Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Lawson Sullivan Date: 10/24/24 DAS Assignment # 1

Name of the defendant: Charlotte Elizabeth Cobb License number of the defendant: 991019

Date action was taken against the license: 01/25/2024

Type of action taken against the license: Probated Suspension

- *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.*

Essentially, the reason this nurse received these actions against their license is because they made egregious errors or was not critically thinking with this specific patient. The patient presented to their ER with hands swelling and behavioral issues. The respondent only did a visual examination of the patient's hands and put them in a waiting area. The nurse failed to do a proper focused assessment of the peripheral neurovascular system of the hands. The document stated that she did not do a capillary refill or radial pulse check. After she put the patient in the waiting area, she went ahead and falsely documented that the patient had, "normal circulation, palpable pulses, and a good capillary refill,". (DAS 99109, FOF 7, pg. 2) The nurse did not go to check on this patient again, after three hours went by, a doctor assessed the patient and determined that they needed surgery for bilateral fasciotomies.

In response to the TBON bringing this finding up to the nurse, the nurse states that the father had been previously instructed to wrap the hands to keep the kid from scratching himself. She goes on to state that after visual examination that she saw a little bit of swelling but since there was no outright discoloration she thought it was a short-term condition. She then goes to make excuses stating that the child had a habit of exhibiting outbursts and harming themself, so she did not want to wake them up. The nurse then says that there was no spot to address all the father's report into the charting system, so she just charts a narrative of the complaints underneath the "other" section of the eMAR.

Summarizing all of the actions the nurse performed that led to this charge against her license: Failure to Communicate with Patient and Family Member, Falsify Documentation, Inability to Utilize Resources to Enable Communication with Other Healthcare Staff, Failure to Properly Assess the Patient, Poor Decision Making (in reference to investigating the visible swollen hands or not. This could also apply to placing this patient in the waiting room even though they needed immediate attention), Lack of Human Caring (due to treating the child in a demeaning way, letting them sleep instead of performing a proper assessment), and I

could even argue that the interactions she has with the people involved reflects her professional role. The reason I say this is instead of accepting responsibility for her actions, she tries to pin it onto the charting system, the father, and even the previous person who instructed the father to wrap the kid's hands.

The previously stated actions this nurse performed could have impacted the child's health and quality of life drastically. The reason the doctor performed the bilateral fasciotomies was to relieve the child from Compartment Syndrome. Basically, Compartment Syndrome is a condition that manifests when too much pressure is built up in a certain muscle compartment, in this case, the hands. The buildup can limit blood flow and present with pain. This condition if not treated in a certain amount of time can lead to inability to use the affected extremity, contractures, and even death.

- *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.*

A lot of this could have been prevented if she performed a proper neurovascular focused assessment of the hands. She says that she did not know that the patient had these problems because of the wraps on the hand, but I mean she could have simply taken them off and performed a proper assessment. In the document it states that she only did a visual assessment and that's all. What I mean when I say proper neurovascular focused assessment of the hands is if she did the following: Assess the pain properly. She did not ask about the provocation, quality, if it was radiating, the severity (which should have been a part of vitals, but it was not stated if she did this during vitals or not), and the time frame of the pain. She did not assess the hands to find if they were poikilothermic or not. According to Elsevier's Osmosis (reference attached to reference page), poikilothermia and pallor is a sure-fire way to find out if the patient is experiencing Compartment Syndrome. She also should have assessed the patient's bilateral pulses and capillary refill. Just taking the extra time to assess this patient could have prevented a lot of this from happening.

Another thing I feel like could have helped both the nurse and the patient in this situation is if the nurse double-checked and asked a coworker if she was documenting her information in the correct spot. She argues that there was not a specific section for her to input this information into the eMAR, but I'm willing to bet that there might have been a way for her to communicate with the provider properly about the swollen hands. She may have even been able to prevent at least the patient's harm from happening if she simply stated she did not perform the assessment in the eMAR and stated why. Sure, she might have gotten reprimanded for not doing a proper assessment, but then she would not have gotten in trouble for falsifying documentation.

- *Identify ALL universal competencies were violated and explain how.*

The competencies that were violated were Communication, Documentation, Critical Thinking, Human Caring, and Professional Role

Communication was violated because the nurse did not properly communicate with the provider and team after finding the "minor swelling of the hands." She says that there was no box to input that information, however she still should have mentioned to the doctor that the patient did present with hand swelling since that is considered an abnormality. She also failed this by not ensuring with her team if she was putting her narrative in the right spot on the eMAR.

Documentation was violated because obviously she falsely documented her findings. She did not perform the capillary refill or radial pulse assessment. However, she still charted that the pulses were normal, and the capillary refill was good. She also improperly documented her narrative, placing it in the "other" section instead of finding a proper placement. She could have even been writing down the father's complaints and charted them into the computer after the father finished. This could have allowed her more time to focus on the father's report and finding where to put it into the eMAR later.

Critical Thinking was violated in a number of ways. She did not properly do the Assessment portion of the SBAR. The nurse stated the patient came to the hospital with a number of other complaints, however she should have understood that hand swelling is a physical abnormality that can be indicative of issues and conditions. She only did a visual examination of the hands, and not a very good one at that, since she left the hands wrapped according to her response. I'm guessing her line of thinking could have been that the person who instructed the father to wrap his hands should have done the assessment, however this was her patient. She should have done the proper focused assessment of the area, would have be able to identify all the other abnormalities aside from swelling like pallor and poikilothermia, and notified the doctor so an immediate intervention could have happened.

In turn, her poor focused assessment impacted her decision making which led to the patient having delayed medical interventions. The nurse stated she chose not to do a proper focused assessment because the patient was asleep, and instead placed them in a waiting area. I am unsure if the patient suffered consequences to the nurse's negligence. However, as I previously stated, untreated Compartment Syndrome could have negatively impacted this child's life forever. The quicker the patient could have been seen by the provider, the quicker the surgery would have happened.

Human Caring was violated because she did not treat the patient with respect or dignity. She stated she did not do the proper physical assessment because the child was asleep and prone to outbursts while awake. That to me shows that she was more worried about the outbursts she may have potentially experienced instead of the health and condition of the child. It seemed that she wanted to spend as little time with that patient as possible, which shows a lack of human empathy in healthcare.

Lastly, **Professional Role** was arguably violated. Maybe not at that specific event, but I feel like this was violated just from looking at her response to TBON bringing this whole situation to her. She stated that in that situation someone instructed the father to wrap the child's hands, blamed the charting system, and even justified her actions because of the child's previous outbursts. In her response, she did not seem to even once think that she made a mistake. I feel like not holding yourself accountable to your actions and blaming others for the mistakes you made is a huge violation of the professional role.

- *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.*

The first thing I would do if I was the nurse that discovered this was happening was report all false documentation to my charge nurse, going up the chain of command as needed. The next thing I would do would be to perform a focused assessment on the child's hands, as calmly and kindly as possible. If the child has an outburst, I would do my best to comfort them and let them know I am here to help with the pain in their hands.

Once I performed the assessment and found all abnormalities, not only would I chart them in the correct spots in the eMAR, but I would report those abnormalities to the doctor as well in the SBAR format. I would do anything the doctor asked me to do afterwards. I would provide cold packs to help minimize some of the pain the child was potentially suffering from. I would try to sit and talk with the father and child trying to find out any other way I can help while waiting for the patient to transfer to surgery. I would then show the nurse so that she would know for next time where to properly chart the information so that all of the healthcare staff can find that information effectively.

References:

Neurovascular Assessment, Lily Guo, Osmosis by Elsevier, https://www.osmosis.org/answers/neurovascular-assessment

Notice of Disciplinary Action 04/24, TBON, License #991019, https://www.bon.texas.gov/discipline_and_complaints_disciplinary_action_042024.asp.html