

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Celeste Gomez

Date: 01/19/2024

DAS Assignment # 1

Name of the defendant: Dianna Gonzales

License number of the defendant: 819999

Date action was taken against the license: 08/18/2020

Type of action taken against the license: Revoked

- *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.*

The charges against the defendant as follows:

- Failure to comply with the Agreed Order issued to her on July 18, 2018 within 1 year (July 18, 2019). (Noncompliance) ([file:///C:/Users/celeg/Downloads/819999%20\(2\)%20\(1\).pdf](file:///C:/Users/celeg/Downloads/819999%20(2)%20(1).pdf))

The following events were what led to the Agreed Order being enforced:

-Failure to titrate Dopamine IV drip that was administered.

([file:///C:/Users/celeg/Downloads/819999%20\(2\)%20\(1\).pdf](file:///C:/Users/celeg/Downloads/819999%20(2)%20(1).pdf))

-Failure to document Dopamine IV drip in eMAR, and to keep the patients blood pressure within parameters.

([file:///C:/Users/celeg/Downloads/819999%20\(2\)%20\(1\).pdf](file:///C:/Users/celeg/Downloads/819999%20(2)%20(1).pdf))

-Administered juice and graham crackers to patient instead of a dextrose bolus at 0530 for a blood glucose reading of 20 mg/dl. ([file:///C:/Users/celeg/Downloads/819999%20\(2\)%20\(1\).pdf](file:///C:/Users/celeg/Downloads/819999%20(2)%20(1).pdf))

-Failure to notify physician of patient's critical blood glucose reading, and failure to recheck blood glucose level after administration of juice and graham crackers. ([file:///C:/Users/celeg/Downloads/819999%20\(2\)%20\(1\).pdf](file:///C:/Users/celeg/Downloads/819999%20(2)%20(1).pdf))

-Failure to reassess temperature after Tylenol administration for a fever of 101.7 at 1122, and failed to notify the physician that the patient had a temperature. ([file:///C:/Users/celeg/Downloads/819999%20\(2\)%20\(1\).pdf](file:///C:/Users/celeg/Downloads/819999%20(2)%20(1).pdf))

-Failure to administer Tylenol at 0442 when patient had a temperature of 101.0, and temperature of 101.7 at 1957. ([file:///C:/Users/celeg/Downloads/819999%20\(2\)%20\(1\).pdf](file:///C:/Users/celeg/Downloads/819999%20(2)%20(1).pdf))

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.

I think a big measure that could have protected this particular nurse license, was complying with her Agreed Order of educational remediation. As for what led to the Agreed Order, I think what could have helped this nurse protect her license is if she had been prudent in her documentation of the medications that were being

administered to her patients, as well as communicating with the physicians and letting them know the status of the patients. I also think that if she had used critical thinking with her diabetic patient and their blood glucose reading, that she would have known that a reading of 20 mg/dl is critical condition and requires medical attention. As well as critical thinking and standard precaution when preparing the dopamine IV drip as it was not properly titrated.

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

Communication:

-The nurse did not notify the physician about the patient's blood glucose reading which was considered to be critical condition.

-The nurse failed to notify the physician about the patient's temperature not breaking and remaining over 101.0 during 3 separate vital signs checks.

Critical Thinking:

-The nurse did not show proper decision making when administering juice and crackers instead of a dextrose bolus for a blood glucose reading of 20 mg/dl.

-The nurse did not show proper assessment related to patient symptoms (fever of 101.0 and 101.7) and did not administer Tylenol either time.

-The nurse failed to revise her decision making of going back and making sure all of her medications had been scanned in eMAR.

-The nurse failed to revise her decision making after she did not titrate the dopamine IV drip and still administered it.

Documentation:

-The nurse violated the universal competency of documentation by not scanning dopamine IV drip medication in eMAR and still administering.

Safety and Security (physical):

-The nurse failed the universal competency of the 7 medication rights, as she did not document the administration of dopamine IV drip.

Standard Precaution:

-The nurse did not titrate the dopamine IV drip before administration and failed to demonstrate proper medication preparation.

- *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.*

I think as a prudent nurse I would first, immediately notify the physician of the patients blood glucose level and immediately administer a dextrose bolus, and stop the dopamine IV drip if I see that it has not been properly titrated, and notify the physician of this as well.

As for the second patient with the fever, I would first immediately notify the physician that the patient has a temperature that has remained elevated after 3 separate vital signs checks, and I would administer Tylenol and apply cool packs to my patient to help decrease the elevated temperature. As well as do a neuro assessment to make sure my patient was not experiencing symptoms of dehydration, pain, or confusion.