Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Mahalei Romero Date: 1/25/2024 DAS Assignment # ___2____

Name of the defendant: Amandeep Kaur Brar License number of the defendant: 827322

Date action was taken against the license: 3-23-2021

Type of action taken against the license: WARNING WITH STIPULATIONS, DEFFERED

The defendant mislabeled their patient's blood specimen (patient A) with another patient's label (patient B). This caused patient B to receive a blood transfusion that was meant for patient A. The defendant agreed that they had made a significant error but also pointed out that there should have been other safety precautions to have prevented from their error leading to the blood transfusion. Two night nurses could not find the order for the transfusion to patient B, so they created a false verbal order from the physician. Another prior mistake that was not the fault of the defendant was that Patient B's label should not have been inside the binder for patient A. The defendant also gave a report at the end of their shift that patient A was to receive one unit of blood meaning that the nurse on shift should have known that the blood transfusion was not for patient B and was another person who could have confirmed which patient the blood transfusion was for.

I think that the main action that could have been taken was if the defendant had double checked the label that they put onto their patient's blood specimen. Besides this small error that the defendant made, all of the other errors that led to the blood transfusion going to the wrong patient were not necessarily the defendant's fault. The other mistakes includes that there was not a physician's order for the blood transfusion to the patient who received the transfusion, there had been a previous incorrect placement of the label in the wrong patient's binder, and a report had been made mentioning the correct patient who was to receive the blood transfusion.

Physical safety and security, critical thinking, and documentation were all universal competencies that were violated for this event even if the defendant did not, themselves, break them. Physical safety and security was broken by not using the 2 patient identifiers to confirm with the label of the blood specimen. Critical thinking was broken when the label was initially placed in the wrong binder. Documentation was broken by a false physician's order being put in the system to administer the blood transfusion.

A prudent nurse would have discovered the error of a mislabeled blood specimen by looking in the system for a physician's order and for documentation of the blood specimen. If there was no indication for a blood transfusion other than the blood specimen, then contact with the nurse who took the specimen and/or the physician would be needed in order to clarify the situation. Any confusion about the blood specimen would lead a prudent nurse to either retake the specimen based on different orders and to not administer any medication based on the blood specimen including the blood transfusion. If the blood transfusion occurred before the error was found, then a prudent nurse would first ensure the safety of the patient by monitoring for any adverse

results of the blood transfusion. The prudent nurse would then tell the charge nurse, notify the physician, and file an incident report.