

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Jasmine Luna

Date: 4/3/2024

DAS Assignment #2

Name of the defendant: Gary A. Berglund

License number of the defendant: 252752

Date action was taken against the license: August 11, 2015

Type of action taken against the license: Warning with stipulations

- *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.*

On May 27, 2013, Gary A. Berglund, a registered nurse at Heritage House of Keller, Keller, Texas, unprofessionally committed multiple actions. His actions were likely to injure his patient and caused an investigation on behalf of the Texas Board of Nursing. While he was caring for one of his patients, he noticed that the patient had a SpO2 level of 46%. Due to the low oxygen saturation, Berglund gave the patient a PRN breathing treatment to increase oxygen levels. After administering the oxygen treatment, Berglund failed to recheck the SpO2 level of the patient and notify HCP. Furthermore, Berglund failed to document his assessments, interventions, and oxygen administration. As the shift progressed, the patient was ultimately transported in an emergency to acute care due to a low O2 saturation level of 66%. According to Berglund, after measuring the patient's first oxygen saturation level of 46%, he assessed the patient's respiratory system. He noted that the patient had no adventitious breath sounds, no congestion heard upon auscultation, no signs/symptoms of hypoxia, shortness of breath, and was the patient was "less alert than usual". As a result of the low SpO2 readings, Berglund reported the low oxygen saturation measurement to the medical facility's Assistant Director of Nursing. In response, the Assistant Director recommended that Berglund administer a nebulizer breathing treatment PRN. However, after receiving and completing the treatment, the patient's oxygen

saturation showed no improvement. As a result, Berglund proceeded to notify the patient's physician.

Berglund's failure to reassess the resident's oxygen saturation, document assessments/ interventions, and notify HCP puts the patient at risk of complications of hypoxia or death. His inadequate interventions thus resulted in the patient being transported to acute care when prevention was available at the start.

- *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.*

Berglund's failure to reassess SpO<sub>2</sub>, document, and notify HCP resulted in warnings with stipulations against his nursing license. When Berglund noticed that the patient had a SpO<sub>2</sub> measurement of 46%, he should have recognized that any reading below 92% was abnormal and required immediate action. Berglund should have raised the head of the bed to thirty degrees or more so the patient could efficiently breathe more. Next, he should have asked the patient to take a few deep breaths while reassessing the oxygen saturation on a different finger. If the oxygen saturation remains the same or decreases, Berglund should have administered oxygen at the bedside through a nasal cannula. From there, he should stay with the patient to assess for any signs of hypoxia, such as restlessness, cyanosis, tachypnea, and dyspnea. Since the patient was less alert than usual, this may indicate that the patient was showing signs of hypoxia. Afterward, Berglund should have reassessed the SpO<sub>2</sub> level of the patient to indicate that oxygen levels are improving after O<sub>2</sub> administration. After providing nursing interventions, Berglund needs to notify the physician and HCP of the low SpO<sub>2</sub> reading and then request an order for oxygen treatment. In other words, Berglund should have communicated with HCP to inform them of the patient's condition and then received an authorized prescription for oxygen. From there, Berglund would need to implement any orders, interventions, and assessments from an HCP or a nursing judgment to improve the patient's oxygenation. After providing proper assessments and interventions, Berglund will then need to document. He would need to record his findings, assessments, interventions, notification of HCP with medical interventions, and medication administration.

- *Identify ALL universal competencies were violated and explain how.*

### **DOCUMENTATION**

Berglund went against documentation competency because he failed to chart and record his assessments, interventions, and findings. He should have documented his patient's low oxygen saturation of 46%, along with the respiratory assessment. In addition, Berglund should have a document entry notifying the Assistant Director of Nursing of the oxygen administration order. From there, he failed to record the administration order of the nebulizer breathing treatment given to PRN. According to the document, Berglund defended himself by stating the reasonings and interventions for his actions regarding the low oxygen saturation level. Even if Berglund performed those interventions, by not documenting, all information is invalid. Berglund's lack of documentation may cause other healthcare personnel to miss out on vital information regarding the care of the patient. As a result, the patient may not receive proper healthcare and is at risk of complications of hypoxia.

### **COMMUNICATION-**

Berglund went against the communication competency because he failed to notify the patient's physician of the low oxygen saturation. After measuring the low oxygen saturation and performing appropriate nursing interventions, Berglund should have notified HCP of the situation. If he was unable to communicate with the physician, he should have gone to his charge nurse or the following person in the chain of command. Although, according to the document, he notified the Assistant Director of Nursing about his patient's situation and administered the nebulizer treatment, he did not document the encounter. Thus, any actions on behalf of Berglund are invalid and did not occur.

### **CRITICAL THINKING-**

Berglund went against critical thinking competency because he did not prioritize any intervention based on the patient's low oxygen saturation. He should have raised the head of the bed and reassessed oxygen saturation. If the reading did not increase, he should have administered oxygen and reassessed the patient again. While stabilizing the patient, Berglund should have notified the physician or charge nurse of the situation. Afterward, he should enter appropriate documentation into the patient's medical record. Critically thinking

about low oxygenation rates in this situation may have prevented the patient from being transported to acute care.

- *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.*

If I were to discover what Berglund did to his patient, I would prioritize patient care and safety first. I would raise the head of the bed and reassess the SpO<sub>2</sub> of the patient. If the SpO<sub>2</sub> remained the same or worse, I would administer oxygen via the bedside through a nasal cannula. Next, I would monitor the vital signs of the patient for any further signs of hypoxia, dyspnea, tachypnea, cyanosis, and restlessness. Afterward, I would notify the HCP immediately of the patient's situation and nursing interventions performed. Finally, I would document all patient care and responses to the treatment given. Once the patient is in stable condition, I would report Berglund to the charge nurse or the following person in the chain of command over his actions toward the situation. In addition, I would respectfully go to Berglund to discuss what he can do better. I would educate Berglund on the importance of critical thinking and documenting. In this case, even if Berglund may have notified the HCP and provided care to the patient, if these nursing actions were not documented, they did not happen.