

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student name: Hanna Wells
Date: 10/16/2024
DAS Assignment: #1

NOTICE OF DISCIPLINARY ACTION – 12/2018

Name of defendant: Patricia Sibley Anthony
License number of the defendant: 714398

Date action was taken against the license: 07/2019

Type of action against the license: Probated suspension

Patricia Anthony had multiple untimely, unprofessional interventions that included lack of assessments, lack of communication, and lack of human care to the patient, which ultimately led to a probated suspension and eventually a voluntary surrender of license. The respondents actions resulted in a delay in emergency medical attention which was needed to prevent further complications with the patient.

Patricia Anthony was working as a case manager for a home and community service provider and sent an LVN to assess the patient who was reported of having continuous coughing and congestions, a BP of 130/110, pulse of 62, and was profusely sweating and had “funny breathing.” The case manager told the sister of the patient “that if she was concerned about him then she needs to take him to the ER herself.” She instructed the LVn to not call 911 in fear of causing patient distress, but by delaying medical attention she caused further complications for the patient that eventually led to his death after being admitted to the ICU.

It was also reported that Patricia Anthony did not schedule timely physician evaluations from the given dates (December 22-December 29). By not considering the patient's vitals signs, signs/symptoms of coughing, and overall patient needs, the respondent had put the patient in harm.

There were multiple actions that could have been implemented that would have ensured the safety and security of the patient. The first step that could have been implemented was ensuring a physician evaluation for the patient, that way the doctor could have given new medications, a larger dose, or other methods that the doctor could have addressed directly. The second action that could have been taken was ensuring timely assessments and evaluations of the patient. Seeing that she was in charge of the LVN who was sent to assess the patient, she did not communicate with her staff properly to ensure timely interventions. Finally, she could have had the LVN call 911 and take the patient to the ER within a timely manner. If he had been seen by the healthcare staff in a quicker manner, then this might have kept the patient from developing pneumonia, and sepsis and kept him from being admitted to the ICU. All of these actions could have been taken in order to prevent the death of this patient.

Universal competencies violated: Safety and Security (physical), Communication, Critical Thinking, Human Caring, and Professional role.

Safety and Security (Physical) was violated when the respondent was untimely about assessing the patient, or sending staff to assess the patient. Respondent's conduct was likely to injure the patient in that the patient's respiratory status changed dramatically due to an untimely intervention

Communication was violated by the RN due to being told numerous times from different staff members about the patient's status, and failed to set up proper evaluations with the physician, as requested by the patient's sister who was responsible for him. The respondent also failed to notify the correct party about transferring the patient to the ER by not telling the LVN present to call 911, and instead had the sister of the patient bring him to the ER.

Critical Thinking was violated by the RN because she did not prioritize the patient regarding his signs and symptoms of diaphoresis and abnormal BP. Along with the patient's declining vital signs, the respondent failed to evaluate, intervene and assess for the patient's previous cough and congestion that had been a previous concern for many days at this point. The lack of intervention was likely to injure the patient, which led up to his transfer to the ER.

Human Caring was violated when the respondent failed to listen to the needs of the patient by not ensuring timely physical evaluations, not ensuring timely assessments, and did not ensure proper transportation to the ER, which led to the patient declining.

Professional role was violated when the RN had a lack of interactions between staff, and the physician when it was her job to provide proper care and physician evaluations which likely led to the cause of harm and declination of the patient.

If I had been the nurse who discovered the patient I would have called 911, instead of allowing the sister of the patient to bring him to the ER. Looking at the patient's vitals and considering his continuous cough, he needed immediate medical attention. I also would have tried to contact the doctor myself and give the physician information about the patient's vital signs to see what route of action the physician would have wanted to take. Seeing that the patient was at home, it was impertinent that the patient got immediate medical action. I also would have brought the respondents actions and lack of attention to someone higher up the chain, whether that be the charge nurse, CFO or the state board if I saw no results, seeing as that the RNs actions may have led to the death of this patient.