

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Jessica Bridges Date: November 9, 2023

DAS Assignment # 3

Name of the defendant: Haleigh Ruth (Anthony) Denman

License number of the defendant: 902996

Date action was taken against the license: August 5, 2020

Type of action taken against the license: Reprimand with Stipulations

#### **Events**

This particular RN had two occasions in which she was working in a Dialysis Clinic and on the first occasion she did not double check that the filtration rate was correctly set on the dialysis machine and so the patient did not receive his dialysis goal for that scheduled date. On a separate occasion and patient the RN again did not set the dialysis machine to the correct settings and the patient had too much fluid removed which caused the patient's B/P to drop and the patient required additional interventions to recover from this episode.

#### **Prevention Measures**

- The first patient's scenario I believe could have been avoided by the nurse slowing down and triple checking the machine before leaving the patient's side. The documents do not state that the RN was overworked or particularly busy on these days but maybe that could have also been playing a role in the mistakes that were made. In the court documents it does state that the button to push to check the patient's BP is directly above the button to start the machine, so the RN thinks maybe she hit the button to run the BP rather than making sure she pushed the correct button to start the treatment. For that scenario I still think her slowing down and double and triple checking the machine could have avoided that situation.
- The second scenario I also read that the RN believes another patient care tech had set the machine to a previous targeted amount of fluid and the RN in this case did not check the machine and/or verify that the information that was previously put into the dialysis machine was accurate. Again these incidences seem like they both could have been avoided by taking a couple extra minutes to verify the orders and rates that are put into the machines and make sure they're running before leaving the patient.

#### **Universal Competencies**

**Safety and Security (physical)**- This was violated by the RN not accurately verifying the 7 Rights of Medication Administration. This was violated because I believe had the nurse double checked all the 7 Rights she would have caught that the machine was not set properly in the first scenario and also on the second that the rate was incorrect on the machine.

**Human Caring**- this was violated by the RN not spending time with the patient, I believe if she had spent more time with the patient it also would have caught the machine errors before they were actually an issue.

Professional Role- I believe this was violated because the RN did not manage the equipment correct or efficiently.

**Prevention**

I think in these two scenarios if I were to come upon them I think I would ask the nurse if she would like another nurse or myself to double check the dialysis machine as a second verification just to make sure everything is set correctly. I don't believe the nurse was intentionally trying to harm either of these patients, it appears like they both were honest mistakes that could have been avoided if she would slow down and double check.