Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Alec Reyes Date: 01-4-21 DAS Assignment # 4

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: Suspend/Probate

On September 22, 2017, Ms. Allen failed to act accordingly to a patient that coded and her lack in initiating CPR led to patients' demise. Ms. Allen ignored the drop in the patients' blood pressure which was taken by the nurse assistant that stated it was at, 86/37, which Ms. Allen said, "a normal finding for sedated, sleepy patient". She also failed to start CPR or call the Rapid Response team when she found the patient not having a pulse or respirations. Ms. Allen claimed that she did not start CPR or call Rapid Response because when receiving report from the patient she was notified that the patient is coming from Hospice and has a DNR.

The response that could have avoided the suspended license of Ms. Allen, is to notify the Physician, charger nurse of the findings of her patient as soon as she recorded these findings. At that point the Physician or Charge Nurse could've notified her that the patient has a DNR in their Medical Records, so there isn't a need to activate Rapid Response, but to make sure the patient is comfortable as much as possible. This simple action of communication could've saved her license from any repercussions.

The actions that I would've taken is quickly check the patient's vitals again and make sure that the findings were correct. Then I would, call the physician and notify the charge nurse of the findings. At that point they can notify me that the patient has DNR on their Medical Record and will not need CPR. The key in this case is that the nurse neglected to respond or communicate with her co-workers about the deterioration of the patient's health.