



# DAS Presentation

Maame Forson    September 10, 2024

Imeda B.  
Beligon

RN611987

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On October 12, 2019,  
Beligon was employed in  
the ICU at the Memorial  
Hermann Greater Heights  
Hospital in Houston,  
Texas

In addition there  
was NO  
documentation that  
the Fentanyl was  
given or wasted.

She reported 2  
infusions from one  
bag from 1959 to  
2000 and 2 from  
one bag from 0359  
to 0400.

October 12  
2019

Charge 1

Charge 2

She incorrectly documented  
the administration of  
Fentanyl in the MAR. While  
her patient was on 20 mL of  
Fentanyl she withdrew 40  
mL, and only documented  
24 mL of Fentanyl.

Beligon also did NOT  
accurately document  
Midazolam in the MAR  
by double documenting  
the administration of the  
medication

# Measurement to prevent action

1. Reinforce eMAR training to ensure all staff are properly trained in using electronic systems for medical documentation
2. Having a clear policy on narcotics wasting, have the nurse document wastage and administration immediately
3. Check/test ICU staff on competency evaluation regarding administering narcotic drugs.
4. Having a non-punitive reporting environment, which encourages staff to report if they make a medication error so that the error can be corrected as soon as possible. Then addressing how that medical error occurred.

1. **Safety and Security:** the incorrect documentation of fentanyl and midazolam posed a high risk to patient safety. Could have been a possible overdose due to improper communication.
2. **Documentation:** double documenting displays a serious medical error that could harm the patient, and does not help the other nurses proper
3. **Communication:** A nurse's clear, accurate communication- both verbal and written is very important to ensuring accurate care.
4. **Professionalism:** healthcare professionals must adhere to ethical standards; which include accurate documentation and communication.
5. **Safety and Security:** inaccurate documentation could potentially reflect gaps in patient care and the quality of care the hospital administers.

## Discovered Incident

If I was the **first nurse** to be informed of the **discrepancies**, I would immediately **check on Beligon's patient**. Collect a **new set of vital signs** as well as **assessment and monitor** the patient. Well doing that I would **inform the charge nurse** about what I witnessed and the status of Beligon patients. I would then **cooperate with any investigation** needed and continue to check on the patient's care if possible.

THE END