Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Jessica K Cortinas Date: April 5, 2023 DAS Assignment # 3

Name of the defendant: Cassie Agredano License number of the defendant: 785509

Date action was taken against the license: May 26, 2017

Type of action taken against the license: License is suspended with suspensions stayed, placed on probation a minimum of 2 years, and additional conditions to fill as requirements of the order.

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.

On July 11, 2016, Cassie R.N., was employed as a registered nurse with Laredo Medical Center, Laredo, Texas for a period of 11 months. On this day, Cassie failed to review the time-out procedure for completion or document a time-out prior to the start of the hemodialysis catheter implantation procedure for a patient in her care. Failing to do so puts the patient at risk for injury. Secondly, Ms. Agredano administered sedation to the patient without the supervision of a physician or another licensed practitioner. Additional supervision is a stipulation of the facilities protocol for sedation of a patient. By failing to follow this protocol, the patient was at risk for respiratory arrest and possible demise. In addition, Cassie failed to verify the code status of the patient prior to the scheduled invasive procedure. The patient became unresponsive, a Code Blue was initiated, CPR was initiated, the patient's Do Not Resuscitate order was identified, CPR was stopped, and the patient was pronounced deceased. Cassie's failure to identify the patient's DNR preference likely injured the patient from care provided without a physician's order and against the patient's wishes. Lastly, for this patient, Cassie pre-documented the patient had tolerated the hemodialysis catheter implantation procedure well and was transported back to her room via bed following the procedure. With the events unfolding as they actually happened, the patient was pronounced deceased in the interventional radiology suite prior to the start of the procedure. Cassie's actions regarding this documentation were viewed as likely to deceive other care providers who needed current information regarding patient status for further care. The infractions led to the decision of suspension with stays and probation with additional requirements for practice.

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.

First and foremost, keeping the patient's and her own safety in mind would have helped her prevent the initiation of her actions with the patient. Performing the time-out procedure herself or confirming in patient chart prior to procedure could have kept the patient, herself, and other care providers safe from possibly providing the wrong invasive procedure to the wrong patient. The time-out procedure could have given her the chance to ask the patient about DNR preferences, and reviewed possible risks and outcomes, informing the patient

thoroughly about the procedure the patient was about to undergo. Ensuring she knew the facility protocol prior to administering sedation to the patient, could help her avoid putting herself and the patient at risk for unsafe care and outcomes. She could have tried to research the protocol on her own to confirm what patient safety protocols were necessary to perform and document prior to the patient procedure. By not documenting outcomes as an expectation given by other nursing staff on the floor, and actually documenting what is going on with the patient, she could have avoided misrepresentation of patient status for further care considerations.

Identify which universal competencies were violated and explain how.

Safety/Security

Failure to follow protocol of the facility regarding sedation. Failure to document/ review time-out prior to procedure. Failure to identify code status for patient. Failure to communicate and inform herself regarding safe practice for invasive procedures and patient care.

Critical Thinking

Failure to assess patient for change in status after sedation. Failure to identify her protocols prior to administering sedation to the patient. Failure to keep her and patient safe in practice prior to invasive procedure. Failure to document real time status of patient. Failure to make decisions based on logical analysis of pertinent objective/subjective assessment data. Failure to prioritize nursing interventions based on evidence-based practice.

Standard Precautions

Failure to follow facility protocols. Failure to follow patient wishes regarding DNR.

Communication

Failure to follow time-out protocol with patient prior to invasive procedure lacking communication of expectations and possible outcomes, or an opportunity to have the patient ask questions as needed. Failure to receive clear instructions regarding safe practice and protocol of facility regarding sedation of patients. Failure to document correct patient status for further care as patient status changed.

Documentation

Failure to document correct patient status. Failure to document standardized form “time-out” prior to invasive procedure. Failure to document ethically in her practice regarding patient success of procedure, when patient did not make it into the procedure at all. Failure to record accurate data

Human Care and Relationship

Lack of care in safety of patient or self. Lack of care of duty to patient care and personal patient preferences, specifically in DNR code status. Failure to ensure patient well-being throughout care provided. Lack of including patient in care plan by failing to do the time out prior to invasive procedure.

Professional Role Performance

Practiced care of patient in unprofessional manner, by not following facility protocol. Failure to provide proof of competency to interact with other nurses and care providers regarding patient wellness and safety.

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.

The prudent nurse would keep patient/self/family safety in mind at all times when caring in practice. The prudent nurse would review chart notes prior to assessing the patient for any type of pre-procedure action. If she clearly communicated the need for her duties and facility protocols prior to her patient assessments and actions, she may have been able to avoid negative patient outcomes. The prudent nurse would have taken all steps to provide clear communication with the patient in time out from expectations and possible outcomes with sedation and procedure with time-out review and opportunity for questions. The prudent nurse would be sure to identify in time-out patient preferences regarding code status. The prudent nurse would document patient status as the care is given or as the change of patient status is happening in real time. Cassie took the advice of her coworkers and decided it was her practice to document unreliable information about the patient, and the negative outcome actually happened, therefore nullifying her early false documentation about the patient having the procedure done and tolerating well.