Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Sydney Sharp   Date: 10/01/2020   DAS Assignment # 1

Name of the defendant: Stephanie L Allen   License number of the defendant: 620556

Date action was taken against the license: 11/13/2018

Type of action taken against the license: Suspension

Respondent failed to notify the physician or call Rapid Response Team when their patient had significant changes in blood pressure. The Respondent deprived the patient medical treatment by not allowing the physician to provide interventions to stabilize the patient. These actions may have contributed to the patient's death.

The respondent failed to assess their patient when the patient was found without a pulse or respirations. The respondent also failed to document findings, this behavior not only created an incomplete medical record but injured the patient because the progressing complications were left undetected.

The respondent failed to initiate cardiopulmonary resuscitation (CPR) when the patient was found without a pulse or respirations. The respondent pronounced the patient as deceased. The respondent's behavior withheld the patient from resuscitation, this may have contributed to the patient's death.

The respondent stated that she manually checked blood pressure and the aid documented the patient's reading of 87/37. The respondent considered 90's/60's to be a normal finding for the "sedated, sleepy patient". Respondent stated that she was told in report that the patient came from hospice with a Do Not Resuscitate (DNR) which is why she did not initiate CPR.

I believe that all of the outcomes in this disciplinary action could have been prevented if the respondent had performed appropriate nursing interventions and assessments. You take vitals for a reason, you perform assessments for a reason and you document for a reason. When the respondent measured the patient's blood pressure and received the reading of 87/37, they then should have referred to the patient's medical record to determine the normal range for the patient. This action allows the respondent to personalize the patient care. After determining that the blood pressure was low, respondent could have performed a cardiac assessment. This step would have helped give a proper report to the physician using elements of SBAR. Not notifying the physician was a major step that was overlooked and could have made this case have a different outcome. By overlooking the progressing clinical complications, the respondent was not advocating for their patient. The patient was later found to have no pulse or respirations and the respondent did not perform critical elements of her job to intervene. The respondent declared the patient deceased instead. The action states that the respondent was told that the patient was a DNR, this is important information that should have been confirmed

by looking at the patient's medical record. The respondent should have gotten to know the patient and their wishes, confirmed with their medical record and then documented. This disciplinary action is a prime example of how little steps in nursing interventions cannot be over looked.

A prudent nurse would have been an advocate for the patient in this situation. Once they have learned there was a low blood pressure reading, the practical thing to do would be to take it again or notify your charge nurse that the patient had low blood pressure out of normal ranges. If there was a patient on the floor that was believed to be DNR, thats a very important detail that should be confirmed upon the patient's admission. The second situation in this action was not initiating CPR properly. If I walked into a patient's room and discover there is no pulse or respirations, I'm calling the Rapid Response Team and starting CPR. In this situation, I would have confirmed with the nurse if it was a DNR, and if not I would have called a code and started CPR. A prudent nurse would have been a patient advocate, that was not the case in this disciplinary action.