# Covenant School of Nursing

## Disciplinary Action Summary Assignment

## Instructional Module 2

Student Name: Ashley Gatica Date: 1/25/2025 DAS Assignment #2_

Name of the defendant: Barbara Metichi Atemba License number of the defendant: 1040588

Date(s) and action(s) taken against the license: 10/19/2023

Type of action(s) taken against the license: Reprimand with Stipulations

- *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 each of them, e.g. drug diversion, HIPAA violation, abandonment, etc.*

  While employed as a registered nurse at HCA Houston Healthcare West, Barbara Metichi Atemba was responsible for ensuring that a patient receives an urgent computerized tomography (CT scan). The respondent failed to provide the patient with the care in a timely manner. Although the respondent stated that the physician ordered the CT scan, she claimed that the patient was too critical to be transported for imaging. She also stated that she did relay this information to the CT department yet failed to notify the ordering physician of the changes in the patient's condition. The nurse subsequently delayed the CT scan for over sixteen hours resulting in an increase in hemorrhaging in the patient. Although the nurse made a clinical judgement to delay transporting the patient, she failed to follow protocols that could have prevented the progression of the patients' diagnoses and caused further damage that could have been irreversible.

- *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.*

- There are several actions that the respondent could have done to prevent harm to the patient. Most importantly communication. Patient safety should have been her priority. While she may have thought stabilizing the patient was the proper intervention, it was not the best way to oversee the situation. Improved communication and clear communication protocols between the nurse, the imaging department or her charge nurse is an essential necessity to ensure these problems get resolved. Better guidelines set in place by the hospital could have prevented further damage to the patient. They could use a tier system listing severity levels and what order of steps are needed in such situations. Maybe have a tracking system in the electronic medical records, sending an alert when procedures, labs or radiology services have not been completed. Similar to an alarm that we set up on our phones, a pop-up that does not go away until it has been documented with time stamps and or results being uploaded to the EMAR. It is easy to forget that the nurse has several patients at one time and so maybe it just slipped her mind, she thought by notifying the CT team that it would be sufficient in delaying the

process. Circumstances such as this is why it is extremely important to adhere to policies and procedures to avoid catastrophic outcomes.

- *Identify ALL universal competencies (4-5) that were violated and explain how.*

  ***Safety and security** were violated when the nurse failed to transfer the patient to their procedure in a timely manner. Putting the patient at risk for further complications and ignoring protocols that are in place.*

  ***Communication** was the respondent's biggest violation. Communication with the healthcare team is a crucial factor ensuring that the patient's safety is the number one priority. Although the nurse had her reasons for delaying the procedure, she compromised the well-being and safety of the patient. With appropriate coordination the healthcare team could have treated the patient in a timely manner.*

  ***Critical Thinking** was a factor in the patient's outcome as well. The nurse did not respond appropriately to the severity of the patient's condition. Although nurses are there to assess all aspects of a patient's condition and treat accordingly, this nurse assumed the patient's critical condition outweighed the urgency of the CT scan, leading to dangerous complications for the patient.*

  ***Professional Role**, the nurse has a responsibility to care for the patient's safety and quality of life. The nurse was responsible for taking the appropriate actions to keep the patient stable, in which it does seem as though that was her primary concern, she failed to communicate that with the physician. Which caused a violation in standards and professional care.*

- *Use the space below to describe what actions 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 find out about what the nurse had done, I would ensure that the patient was stable and send the patient to the CT department immediately. I would report to the charge nurse and physician and follow the chain of command as deemed fit. I would document my findings in the EMAR, and make sure to have a witness present as well as documenting any discrepancies and assessments that I observed. I would then approach the respondent to get a better understanding of why she waited to send the patient for imaging and ask what care she provided for the patient while they were being treated during her care. I would try to be sympathetic with her, I understand that sometimes it gets hectic but just try to reiterate the importance of slowing down and following the proper protocols.*

**Texas Board of Nursing.** “Discipline & Complaints.”, *Texas Board of Nursing* Texas Board of Nursing - Discipline & Complaints. Accessed 1/31/2025.

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