Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: **Kyle Ewing** Date: **8/24/23** DAS Assignment # **1**

Name of the defendant: **Christine D. Ahrens** License number of the defendant: **RN 245304**

Date action was taken against the license: **Feb 12, 2013**

Type of action taken against the license: **Warning with stipulations**

Christine Ahrens was a Labor and Delivery Charge Nurse at Austin's Women's Hospital. On April 15, 2010, Aherns failed to act appropriately in patient care leading to two losses of life. Aherns did not report or act on a minimal to absent variability on the fetal heart monitoring strips for a set of twins. This abandonment of duties led to a delayed cesarean delivery in which both babies were delivered with an Apgar score of 0/0/0. It was discovered the mother had suffered an anterior placenta abruption, post operatively.

Aherns had completed a Fetal Heart Monitoring course not even two years before the incident, she had no reason in not being able to recognize the issue at hand. If she would have simply not skipped or overlooked the strip and monitored (and/or) reported the strip's finding, like she had been trained to, the babies would have at least been tended to before reaching such a dire state. It is a clear case of routine, yet vital duties not being performed leading to a tragic loss of multiple lives.

Aherns actions directly contradict her professional role as a nurse and her documentation skills. Aherns neglected a vital monitoring station, a clear example of mishandling equipment, a fetal heart monitoring device in name alone sounds vitally important and clearly ignoring such a device is a failure to live up to universal precautions. In hand with not paying attention to a machine informing you of dire instances, when you fail to report verbally or electronically to anyone, you are again failing documenting with universal competencies.

This situation must have been so traumatic for the mother, but as well as the team of nurses. They did not know the true conditions of the twins until the delivery was complete. I think a more prudent nurse would have caught the fetal strips before the situation reached this apex. While you can not blame anyone in the situation as it was unfolding, I believe if I were to be the one who connected Aherns to the twin's deaths, I would just ask her why? What was so important you could not take one minute to read a preform such a vital task. I do not agree she should have been just declared as a warning with stipulations, such an easy and quick task should never lead to the deaths of a baby, let alone two at the same time. I believe her license should have been revoked.