

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Kaitlyn Foster

1/15/2025

DAS Assignment #1

NOTICE OF DISCIPLINARY ACTION: 0/0939759/0:291

Defendant: Lorena Cantor Hamilton

RN # of Defendant: 939759

License: Registered Nurse

Date Action Taken Against License: January 19, 2023

Type of Action Taken Against License: Warning With Stipulations

On May 17, 2021, Lorena Cantor Hamilton failed to document several things pertaining to her patient's postoperative care, therefore putting her patient at risk. The patient had undergone surgery that day, and Lorena did not notify the physician that the patient's vitals were elevated. The patient's heart rate was in the range of 130-140 and was experiencing tachycardia. Along with this, the patient's blood pressure was decreasing, as well as hemoglobin levels dropping from 12.8 to 8.8, all of which was not reported to the physician by Lorena Hamilton. Lastly, the nurse failed to document her administration of fluids, intravenously. These mistakes led to the incompleteness and inaccuracy of this particular patient's records, therefore leading to possible mistakes in their future care.

In response, Lorena stated that the patient had been encountering an elevated heart rate since being transported from the Post-Anesthesia Care Unit. The respondent also gave further insight into the patient's condition - the patient presented with a speech deficit, contractions in all peripheral extremities, and required total assistance with incontinence care/moving in the bed throughout several bowel movements. The patient was also experiencing a severe amount of pain and discomfort. The respondent stated that their belief was that the patient's pain was of higher importance than their abnormal vitals.

As a result of this care, Lorena Cantor Hamilton was found responsible for the actions listed in this case and was ordered to complete a remedial education course within thirty days of the entry of the order. The respondent was also ordered to complete additional education within one year of the date the order went into effect. The education order is meant to help improve

critical thinking skills, as well as re-educate individuals of policies regarding documentation and ethics.

I think this incident could have been avoided entirely if the nurse had remembered the policy for when a patient returns from a procedure. It is policy to check a patient's vitals every 15 minutes for the first hour after returning, every 30 minutes for the hour after that, followed by two hourly checks. Especially with a patient who's vitals are already out of normal range when returning to their room, the patient should have been flagged for the nurse as someone who needs to be checked on frequently. Because the nurse stated she was spending time in the room regardless, because she stated he had to be moved/cleaned frequently, this would have been an ideal time for her to perform an assessment, including taking postoperative vitals. Also, if the nurse would have remembered the importance of documenting accurately, she wouldn't have failed to document her administration of fluids. By doing these things, the nurse could have prevented putting her patient at risk of injury or medication errors.

Several universal competencies were broken by this nurse throughout this incident. The first one being documentation. The nurse broke this patient right because they did not keep an accurate record of their actions involving the patient, nor the patient's status after their procedure. The next competency that was broken was communication. Because the nurse did not document accurately, critical information regarding the patient was not passed on to the next shift, and so on. Therefore, the nurse broke the chain of communication, putting her patient at risk. Lastly, the nurse broke the competency of proper critical thinking. If the nurse had kept the policies and standards of nursing in mind throughout her care, these errors could have been prevented. This is why retraining and improving this nurse's critical thinking skills is necessary.

If I was the person to first discover what this nurse was doing, I would immediately take a set of vitals on the patients and notify the charge nurse, as well as the physicians in charge of this patient, so that first and foremost more individuals can be aware of the situation and be involved in mending it. I would then have a conversation with the nurse assigned to the patient and see what their thought process on the situation was. I would remind them of the importance of hitting each and every universal competency during patient care.