

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Marissa Torres

Date: 1-19-24

DAS Assignment #1

Name of the defendant: Angela Ikeji, RN

License number of the defendant: 984127

Date action was taken against the license: 10/20/2022

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

- *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.*

In August 2020, the respondent intervened in MRN 91935347 inappropriately by failing to verify patient status and orders before ambulating the patient to the bathroom without required oxygen. The respondent claims that the patient was not wearing an Opti-flow oxygen mask when she arrived to provide assistance. Resulting in the patient's oxygen saturation to reach 48% when the patient was returned to the bed. The oxygen status of the patient required intervention from the rapid response team. Rapid response team intervention included the placement of a non-rebreather mask on the patient to improve the oxygen saturation level. The patient was placed at severe potential risks that can occur when the brain is deprived of oxygen at dangerous levels.

In September 2020, the respondent failed to intervene appropriately following the hospital protocol for hypoglycemia. MRN 70334927 had a blood glucose level at 0845 hours of 66mg/dL. Intervention was not provided to the patient until 1045 when the blood glucose level reached 45mg/dL. The respondent provided apple Juice at this time, the patient's blood glucose level raised to 105 mg/dL. The respondent failed again to do the glucose re-check at 15 minute intervals to ensure stabilization. Failure for follow up care resulted in the patient's glucose level to decrease again at 1529 hours to 66 mg/dL. Respondent failed to take the proper steps in a timely manner to prevent adverse reactions that can occur with hypoglycemia in prolonged periods of time.

In December 2020, the respondent failed to perform interventions for MRN 90857578 in the event of hyperglycemia. The blood glucose level of 508 mg/dL was not sampled and sent to the laboratory for further confirmation of the exact measurement. When respondent rechecked at 1440 hours the blood glucose level was still elevated at 469 mg/dL. The respondent failed to notify the patient's physician of the blood glucose patterns. Therefore, could have caused the patient to suffer from further illnesses and potential infections caused by prolonged elevated glucose levels.

In January 2021, the respondent failed to verify the physicians' orders for fluid administration of MRN 95600283. The patient was already receiving an infusion of normal saline at the rate of 75 mL/hr per the first provider's orders. The respondent failed to get confirmation for a new infusion of lactated ringers at the rate of 100 mL/hr. The respondent gave these two infusions together, placing the patient at a high risk for adverse complications such as hypervolemia, edema, and elevated blood pressure.

- *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.*

The respondent failed to follow proper protocols in all the situations listed above. These patients were placed at very high, unnecessary risks for suffering major injuries from illnesses caused by poor care. Had the respondent performed best nursing practices and followed hospital protocols, all the above occurrences could have been prevented.

- *Identify ALL universal competencies were violated and explain how.*

-Safety and Security (physical)- The nurse didn't follow the 7 rights for medication administration for the patient that received normal saline and LR at the same time.

-Communication- The nurse did not provide patient teaching for how to prevent or aid hyperglycemia, hypoglycemia, and diet. The nurse also didn't provide teaching when administering the LR infusion. Had the nurse provided patient teaching about the infusions this might have made her double check the orders, verify with the physician, and prevent the overdose.

-Critical thinking- SBAR- The nurse failed to assess the patient status and situation for the patient who suffered from low oxygen saturation when going to the bathroom. For the patient to have had such a low saturation level so quickly the patient had to have been symptomatic with trouble breathing, disorientation, confusion, cyanosis, increased respirations before attempting ambulation. The nurse did not prioritize the needs of her patients with blood glucose instabilities. This could have caused bigger illnesses and infections to arise. When she noticed that she didn't get a timely response from a physician she could have tried to reach them again or even check with the charge nurse on the next actions to take in order to prevent the patient becoming critical. The nurse did not provide the proper assessments related to the symptoms that each of these cases were experiencing. Which could have caused her to overlook critical information in order to provide the patient with the best care.

-Human Caring- The nurse did not involve the patients in their plan of care when it came to things that could have prevented the raise or drop in blood glucose. Teaching the patient preventative measures and helping them recognize the signs and symptoms of the problem they are facing before it gets to a level of deterring their overall health.

-Professional Role- The nurse did not have proper interaction with staff. In the situation that she didn't reach out to the physician to verify orders before administering new medication. She also failed to get full report or even attempt to ask for any critical information that is needed before providing assistance to the patient to go to the bathroom. He could have been immobile, not oriented, on narcotics that can cause dizziness, etc.

- *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.*

As the prudent nurse in these cases, report the problems observed to the charge nurse immediately and with discretion. This would prevent the nurse from causing any further harm to patients in her care. Reporting the nurse in discretion would ensure patient privacy and prevent the possibility of retaliation to the reporting nurse, resulting in a possible hostile work environment. A negative work environment would prevent proper timely nursing interventions for patient care and poor communication as a team to provide care to the patients using best nursing practices.

<http://204.65.111.68/THP/View.ashx?d=n&DID=3315983>