



DAS Presentation

Who, What, When?

Name of defendant: Evangelynn Loeaine Smith Loraine

License Number: 704201

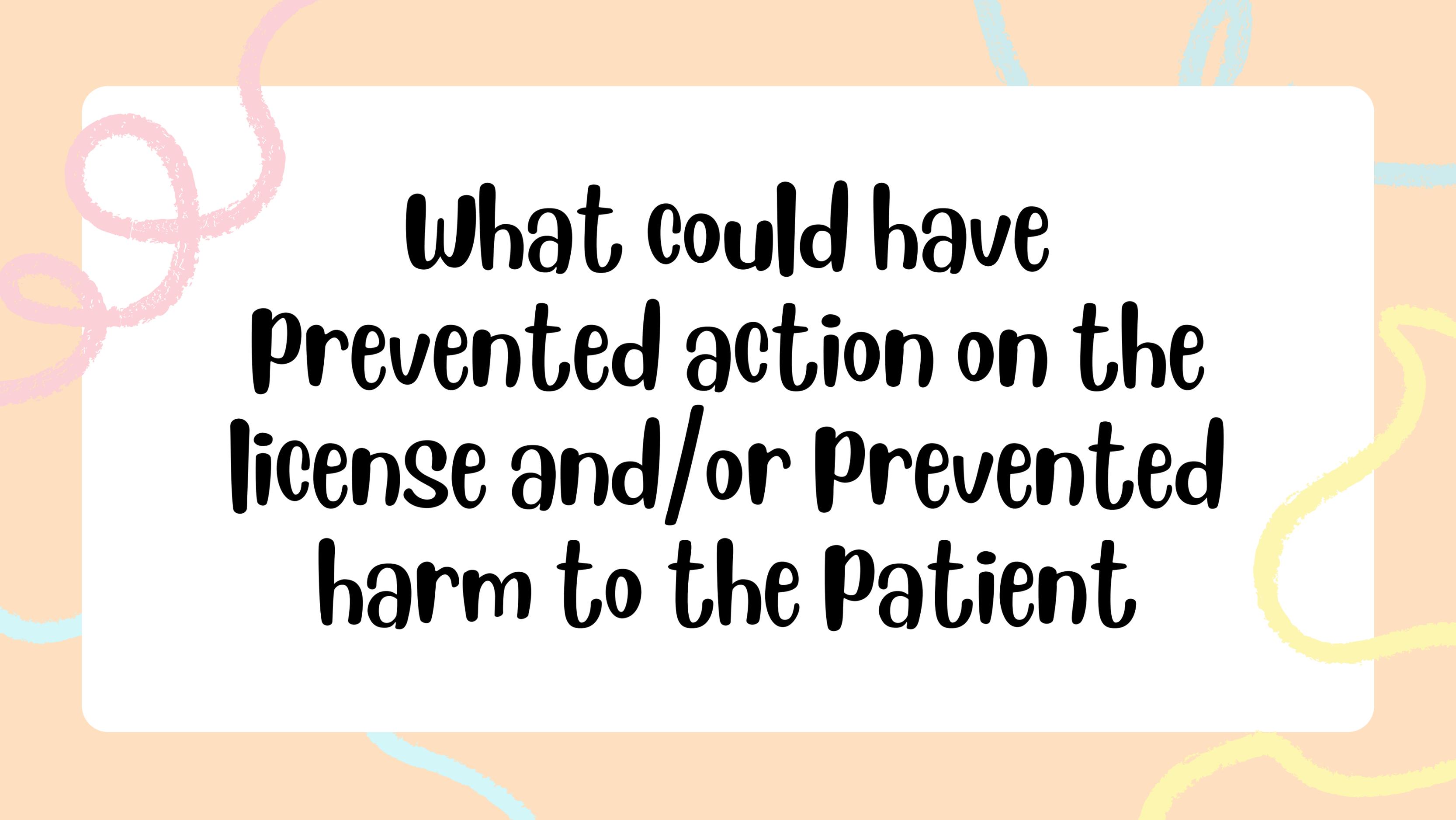
Date action was taken: 03/08/2022

Type of action taken: Warning with Stipulations

Events which led
actions against the
license:

- The respondent failed to label and administer IV medications correctly. The respondent mislabeled the IV tubing for both Pitocin and LR.
- The LR fluids were infusing via a pump at the rate the Pitocin should have been administered, while the Pitocin was infusion without a pump at a rate unknown.

Later on in the shift when the nurse was on break the patient requested an epidural. The nurse who was breaking the respondent opened the line the respondent labeled LR using the roller clamp and administered a fluid bolus for preparation for the epidural. The nurse did not realize until the bolus was done that it was Pitocin that had been bolus and not LR



What could have
prevented action on the
license and/or prevented
harm to the patient

For the respondent to have prevented any action taken against her license she could have made sure to correctly label her lines. Using the verification steps and seven rights she could have labeled the medication and fluids correctly during that time.

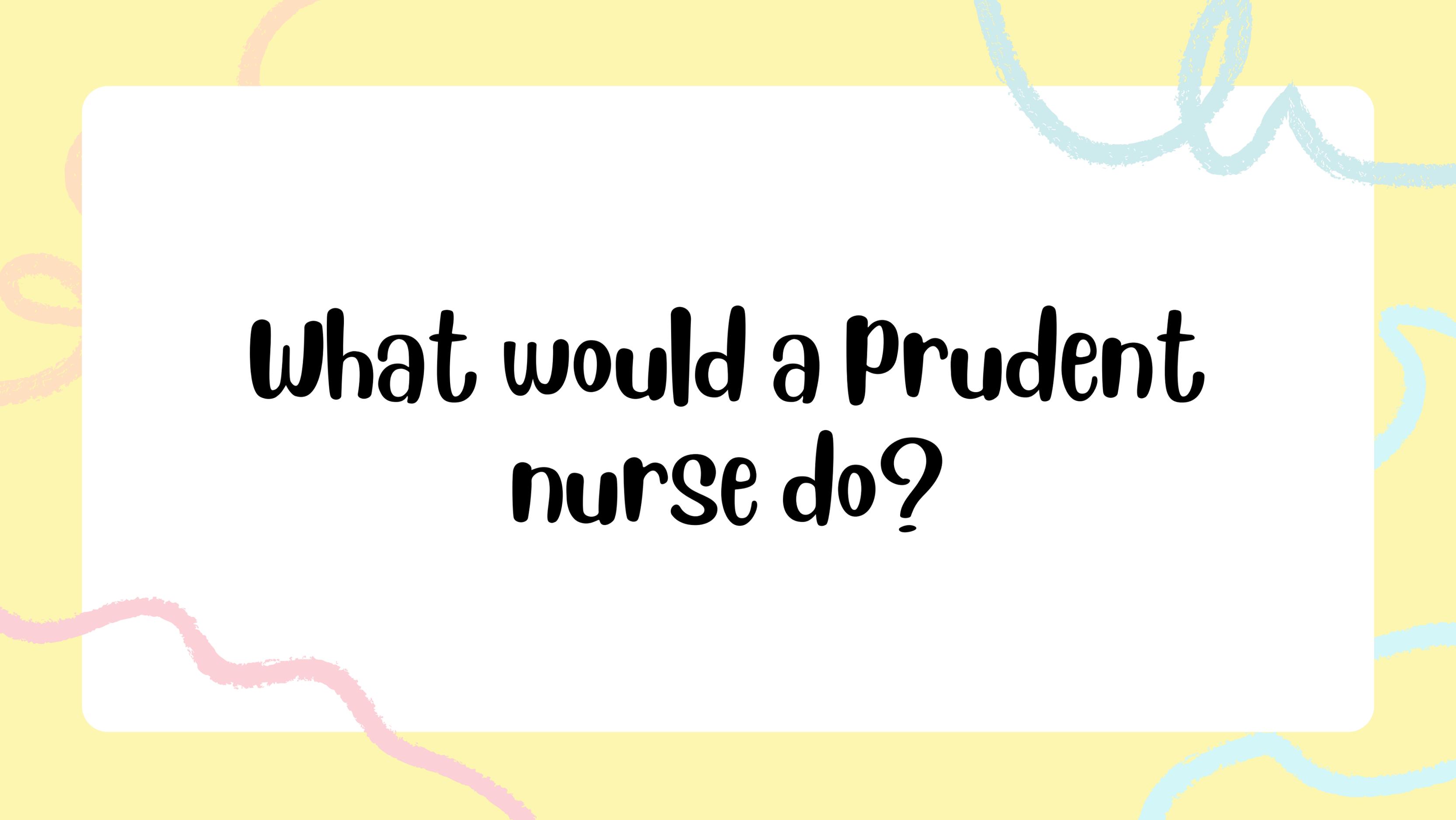
The nurse unfortunately did cause harm. Due to the Pitocin, the patient's fetus experienced prolonged deceleration. This could have caused fetal hypoxia and acidosis in the fetus, fortunately, though the the fetus recovered.

The image features a white rounded rectangle centered on a pink background. The text is written in a black, casual, handwritten-style font. The text is arranged in four lines: "All Universal", "Competencies that", "were violated", and "were violated". There are several colorful brushstroke accents: a yellow one on the left, a light blue one at the top, and a yellow one on the right.

All Universal
Competencies that
were violated
were violated

The respondent violated two universal competencies which included safety/security and documentation. She violated safety and security in two ways. She violated the seven rights of medication administration by not following the right drug in the correct route. She also violated the patients' and coworkers' trust by mislabeling and not administering the medication and fluids correctly

The respondent also violated the documentation of universal competency. If the scanning of the medications and proper documentation had been taken the system or the nurse would have been able to identify an error before it had occurred.



What would a Prudent
nurse do?

As a prudent nurse I would do the following:

- If I was the first one to discover the event I would first confirm the lines and where they are going and make sure to change the labels correctly.
- I would then assess the patient and make sure both her and the fetus is okay before finding the nurse and notifying her of what I had found

- After notifying the primary nurse I would then let the CN know that way she can follow-up with higher management and follow the patient and her baby to make sure there are no other side effects from the medication and fluid error.