Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Marissa Torres Date: 4-4-24 DAS Assignment # 2

Name of the defendant: Mary Claire Florey License number of the defendant: 252411

Date action was taken against the license: December 17,2020.

Type of action taken against the license: voluntary surrender

- *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.*
  During the time of this violation the respondent was employed for 2 years as a registered nurse with Educare, Longview, Texas. Around September 23rd, 2019, during her employment the respondent failed to provide the appropriate medical care which resulted in patient demise. The respondent was notified via text message about the patients' complaints and went to the patient's home to assess the health condition. The respondent failed to notify the HCP about the worsening conditions and failed to refer the patient to the emergency room for further evaluation and treatment. The patient was experiencing emesis of brown bile, change In bowel habits, cough, and vomited after a tube feeding. The respondent failed to do an appropriate focused assessments of patient's vital signs and conditions because she stated that the patient did not want to be moved. Approximately 3 hours after the respondent left the home assessment the patient expired. The respondent then expressed the desire to voluntary surrender her license.

- *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.*

  Actions that could have been taken by the nurse could have potentially saved her patient from death. Even though the patient was not wanting to be moved, she as a care provider could have accommodated the patient as far as being more careful or more sensitive to the patient's discomfort. The respondent still needed to make every possible attempt to do the appropriate assessments of the patient. Should the respondent have still encountered Issues with assessing the patient correctly she should have advised them to go to the emergency room and provide patient teaching on what could happen should the symptoms be Ignored. Notifying the HCP of

her findings during her home visit would have raised at least a bit of concern and the HCP could have advised her to refer the patient to the hospital as well. Should the patient have declined going to the emergency room the nurse would have done all that she could in her power. It seems as though not doing an appropriate assessment of the abdomen, lungs and heart prevented her from catching something worse than she was seeing with her naked eye. For the nurse to have voluntarily surrender her license after the expiration of this patient, It shows that she might have had some guilt and or wronged feeling to surrender a licensure that allowed her to support her daily living for many years.

- *Identify ALL universal competencies were violated and explain how.*
  The following universal competencies were violated:
  1. **Safety and security (emotional)- The respondent didn't promote trust and respect for herself and her patient's health. Leaving the patients home without further trying to provide treatment shows lack of respect for human life, and the Impact nurses can make.**

  2. **Safety and security (emotional)- even though the situation didn't take place In a hospital setting, the respondent didn't provide proper AIDET. Explaining herself to the patient and the steps she needed to take to provide proper assessments for just a few short minutes of discomfort In exchange for more accurate Information to provide quicker relief If possible. Explanation of her processes could have also helped her build rapport with the patient, which would promote more trust.**

  3. **Communication- the respondent failed to provide patient teaching on the adverse complications that could arise from the vomiting and cough. Creating a better picture and understanding for the other Issues that could exacerbate symptoms that are already present. The respondent also failed to explain the Importance of going to the hospital for a higher level of care and why.**

  4. **Critical thinking-SBAR why was this patient receiving tube feeds? What was their current health state? Did vomiting after tube feeds happen often? When did the symptoms begin? What made it different from another similar experience that could have indicated the patient's body was shutting down? the respondents decision making was not appropriate . Without having being there to witness the situation, Its hard to tell If her attitude and presentation with the patient meant well and not with negative Intentions. We should never assume that a patient Is safe upon leaving them unless we are absolutely sure we've done everything In best practice to ensure safety and provide the best care possible.**

  5. **Documentation- the respondent failed to report the worsening symptoms to a HCP. For recommendations or even to ask for help with communicating the priority of why they need more help. This left the patient suffering In discomfort with the false hopes of the nurse being able to alleviate something.**

6. **Human caring- based off of the given Information she didn't treat the patient with respect and dignity. No matter how bad someone may feel, there Is always a way to create comfort for a patient no matter how big or small that may be. The respondent did not Involve the patient with their plan of care and do more teaching on signs and symptoms of how to recognize things may have gotten to a critical point. Spending more time with the patient could have provided more trust between patient and nurse, which could've led to more cooperation on both sides.**

- *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.*

Due to this situation not being In a hospital setting, nobody saw the actions or the treatment that the nurse gave to her patient. It was only discovered because the patient expired. Requiring further Information on the health status of the patient upon her arrival and departure. otherwise, It would have gone unnoticed. The nurse In good conscience should have at least contacted someone above her to follow up on what little Interventions she did take. The patient had to have other symptoms of death approaching such as decreased output, dark urine, was the patient putting out a strange odor? changes In respirations? Overcompensating? The coughing could have been mistaken for what may have been chain stoking, or caused by the "death rattle" collection of secretions In the throat, or maybe decreased oxygen saturation. Low O2 saturation could have altered the patients LOC and ability to understand the nurse, also causing confusion. The patient could have also appeared darker than normal for his race or cyanosis around the lips and darkening of the extremities. What about capillary refill? For the nurse to be able to be qualified enough to do a home visit to provide healthcare she should have used her better judgement on just laying eyes on her patient. I've only experienced two end of life situations as an unexperienced family member, and even I could tell when death was nearing. Someone with years of experience should know better. People do make mistakes everyday, we are human, this end result may not have been able to be prevented, but the awareness of expiration nearing could have been made should she have assessed more carefully. Maybe after being In healthcare for so long she was burned out and she didn't feel like providing best nursing practice. Unfortunately, It ended negatively for both her and the patient. My heart goes out to both this former nurse and the patient's family.

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