been mostly the same depending on certain timeframes. If I would have discovered this infraction post-op, I would have advised the nurse to make a call to the relevant authorities and acknowledge her mistake to allow appropriate measures to be taken. If I would have discovered this pre-op, I would have advised the nurse to call the lab and check if there was anyway to discard the incorrectly obtained blood sample, while simultaneously advising the nurse to obtain a fresh sample that doesn't violate any policies.