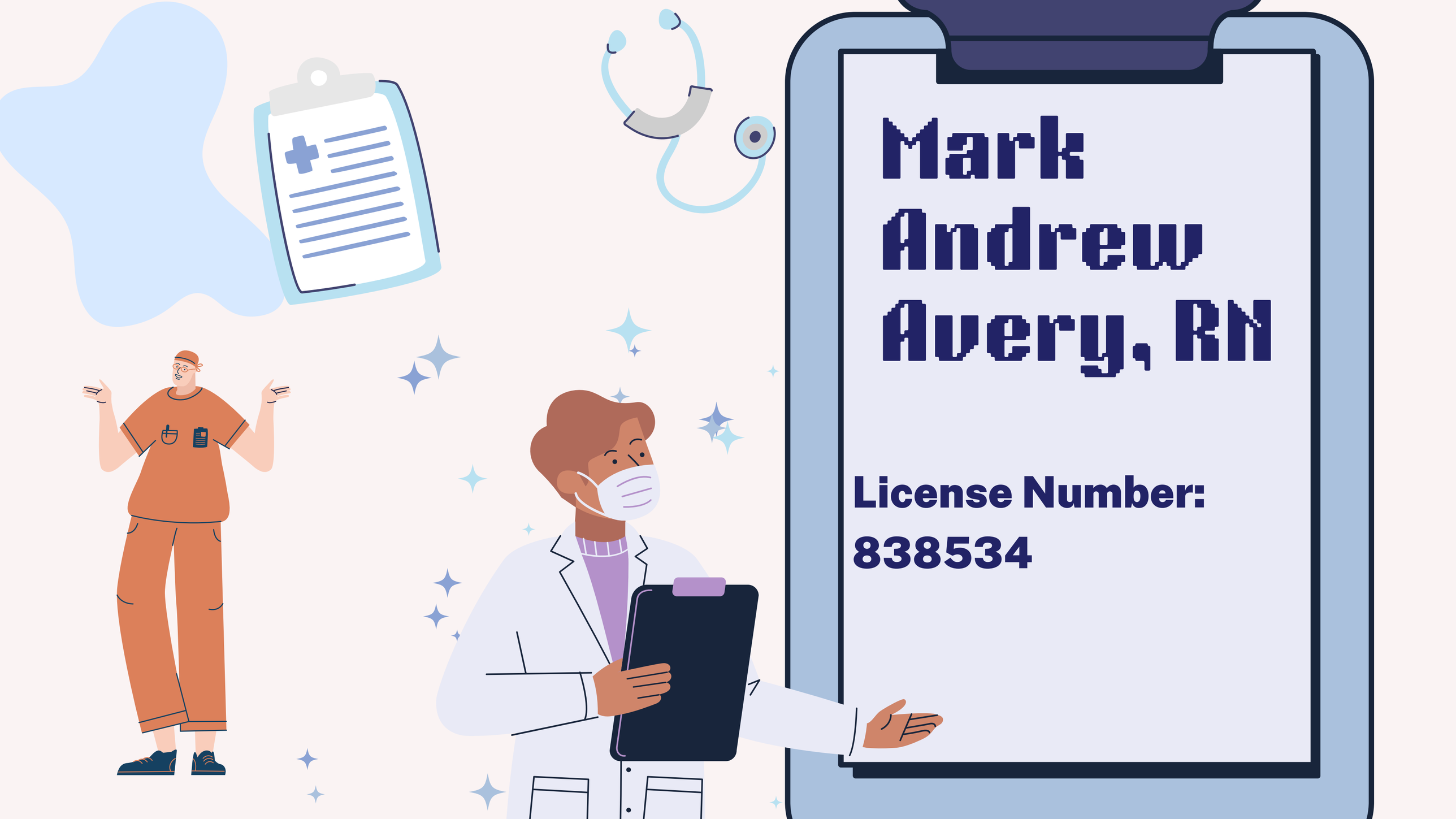
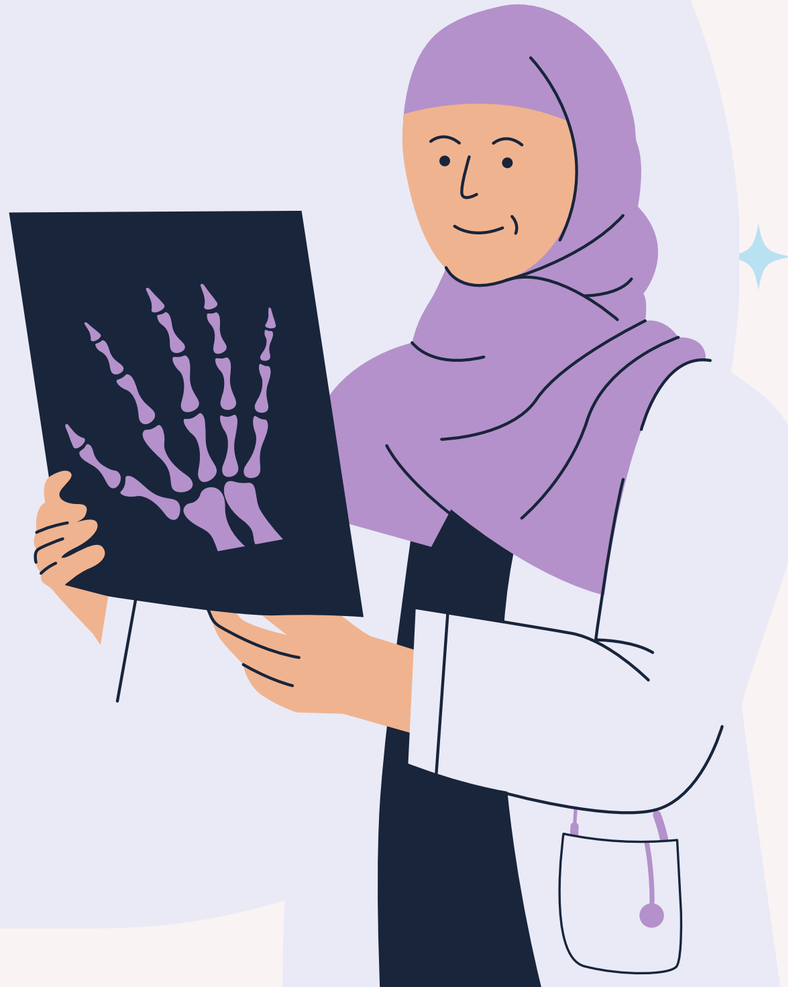
Magy Hernandez 04/11/2024

Disciplinary Action Summary


Mark
Andrew
Avery, RN
License Number:
838534

Warning with Stipulations 06-12-2018

Around December 25, 2016, Nurse Andrew was employed at Dell Children's Medical Center in Austin and did not document a Chlorhexidine gluconate bath. Two days later, the nurse failed to label a lab specimen, and when scanning the specimen, failed to realize there were two different patients and labeled both specimens with one patient's information.



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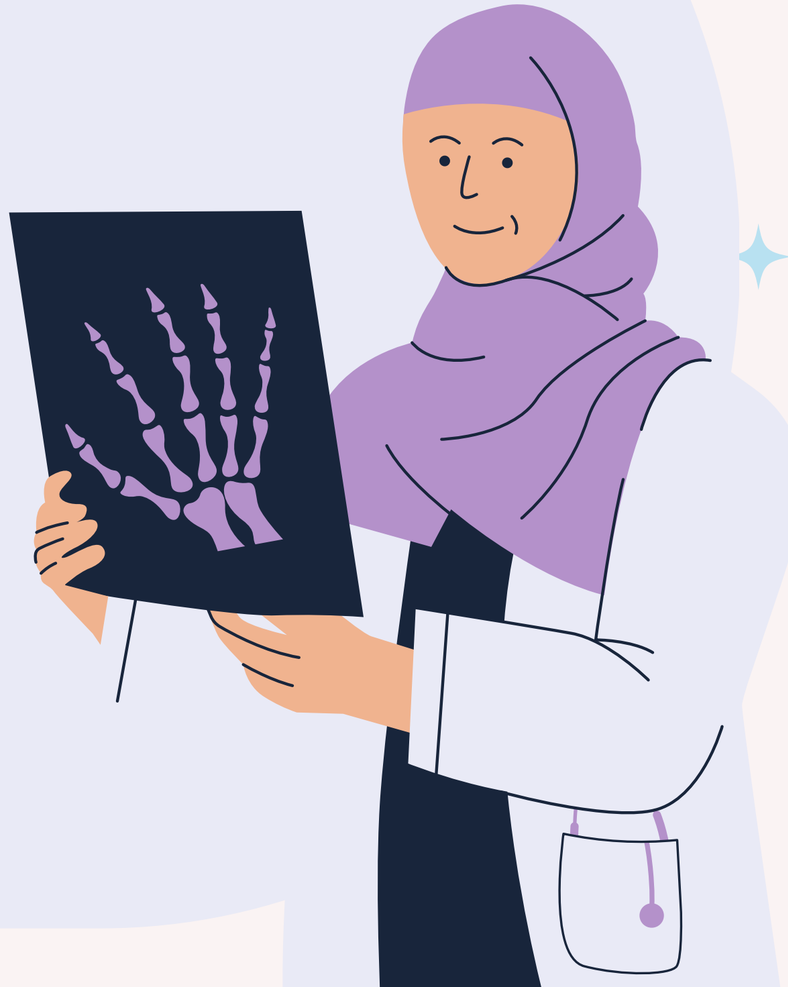
- March 29th, 2017, Andrew failed to administer IV immunoglobulin (IVIG) as ordered and did not follow up to ensure the IVIG was done as reported by the off-going nurse. When the IV pump began to beep, indicating the IVIG was completed, the nurse flushed the line, not realizing there was a mistake with the pump and it was not done infusing.
    - April 5, 2017, the nurse failed to document another CHG bath
    - May 9, 2017, Failed to administer Sinemet as ordered at 0400 and was noted in the MAR as “Rescheduled”.



Response

Nurse Andrew took responsibility for the errors, lack of attention, and follow up on his documentation. He also admitted that he did not know the IV pump was incorrect and confessed he did not administer the Sinemet as scheduled.

Measures to Prevent Action/ or Harm

Double checking all documentation has been completed at the end of the shift, or write down notes as you work.

ALWAYS check IV bags when in a room with a bag hanging.

Verify patient information before collecting specimens.

Universal Competencies

Safety and Security

The nurse failed to ID the patient and ask for 2 patient identifiers prior to collecting a specimen and putting a label on it.

Critical Thinking

Nurse Andrew decided not to administer a medication and document it as “Rescheduled”

Documentation

Two CHG baths were not documented, so this prevented the patients from getting proper care.

Professional Role

The nurse did not verify that the bag was completed prior to flushing the IV, although the IV pump said it was completed, failing to manage the equipment properly.

Human Caring

Andrew failed to listen to the patient’s needs when he did not give the medication the patient needed to help them feel comfortable.

How Would I React?

If I were to discover the incident, I would have asked the nurse why he had not given the medication yet, double-checked if he had documented everything he needed to, and let him know the bag had not finished infusing.

Thank you for your attention