

Covenant School of Nursing  
Disciplinary Action Summary Assignment  
Instructional Module 2

Student Name: LaTonya Esquibel    Date:10/27/23    DAS Assignment # 1 (1-4)

Name of the defendant: Virginia K. Austin    License number of the defendant: 648218

Date action was taken against the license: 2/13/2018

Type of action taken against the license: Warning with stipulations

RN Virginia had assisted in a procedure in the OR. When the procedure was finished, she attempted to cut the sterile drape off of the patient and while doing so she cut the patient's top left thigh. The surgeon had left the operating room already, so Virginia disinfected the wound and applied skin glue on the wound without an order from the physician. Virginia responded by saying she didn't realize she caused a wound until transferring the patient to another bed and decided to clean and put the skin glue on. Although the physician was not in the OR room at the time, she asked another RN to make a note in the chart about the wound and would notify the physician when she found him later but accidentally forgot. Actions taken were she could not work outside the State of Texas as an RN, complete an online Board's course within thirty days, take two specific board approved courses, work as an RN in Texas providing direct patient care in a health care setting for 64 hours a month for 1 year, and notify employer of the the order and any other medical errors that occur.

I understand accidents happen; they happen to all of us. I think she should have called the physician and asked what she should have done to the wound. She should have called him or made more of an attempt to find him. She was probably pressed for time and needed to get the patient to recovery and maybe that's why she took matters into her own hands but as soon as she dropped that patient off, she should have imminently got ahold of the physician.

The universal competence that was violated was communication because she had no orders to do an intervention which is protocol, she also failed to not let the physician know about the situation. She decided to wait and tell the physician about the wound, cleaning it, administering something without an order and ended up forgetting to tell him, which eventually caused her to receive a warning and stipulations.

The actions I would have taken if I were the first person to discover the event by the RN would have been to exhaust every resource, to find the physician. If we had not choice, I would have placed a gauze of some sort if it were bleeding, notified the RN taking the report and after hand off, I would have got ahold of the physician to let him know what had happened and give orders to the nurse that is taking care of the patient. I think Virginia did do a good job on notifying another RN and asked them to chart what had happened.