

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Olivia Palermo

Date: 04-13-2023

DAS Assignment #4

Name of the defendant: Tina Baggett

License number of the defendant: 577672

Date action was taken against the license: 14-May-2013

Type of action taken against the license: Suspend/Probate

*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 September 10th, 2009, while working as an operating room registered nurse at the Diagnostic Hospital in Cleveland, Texas, Baggett was helping close sutures on medical record number 20100003707, case number 9042, when she failed to count the surgical sponges used before closing the patient. As a result, a sponge was left in the patient's abdomen post-surgery. Two days later, an x-ray showed an unknown structure in the patient's abdomen, but the patient was still discharged after the radiologist wanted further testing. Approximately three weeks later, the patient returned to the hospital with a seven centimeter abscess due to the sponge left by Baggett. Once this information was obtained, a second surgery was completed to remove the foreign object from the patient's abdomen. However, days later, the patient developed blood clots from his upper right leg to his ankle, which required him to be readmitted to the hospital, so blood thinning medication could be administered. This action completed by Baggett put the patient through more health risks and surgeries that could have been prevented if Baggett had checked the sponge count before his abdomen was sutured. Furthermore, on October 27th, 2009, Baggett reopened and documented on medical record number 20100003707, case number 9042, to state that she notified the surgeon of the correct sponge (instrument) count, the electro-cautery pad was removed, and pressure areas were checked before being transferred to the Post Anesthesia Care Unit for observation. After documenting these findings, Baggett did not state this information as a "late entry" in the patient's medical record.*

*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.*

*To prevent patient harm caused by a foreign body, Baggett should have counted the sponges in the operating room before suturing the patient. After counting the instruments, she would have realized she was missing one sponge used during the surgical procedure. The instrument needed to be found before closing up the patient, preventing a foreign body from being sutured into the patient's abdomen causing more harm to that individual. To prevent a late entry from occurring in the documentation system, one needs to either document while the actions are happening or sitting down during one session to complete the paperwork; however, when looking at Baggett's situation, it looks like she was trying to cover up her actions since it was her fault the patient was*

*put in a harmful circumstance. As a nurse, we must look at every fine detail during the procedure to give the patient the care they deserve while documenting the information correctly and during the correct period.*

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

*The universal competency "standard precaution" was violated when Baggett forgot a sponge in the patient when she should have checked her instrument count. This caused harm to the patient by causing a life-threatening abscess that needed him to be readmitted to the hospital, all caused by human error. The "documentation" universal competency was also violated when Baggett reopened a patient file and changed information without stating her actions in the records as a "late entry." When documenting in a patient file, one must chart when the action happened. Charting is a significant component in the nurse's role by describing what is done daily and how the patient is or is not getting the care they deserve. If the records need to be updated at a different time, the nurse must title the new information as a "late entry" and provide their initials to show what was updated and by whom. Since Baggett edited the file weeks later, this shows the realization of her mistake and her actions of wanting to cover up her errors portrayed to the patient.*

*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.*

No matter what occupation one is in, there are times when we do tasks so often that we forget to take a second and determine if the steps were completed. If I was the first person to discover Baggett's actions, I would first visit her personally to see if she knows she made a mistake. After talking with her and getting her side of the story, I would go to the department's charge nurse and explain how I believe Baggett was not doing her job efficiently, and I believe an instrument is still in the patient. However, if I was the first nurse to discover Baggett's documentation on a patient's file months after her actions occurred, I would go directly to someone higher up, such as the charge nurse, to describe what I saw. Charting is a major portion of a nurse's job. Without documenting correctly, the patient is left in the dark about what has been completed or is missing in their file. Since Baggett documented without putting a late entry into the record, shows a competent nurse she is trying to hide her actions. Our main job as nurses are to keep people safe, and Baggett is not doing her job correctly, which needs to be stopped by someone with authority.