

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: MISTI DAMRON

Date: 04/04/2024

DAS Assignment #: 2

Name of the defendant: VALERIE DENISE CLEVELAND

License number of the defendant: 684129

Date action was taken against the license: 03/14/2023

Type of action taken against the license: WARNING WITH STIPULATIONS

- *Valerie Denise Cleveland made a careless, fatal mistake on January 24th, through January 25th, 2022. Ms. Cleveland was employed at Texas Health Harris Methodist, Fort Worth, Texas for 19 years and 11 months. When she came in for her shift during the report she stated that she “did look at the patients Heparin pump” however, she did not verify that the infusion of Heparin was programmed into the pump at the correct rate she basically trusted the nurse prior to her shift and unfortunately, the infusion rate ran just over 3 times of the unit/hr. that was prescribed by the physician. Instead of 800 units/hour it was infusing at 2500 units/hr. and ran for approximately 11 hrs. Ms. Cleveland did draw labs twice and the Heparin Anti-Xa levels were critically high, they were above 2.2. After the first confirmation from the lab that this level was critical, she turned off the infusion and drew the patients’ blood again which came back the same. Ms. Cleveland did research the administration records on how to proceed with the overload of Heparin she then reported the fatal mistake to the charge nurse, pharmacy and the physician. Ms. Cleveland noticed that the patient had a change in condition including his pupillary response. He was taken to CT for a brain scan and the detrimental results were a subarachnoid and intraparenchymal hemorrhage. On January 27, 2022, the patient had expired due to the carelessness of the nurse’s actions. For her to retain her license she was required to take a course in nursing jurisprudence and ethics, medication administration course, and a “Sharpening Critical Thinking Skills course.” In addition, with the courses she, will also have to work a minimum of 64 hrs. per month, notify all present and past employers, inform the BON if she changes jobs, and she will also have to have indirect supervision.*
- *The RN should have checked the rate of the medication Heparin during report and double checked the order from the physician. If she would have done that this horrible incident possibly could have been avoided. After the first call from the pharmacy, she should have contacted the physician and charge nurse immediately and followed his/her protocol.*
- *The universal competencies that were broken were safety and security, critical thinking, human caring and the professional role.*

- *Safe and Security (Physical) was violated by Ms. Cleveland by not checking the dose that was programmed into the pump this is considered the 7 rights for medication admin.*
- *Critical Thinking was also violated by Ms. Cleveland by not contacting the physician and charge nurse after the first set of labs came back as critical. She did not assess the patient after the first lab value came back critical.*
- *Human Caring was broken by not checking the medication dose that caused a hemorrhage that later killed the patient.*
- *Professional Role was violated by not checking the physicians' orders.*
- *If I had been the nurse to discover this error by the nurse, I would respectfully ask her to double check the patients order for heparin and if she refused then I would take it to the charge nurse. This was a careless mistake that cost the patient his life.*