Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: **Alina Elizarraraz** Date: **10/30/24** DAS Assignment **# 2**

Name of the defendant: **Donavan Andrew Whitfield Jr.** License number of the defendant: **603295**

Date action was taken against the license: **February 10, 2017**

Type of action taken against the license: **Reprimand with Stipulations**

- *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.*

Whitfield had a few very important unprofessional action that fall under being unprofessional. Whitfield failed to note the physician when his patient had a clear change in condition, he failed to handle the alarms going off in a correct manner, and lastly he did not perform the basic life support that his patient clearly needed during his shift. These actions led to the patient not receiving the best possible care, and even a chance of leading his patient to death. This would not have been good because our job is to protect the patients, and ensure they feel well taken care of in the hospital.

One of our jobs as nurses is to report any change in condition to the primary physician. Whitfield failed to do this action, so that opens up the patient to so many more complications. It was also stated that the patient was a post operative patient which just shows hoe much more important his state of condition was. I do not know the extent of the surgery, but if it was something severe his status could be the most important job I do for the day.

Alarms are set up all throughout the hospital for a reason. These alarms are trying to get our attention because something needs to be done immediately most of the time. In this situation Whitfield heard the alarms going off because it showed up that he silenced them. Silencing the alarms was not the problem. The problem was that Whitfield did not take any action on why the alarms were going off. In this case it was because of the patients high respiratory rate and low oxygen rate. These vital signs are so important especially in a postoperative patient. The two vital signs that he chose to ignore dealt with the patients abc's (airways, breathing, and circulation), these should have been the nurse's priority in this situation.

Lastly, Whitfield failed to provide Basic Life Support to the patient. The patient had completely stopped breathing and became pulseless. It was stated that the patient had gone into respiratory and cardiac arrest. It is extremely dangerous and scary that Whitfield failed to take any action. The only way this patient was able to receive help was because another nurse had spotted the patient, and called a code.

The absence of Whitfield's actions throughout this patient's care caused a delay in their healing, and led to even a possible chance of death to the patient.

- *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.*

Whitfield failed to report changes in the patient's status to their primary physician. This could have been prevented in so many ways. Even if Whitfield felt like he had it "under control" he could have followed the hospital's guidelines correctly. I am sure there is somewhere in the guidelines that state that any change in a patient's condition should immediately be reported to the physician.

A way that ignoring the alarms could have been prevented was by not silencing them. The silence button is supposed to be there to help us out in stressful situations when we need quiet to think. Whitfield used this button inappropriately, and if he wanted to not do his job he should have allowed it to continue beeping. The continuous beeping would have gotten another nurses attention, and then maybe the patient would not have gone into respiratory and cardiac arrest.

I find it very off that the patient became unresponsive, and Whitfield still did not do anything to keep the patient alive. If you look we notice Whitfield had been a nurse for about 23 years. He clearly knew what needed to be done in this situation, so the fact that nothing was done by him himself is scary. If he did not have the correct mindset that day he should have put his patients first, and called into work. This could have prevented this whole mess.

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

<u>Safety & Security (emotional):</u> This universal competency was violated because Whitfield failed to provide that trust and respect with the patient. It seems pretty clear that he did not want to do his actual job, so it would make sense that he did not go out of his way to form this relationship with the patient. Patients go into the hospital putting their life into the healthcare workers hands, and that almost causes the patient to lose his life. This just shows no trust or respect was promoted.

<u>Communication:</u> This universal competency was violated because of the lack of communication between the nurse and the patient as well as the nurse and the physician. Communication is vital in the hospital. This provides trust with the patient, and allows them to feel more comfortable. Having good communication with your coworkers is just as important. There is nothing the physician could have done if the nurse never let them know anything was wrong. Communication should have been a necessity for the nurse, and he put it off way too much.

<u>Cristal Thinking:</u> As nurses we use Critical thinking in almost everything we do. It is important for us to prioritize our tasks and make decisions based on our patients' decisions. This help our patients stay safe, feel comfortable, and most importantly stay alive. Whitfield failed to do any Critical thinking on this shift, and it nearly ended his patients life. Seeing a low oxygen saturation should have been a priority, and like stated he failed to prioritize the task.

<u>Human Caring:</u> He violated this universal competency by not respecting the patient, not listening to the patients needs, and not involving the patient. The patient probably complained of SOB or maybe even felt extremely weak, but the nurse did not provide the human caring and take care of the patient.

- *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.*

If I was the first person to discover the nurse not reporting changes to the physician I would first talk to the nurse if it was not a life threatening change. Maybe the nurse accidentally missed it when assessing the patient, but I would let them know what I assess so that it could be reported to the physician.

If I was the first nurse to realize Whitfield was silencing the alarms and not taking care of the problem I would immediately fix the problem. In this cause it was increased respirations and a decreased oxygen saturation which are extremely important. These require immediate attention, so after dealing with that situation I would talk to our charge nurse and let them know what was happening. Then hopefully the charge nurse would take the steps needed to be taken.

Lastly failing to provide life support is so important. The care needed to be taken for the patient would be the first priority. At this point it was life or death for the patient, so I would do everything in my power to provide the care the patient deserves. Afterwards this would be immediately reported to the charge nurse, and hopefully the nurse would be taken off shift immediately.