

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Kindal King

August 17th, 2024

DAS #1

Defendant: Monica Ann Howe, RN

License Number:

609244

Date action was taken against the license: 5/8/2019

Type of action taken against the license: Voluntary Surrender

Events that Led to Action

- The defendant failed to elevate care and document appropriately for a patient who presented signs of sepsis. The patient was antepartum with pyelonephritis. The patient was hypotensive and tachycardic. The patient's vital signs were 78/37 mm Hg and pulse of 112 bpm; they were taken again resulting in 83/35 mm Hg and pulse of 124 bpm. The defendant did not document that the vitals were taken or notify the physician of the hypotension and tachycardia. Monica stated that she assessed the patient and the patient denied feeling any symptoms. Monica states there were no physical symptoms and the patient got up to use the restroom. Monica stated she failed to chart the vital signs and assessments because there were no physical symptoms. It was found 8 hours later that the patient was septic and needed transfer to an Intensive Care Unit.

Preventative Measures

- If Monica properly documented all assessments and notified the physician, there would be no need for disciplinary action. Medical intervention for the sepsis would have happened much sooner and the patient would have gone to the Intensive Care Unit sooner as well. She should not have dismissed the hypotension and tachycardia, even if the patient verbally stated they were not symptomatic and there were no physical symptoms. Everything must be documented, even if the nurse does not feel it 'significant'.

Violated Universal Competencies

- **Communication** failed when she did not report the decline to the physician or charge nurse. Signs of sepsis must be reported up the chain of command, especially to the reporting physician.

Critical thinking failed in every aspect. She dismissed the hypotension and tachycardia because she claims the patient did not have physical symptoms. She did not make the important decisions for medical intervention for sepsis, including elevation of care or contacting anyone to report the vital signs. She did not SBAR because she did not let the physician know of the decline at all. She failed in a proper assessment related to the patient's symptoms of hypotension, tachycardia, pyelonephritis, and being antepartum.

Documentation completely failed by not documenting anything. The declining blood pressure, increasing pulse, and physical assessment was not documented at all. Monica left no record of any signs of sepsis on the eMAR.

Professional Role was violated when she did not adhere to the policies of sepsis intervention and chain of command.

If I had discovered the events

- If I was the first person to discover these events, I would alert my charge nurse immediately. Knowing how dangerous sepsis is, I would act quickly and efficiently. I would call the patient's physician and tell them all the vital signs and details of what had transpired. If the charge nurse did not already, I would inform the House Supervisor to see what actions need to be taken next. I would ensure that Monica documented all the vital signs and assessments that were done. I would help in any way I could in medical intervention and transportation to the ICU. I would communicate with Monica the importance of documenting everything and the signs of sepsis.