



DAS#3 Presentation



Gillian Cardenas

Cherly Lynn Harvill

License type: RN

Registered Nurse License

Number: 645798



Cherly Lynn Harvill

Date event happened: December 27, 2019

- Cherlyn Harvill performed a blood test on Patient A when it was supposed to be for patient B.
- With Patient A blood results Cherlyn Harvill adjusted patient B medication to an incorrect dose.
- It was not noticed until shift change in the morning when the oncoming nurse noticed and immediately informed Cherlyn and the other RN present.



Date action was taken against Cheryl Lynn Harvill: October 29, 2020

Terms of order

I. Sanction and applicability

II. Compliance with law

III. KSTAR Program



IV. Further competency issues and violations

V. Restoration of Unencumbered License(s)



Universal competencies breached

Safety and security- 7 rights for medication admin

- By giving the wrong dose of heparin to patient for many hours

Communication

- The nurse didn't communicate with patient when taking the blood draw or when changing the second patient's heparin medication. If the nurse would've she would've known that she didn't do the correct patient blood draw.

Documentation- eMAR medication scan

- Did not scan the patient or check when doing the PTT test or when changing meds for patient B

Professional role

- The nurse did not care for the patient how she should've been cared for. The put two patients at risk. The fist patient got an unnecessary blood draw, and the second patient had a wrong med administration for a prolonged period.

Critical thinking

- When both her and the other nurse when in the room doing the PTT blood draw, they should've known the patient and known that they didn't need to do it on a patient not on heparin. and when changing heparin on the other patient they should've known who they did do the blood draw on and even triple checked



What measures
could've been
taken to
prevent action
or harm?



Both nurses should've used 2 patient identifiers before administering/changing meds and doing any lab work

Before changing the meds or administering they should've gone through the patients 7 rights.

Use the EMAR to check everything at least 3 times. And document everything

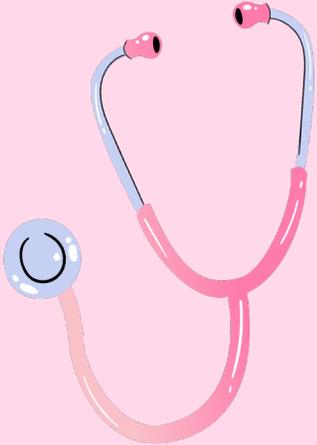
What would I have done if I discovered it first?



The First thing I would've done is check on the patient to make sure they are okay.

After checking on the patient I would then notify the charger nurse and see how they want to proceed with the patient care

Monitor the patient very carefully through the entire shift and make sure the two nurse get report for negligence.



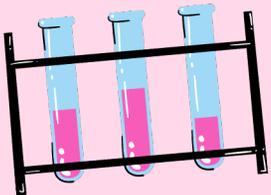
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THANK
you!



*“Let no one ever come to you without
leaving better and happier .”*



Mother terresa

