Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Gabby Barrientes Date: 11/4/2022 DAS Assignment # ____2___ (1-4)

Name of the defendant: Joy Sylvia Stephenson License number of the defendant: 795621

Date action was taken against the license: 12/8/2020
Type of action taken against the license: Reprimand with Stipulations

Stephenson was a Registered Nurse at Harris Health Systems where she had her event occur. Stephenson's offense was leaving a patient unattended while waiting for an MRI. The event escalated when the patient started having multiple things going wrong, such as slow breathing, a weak pulse, and even the patient's fistula started to bleed on the site. A code blue was then called but the rapid response team was not able to resuscitate the patient. The reason Stephenson was not present when all other events occurred was because of her worrying about the other patients she had left in the unit and to check on patients who were receiving blood. Stephenson knew of this patient's current status of stroke-like symptoms but all tests were coming back negative and the patient was stable.

Stephenson had other patients to care for, but also she did not take into considerations the priority of the current patient at hand status. The patient that Stephenson went to go see while leaving her other patient unattended could have waited, they were receiving a blood infusion and Stephenson went up there for 5 minutes to check on her. Stephenson could have easily used her viscera and asked a colleague to go check on her other patient receiving blood, while staying with her more prioritized patient that was going in for an MRI due to stroke-like symptoms. The patient was receiving an MRI because the family had noticed a facial droop on the patient, but the MRI had a 10 minute wait. Stephenson should have never left her patient by herself in those conditions she was in. The patient's symptoms became life changing in the 5 minutes Stephenson reported she was gone, but those 5 minutes were critical to that patient's life and outcome. The universal competency violated here is Critical thinking because Stephenson did not prioritize her tasks/procedures in a matter of life or death. Furthermore, Stephenson did not assess the patient's symptoms. If she would've done the proper evaluation, she would have caught these symptoms sooner that ultimately cost this patient their life.

As a prudent nurse, I would have told Stephenson to go ahead and stay with her patient as she was waiting for the MRI while I go check on her other patient receiving the blood infusion. I

would have told Stephenson that her patient was fine when I came back, and maybe the other patient would have gotten the correct medical attention that she needed. The code blue would have been called faster, and so would the rapid response team. The end outcome may have turned into a patient that is still alive today, if it wasn't for the Stepheson thinking she could do it all, instead of using a coworker's help.