

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Alexxys Riojas

Date: 03/25/2024

DAS Assignment # 1

Name of the defendant: Amber Noel Wagner

License number of the defendant: 910940

Date action was taken against the license:

Type of action taken against the license: Suspension

- *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.*

*Nurse Amber Wagner failed to document important vital signs for her patient thus allowing the patient's medical record to not be accurate. The nurse also did not administer the patient's nasogastric tube feedings. Nurse Wagner also did not properly document her findings of the patient's changes following a neurological and respiratory assessment.*

*The improper documentation of the patient's neurological assessment can not only have caused harm to the patient but also the medical staff or visitors that the patient may have had. This also could have been a significant finding to an underlying issue that could have really put the patient at risk. Nurse Wagner also failed to properly document the patient's respiratory assessment, again this could have caused issues because the patient may have been put on oxygen or may have needed it but was denied it by a provider because the documentation was incorrectly inputted into the medical record.*

*Nurse Wagner also failed to document the patient's temperature for her entire shift. Although the temperature may seem minor it plays a huge role in the caring of our patients. It is a piece to the puzzle. While the RN failed to document her findings throughout her shift, while giving report on a different patient the nurse who was taking over on this patient noted that based on the report nurse Wagner gave this on coming nurse the patient had a significant change in temperature. Properly documenting these findings every time, we take them allows for us to see a trend or note when a new issue may have arose such as spiking a fever due to an infection. Nurse Wagner also failed to gain baseline vitals before giving medications which ultimately could have contributed to the drop in her patient's blood pressure and pulse.*

- *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.*

Proper documentation could have easily helped this situation, stopping to really assess the patient and their vitals and assessments before administering any medications. The hospital has guidelines in place in order to have a set of rules that EVERYONE as a caregiver must follow. These are also in place so that there is a standard held across the board and everyone has the same structure. These policies are meant to help keep our patients safe. Documentation is a HUGE piece of these policies. Documentation and the proper use of documentation is important in the medical field as we care for multiple people at one time. A person can not remember everything when going back and forth between 3-5 patients and not expect to get some information mixed up or forget something, this is why documentation is important. If we document as it is happening or right after we can keep the relevant information for the patients to the correct patients. You can also not determine what is really relevant or not, a provider needs all information to help make a diagnosis sometimes so even just documenting a slight change in a temperature can be significant. The mental status and respiratory status of a patient is important as well, knowing how to document these assessments are very important as it can be a indication that something deeper is going on with our patient, that something has changed.

- Identify ALL universal competencies were violated and explain how.

Documentation was violated because nurse Wagner failed to provide all vital signs each time they were taken, on two of her assessments she failed to properly input the findings of the assessments. This left the medical record incomplete and potentially allowed for medications that could have been ordered by the provider to care for the patient to not be met due to lack of information. The provider may not have even been able to order proper labs to help identify new risks for the patient based on the lack of information in the chart due to the nurse's actions. Safety and Security was violated as well. As a member of the care team a nurse should contribute to the promotion of trust and respect, nurse Wagner violated this by not properly documenting the vitals or assessments. Her patient trusted her to help get them feeling better, to help the providers by suppling all the needed information to help with their illness, but by leaving out even the slightest information she put her patient at risk. She also failed to use critical thinking. This universal competency was violated because she did not take base line vitals before giving a medication which in turn could have/ did have an effect on her patient. Also critical thinking can apply to her reinserting the NG tube but failing to administer the medication/ feedings as the two go hand in hand.

- 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 first person to have notice that these events have taken place, I would first asses the patient myself to have a baseline to work with. From here I would notify the charge nurse and the provider taking care of the patient so that all information is passed along to the appropriate care team members. The patient needs to be reevaluated to address all issues that had gotten left out on the records due to lack of documentation. I would also feel that the nurse needed to be retrained on the importance of proper documentation, and why we as nurses take vitals multiple times during a shift, as well as why we take baseline vitals prior to giving medications that have been ordered as some may alter these said vitals, for example the patient's blood pressure. If it is not documented in full detail it did not happen, there are reasons that we implement documentation.

