



DAS Presentation

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1. On April 8, 2011, while working at Ben Taub general hospital in Houston, Gregorio failed to document an assessment regarding a patient that was transferred from another hospital with a decubitus ulcer on their right heel.
2. On August 2, 2011, while still employed in the same hospital, he administered a full dose of NPH (neutral protamine Hagedorn) insulin when he should have only given half a dose while the patient is NPO. This led to the patient becoming hypoglycemic with a blood sugar level of 59(70-100).

Events Leading to the action...



3. On October 24, 2011, still working at Ben Taub general hospital, he failed to assess, document, and intervene for the pt's MRN who was experiencing a hypotensive crisis. In response to these findings, he states that early morning the pt's BP dropped to the 70s. After intervention, he stated that he did not know about the patient's hypotension crisis and wasn't aware of patients VS. He admits his documentation error was due to him not documenting his follow-up.

**Events
Leading to
the action...**



Violation #1 – properly documenting patients assessment

Violation #2 – carefully reading the HCP's order and paying more attention to the medication that is being administered at the time, 3 checks?, being more present in the moment

Violation #3 – assess patients thoroughly, document properly so that other caregivers providing care, present or in the future, will be able to provide accurate care.

Measures to
prevent
action
and/or
harm...



Safety and Security was breached when the RN gave a full dose of NPH insulin instead of giving half a dose. This led to the patient becoming hypoglycemic and put the patient at risk of fall related injuries or worse, stroke or a coma.

Documentation was breached when the RN failed to document that his patient had a decubitus ulcer on his right heel.

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Communication was breached when the RN failed to assess, document and intervene for the patient that was experiencing a hypotensive crisis. This is a communication error due to the patient not having an up-to-date assessment which provides the wrong pt Hx to other caregivers.

Critical Thinking was breached in all 3 violations. #1-deprived the pt of detection and timely intervention, #2-decision making, #3-failed assessment to patients symptoms

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Professionals Role was breached when the RN failed to abide by his nursing practice/license.

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If I was the person to discover this events, I would immediately notify the charge nurse and the patient's PCP about the events that unfolded. I would discuss these events with Gregorio and work with him to minimize the mistakes that was committed. If he is still able to practice nursing, then I would suggest to him to go back to the "basics".

**How would
you react...**