Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Dawson Delaney Date: April 7, 2023 DAS Assignment # 3

Name of the defendant: Sherri Renee Garza License number of the defendant: 771590

Date action was taken against the license: January 19, 2017

Type of action taken against the license: Warning with Stipulations

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.

There were three events that led to disciplinary action in this case. These events occurred on March 19 and April 19 of 2014, as well as on April 4, 2015. The nurse being discussed was employed in a clinical setting involving inmates of a prison. The first event that occurred on March 19, 2014 involved the nurse in question failing to properly adhere to the chest pain protocols set in place. The nurse failed to administer oxygen and also failed to start an IV, which are both part of the facility protocol regarding chest pain. The patient also had an abnormal EKG and a history of cardiac problems. The nurse released the patient from the clinic and he was later found in his cell unresponsive and eventually passed on. On the second date in question, the nurse assessed a patient and obtained a blood pressure reading of 183/114, and she failed to notify the provider. This conduct exposed the patient to an increased risk of harm. On the third date, April 4, 2025, the nurse gave a patient's medical record to a different patient asking them to make a copy. This conduct is a violation of HIPPA.

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

In this case, the nurse made many mistakes that had to do with patient safety. For the first event that occurred, the problem could have been avoided by the nurse having a better understanding of the protocols set in place by the facility. If the nurse would have known why these protocols are in place and how they protect the patient, this event would never have occurred. The second event could have occurred for a couple different reasons. It could be that the nurse did not know that she should have notified the provider, in which case it could have been prevented by an increased understanding of blood pressure. It could also be that the nurse was just being careless. If that is the case than the error could have been prevented by the nurse having a more caring attitude towards her patient. The third event also occurred because of carelessness. The nurse, plainly put, didn't care about the patient's private information.

Identify which universal competencies were violated and explain how.

In the first event, the nurse violated the critical thinking element of the universal competencies. The nurse did not perform the correct assessments in relation to the patients symptoms. There was protocol in place for when a patient presented with chest pain and she did not correctly perform the assessments associated with that protocol. For the second event, the nurse violated the communication element of the universal competencies. The nurse did not utilize her resources to notify the provider of the patient's high blood pressure. The last event involved violating the safety and security aspect of the universal competencies. Patient confidentiality was compromised by the nurse's actions and in turn she violated HIPPA.

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.

In each of the three events that ultimately lead to disciplinary action, if I had noticed the errors I would have gone to the supervisor to report them. In many other cases, I would likely go to the nurse first to talk with them about what has taken place. However, In this instance I believe many of these errors come down to the nurse being careless. Because of that, I think the supervisor should be made aware of these careless actions made by the nurse immediately. I feel that carelessness is a large factor when it comes to maintaining patient safety.