

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Renee Hall

Date: 01/15/2024

DAS Assignment #   1  

Name of the defendant: Arnold Robert AC Abernathy, RN License number of the defendant: 679042

Date action was taken against the license: 10/30/2019.

Type of action 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 them, e.g., drug diversion, HIPAA violation, abandonment, forfeiture on student loans, etc.**

Around April 11, 2018, the defendant (RN) was working on the Behavioral Management Treatment floor and did not properly perform a full assessment and document the assessment findings of the patient. The RN also falsified the patient's behavior and response shown toward the restraint release assessment. The defendant's failure to document and assess correctly resulted in an inaccurate medical record and could've injured the patient. (Pg. 2 point 7)

- Around April 11, 2018, the defendant (RN) was working on the Behavioral Management Treatment floor did induce neglect towards the patient by enabling the transportation of the patient from their quiet room without a proper assessment to find if this was the correct and proper decision. The RN was unsuccessful in making sure the patient stayed a 1:1 continuous observation. Due to the defendant not making sure that the patient was awake, the RN exposed the patient to needless risk to harm in that failure, resulted in the patient not getting the care he deserved. (Pg. 2 point 8)
- After the points (7 and 8), the defendant (RN) states "Being a nurse he cannot stress the importance of accurate and timely communication between caregivers." The RN also says, "False information given to a caregiver can lead to delay of patient treatment and possibly and adverse effect." When the patient was released, the defendant delegated the "PNA RR" to remain with the patient until he wakes up and if so help him to his bed area. The RN knew that the "PNA RR" was delegated to the 1:1 observation patient and the "PNA RR" should have stayed with the patient to see until he woke up so the RN could re-assess. The defendant did not know that the "PNA RR" left the room and did not stay with the 1:1 observation patient, the "PNA RR" shut the door and the patient could not be viewed by the staff of the floor. The defendant states that "at no time was he notified that the client was in distress." When the RN was told that the patient was asleep, he assessed the patient and proclaimed that the patient was showing no signs of distress. RN said that "he was unaware that the client had been asleep for one hour prior to the time he released him." (Pg. 2 point 9)

- **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.**

- The measures that could have been performed to avoid the actions that had on the defendant should have been to go into his patient room and do the assessment needed for the patient before he was released to make sure that the patient was able to leave that floor. The RN should have documented what was going on with his patient instead of documenting falsely and putting the patient in a substantial risk of getting injured due to his lack of assessing and falsifying documentation.

- **Identify ALL universal competencies were violated and explain how.**

- The competencies that were violated were:
  - o Critical Thinking was violated by the RN not doing an assessment on his patient before being released.
  - o Documentation was violated by the RN falsifying his documentation on the patient's behavior and the patient's response toward the restraint release assessment.
  - o Professional Role was violated by the RN not going into the patient's room when he noticed the door was shut and not staying with the 1:1 observation patient.

- **Use the space below to describe what action 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 discovered the patient or found out what the RN had been doing (not an assessment and falsifying documentation), I would go to the manager of the floor and tell them what I had seen, and that the RN could have harmed a patient.