

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Quinton Sherrod

Student Name: ^

Date: 9/8/23

DAS Assignment # ___3___ (1-4)

Name of the defendant: Anita L. Bates

License number of the defendant: 507915

Date action was taken against the license: 1/2012

Type of action taken against the license: Remedial Education

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.

Charge one: Anita L. Bates failed to document "assessments or interventions" that she may or may not have done while caring for a post anesthesia/post procedure patient that was assigned to Anita.

Charge two: Anita L Bates failed to perform a focused/comprehensive assessment of her patient who was a post anesthesia/post procedure patient who was admitted for a G-tube placement. This led to this patient being placed into the PICU unit (where this nurse was working) and this is when the nurse failed to notice a "developing fluid overload" in the patients left lung. This action was found by the Texas Board of Nursing to be exposing this patient to an unnecessary risk of harm and an ineffective treatment that could result in a delay in the patients' recovery.

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.

For the first charge I've said it many times before but from what we have learned both in class and in the clinical setting documentation plays a significant role of the patients' wellbeing. In this case however documentation may have played a dramatic role in this nurse not being investigated for not doing certain procedures that could have been critical for this patient. In the text the nurse claimed to have been trying to contact the physician however this was not documented and she also did admit to her documentation being very poor and not relating the amount of bedside care and attention that she was giving this patient, so to be able to prove that she had done certain things such as contacting the physician as many times as she claimed with her documentation could have played a key role in her case. To conclude the first charge a simple fix of giving a thorough yet brief summary of what the nurse had done with this patient every time she entered the room would be a clear fix for the charge of no documentation.

For the second charge of not noticing the fluid buildup in the left lung this is also a fairly simple fix, we have learned that no matter what when you first get on shift or acquire a new patient in general, we need to always do our own assessments. This is just in case the nurse from the previous shift or the previous floor the patient was on did not notice something such as a fluid buildup in the lungs we can catch it. Overall, a head-to-

toe assessment is very necessary to do for the wellness of our patients and for us as healthcare providers to have a better understanding of the person that we have been tasked with caring for.

Identify which universal competencies were violated and explain how.

Failing to have no documentation or poor documentation over the observations or procedures done on this patient falls under the documentation category of our Universal Competencies. The reason for this is that we should document all things pertaining to the wellbeing of our patients such as contacting the healthcare provider for assistance, or the overall assessments done on our patients and the finding of those assessments.

Failing to notice the fluid buildup in the patients left lung I believe would fall under the Critical Thinking Category of our Universal Competencies. With the information that the nurse was giving about this being a post operative patient whom did have a significant amount of IV fluids during the operation we should always be extra careful and check for any signs that our patient is holding this fluid in any parts of the body, this also ties back to our head-to-toe assessment because if we did this we are more then likely to hear crackles during our respiratory part of the assessment if I am not mistaken.

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 this particular situation if I would have noticed this nurse being as overwhelmed as they were in their attempts to take care of all of their patients, I would have tried to lend a helping hand if I was able to do so. However, when I would have noticed the poor care that was provided in the sense of little awareness of her patients and little to no documentation to go with this, I would have reported this to the charge nurse. However, in this case I am glad that her license was not suspended or revoked, and I do not feel like there was any malicious intent when it came to some of the mistake that were made, and from what I could tell no harm came to the patient. Overall, I believe that in this case the requirement for remedial education was a good punishment.