

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Zakeia Brown

Date:10/30/24

DAS Assignment # 2_

Name of the defendant: Kay Ann Little, RN

License number of the defendant:658503

Date action was taken against the license: July 28, 2015

Type of action taken against the license: Revoked

- *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.*

The events that led to the actions of Kay, an RN-labor and delivery nurse, began with a series of critical oversights while working at two different hospitals. On August 22, 2010, she failed to document essential assessments accurately, particularly regarding the respiratory rate and lung sounds of a patient. This lack of documentation could have misled the physician in diagnosing the patient, resulting in an incomplete medical record that compromised patient care.

On September 2, 2010, her failure to notify the physician about the patient's Magnesium Sulfate level further exacerbated the situation. The patient was undergoing magnesium treatment, and without proper assessment, the patient's level, which was already therapeutic, was not communicated. This negligence resulted in the patient receiving a toxic dose, leading to severe complications, including pulmonary edema and nasal bleeding.

In another instance, she conducted a vaginal exam without consulting a physician, which raised the risk of infection for the patient. The most critical failure occurred on November 14, 2012, at Fort Duncan Regional Medical Center, where she did not call the rapid response team for a patient experiencing hypotension after a C-section delivery of twins. The patient began to bleed profusely and required immediate surgical intervention, but tragically, she died on the operating table. These actions collectively exposed patients to significant harm, increasing the risk of injury, complications, infections, 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.*

To prevent adverse outcomes, she could have taken proactive steps, such as completing a thorough assessment of the patient's condition, documenting her findings, and promptly reporting them to the physician. Proper documentation in the patient's medical records would have ensured that all relevant information was available to the entire medical team, supporting more coordinated and informed care. Additionally, by revisiting the patient's lab results and verifying magnesium levels before administering treatment, she could have avoided the risk of a non-therapeutic outcome.

During her examination, consulting with the physician immediately afterward would have allowed the medical team to understand the patient's status in real-time and plan accordingly. Effective communication with the physician ensures that all healthcare providers know what they may encounter, which is crucial for prompt and accurate interventions. In this case, her failure to follow up with the physician after the assessment may have contributed to a lack of timely support.

Finally, had she strictly adhered to protocols and called the rapid response team as soon as she noticed the patient's hypotension post-C-section, the critical decline might have been avoided. Alerting the surgical team and rapid response would have provided the necessary support to manage the emergency effectively. The tragic outcome where now these babies are motherless, it could have potentially been prevented with swift action and strict adherence to established protocols.

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

Standard Precaution: Using special precaution. Calling the rapid response team as soon as she notices the lady had complications after having twins. Following the hospital protocols would've ensured the patients life possibly

Communication: not giving the physician the correct information when patient was administered magnesium and caused her to have toxic levels in her system.

Critical Thinking: giving an SBAR would've helped her give information to the physician correctly. Assessment related to patients' symptoms. She did not assess the lung sounds and respiratory rate which lead to pulmonary edema.

Documentation: not documenting what assessments were taking. She

- *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 were the first person to witness these events, I would immediately approach her to understand what she was doing and offer my assistance. It's crucial to ensure that the patients are always in good hands, even if it means risking a disagreement with the nurse. Prioritizing patient care is paramount, and sometimes it requires stepping in to address potential issues directly.

Next, I would inform the charge nurse about my concerns and request her to review the situation. As nurses, our primary responsibility is to advocate for our patients, especially when they cannot advocate for themselves. Ensuring that the charge nurse is aware of the situation allows for a thorough investigation and appropriate action to be taken if necessary.

Finally, I would review the hospital's protocols to ensure that patients receive the proper care they need. If the nurse in question is dealing with personal issues, it's important to see how we, as a workplace, can support her. Providing assistance and understanding can help maintain a positive work environment and ensure that all patients receive the best possible care.