

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Nikkita Moreno

Date: 10/25/24

DAS Assignment # 1

NOTICE OF DISCIPLINARY ACTION — 10/2020

Name of the defendant: Susan Dawn Ferguson, RN

License number of the defendant: 789084

Date action was taken against the license: June 9, 2020

Type of action taken against the license: Revoked

- ***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.***

On November 28th to November 29th, 2019, Susan Dawn Ferguson, RN, performed a series of unprofessional and negligent actions that resulted in the defendant's license being revoked. These actions included: failure to notify physician of significant change in patient's condition, failure to assess vital signs and perform assessment after patient experienced multiple falls, and failure to respect patient's right to self determination. The defendant's actions led to harm, and ultimately, left the patient unresponsive and in respiratory distress. The defendant's failure to assess the patient and report their condition to the physician prevented the patient from receiving timely interventions to stabilize their condition.

The nurse failed to follow basic protocol when a patient experiences a significant change in condition, whether a major decline or improvement. The patient was presenting signs of a decline in mental status (confusion, agitation, yelling for help) and physical condition (multiple falls). The nurse was responsible for notifying the physician and implementing nursing interventions to stabilize the patient's condition. The patient's change in mental status was a sign that something was wrong, and if the nurse would have reported it, the physician would have been able to implement medical interventions to improve the patient's condition.

The nurse did not implement interventions associated with a fall risk to protect her patient from falling, and the legal document states the patient experienced "multiple falls." Following the last fall, the nurse acted negligently and left the patient on the floor with a pillow and blanket. This is unsanitary and puts the patient at risk for infection, as the floors of health care facilities are often contaminated with bacteria and pathogens. The nurse failed to treat the patient with respect, dignity, and compassion by leaving them on the floor. The nurse assessed for injuries and provided incontinence care, so she assessed the situation, and deliberately made the decision to leave the patient on the floor; this is neglect.

The nurse did not assess the patient's vital signs, after the patient was found on the floor. The nurse should have assessed vital signs, as they could be a clue for possible causes of the fall. Assessing the

patient's vital signs could also provide early detection of serious injury as a result of the fall. Vital signs can help guide the nurse and physician in deciding what actions, testing, and course of treatment to pursue regarding the patient's health.

The nurse had the responsibility of respecting and promoting the patient's right to self-determination. Despite the knowledge of a signed DNR, the nurse chose to perform CPR when the patient was found unresponsive and in respiratory distress an hour and forty minutes after she left the patient on the floor. She denied the patient the right to make decisions regarding their medical care.

- ***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 multiple measures that could have prevented action being taken against the nurse's license and would have prevented harm to the patient. First off, the nurse could have notified the physician of the patient's change in mental status and the patient's fall. The nurse then could have implemented fall precautions to ensure the patient remained safe. Although the exact situation is unknown, the nurse could have implemented a sitter to ensure the patient's safety and prevent subsequent falls after the first incident.

Obtaining the patient's vital signs and assessing respiratory status might have indicated the patient needed interventions to prevent respiratory arrest. The nurse might have found rapid breathing or low oxygen saturation that could have been addressed prior to respiratory arrest. The nurse might have found factors influencing frequent falls, such as low blood pressure. The patient's decline in mental status could have been directly related to a decline in oxygen saturation. Whatever the situation was, the patient's vital signs should have been obtained to help the nurse assess the situation, diagnose, and implement interventions to improve the patient's condition.

The patient and their choices should have been treated with respect. The patient should have been placed back in bed and instead of being left on the floor. The nurse should have checked on the patient sooner than an hour and forty minutes after the fall; she should have gone back in 15 - 30 minutes later, if not sooner. The patient's DNR wishes should have been respected.

Overall, the nurse could have simply cared. Every action taken by Susan Dawn Ferguson depicts a lack of caring. She did not care for the patient's well being and she did not care to take the appropriate actions to ensure the patient's safety. The nurses' actions lack compassion and competence.

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

Safety and Security was violated when the nurse left the patient on the floor following a fall. The fall bundle and other precautions could have been implemented to ensure patient safety and security.

Standard Precautions was violated when the nurse allowed the patient to remain on the floor and provided incontinence care on the floor. Although it is not necessarily standard precautions, it is unsanitary to have the patient on the floor and to provide hygiene care on the floor.

Communication was violated when the nurse did not utilize resources to enable communication consistent with agency policies. The nurse did not contact the physician when the patient experienced a significant change in condition.

Critical Thinking was violated when the nurse decided to leave the patient on the floor, did not check on the patient sooner than an hour and forty minutes, did not assess vital signs, did not do focused assessment related to patient symptoms.

Human Caring was violated when the nurse did not treat the patient, and their wishes, with respect and dignity. The nurse performed CPR despite the patient's signed DNR. The nurse did not listen to the patient's needs when the patient was yelling for help.

Professional role was violated when the nurse disregarded all aspects of a registered nurse license. The nurse failed to provide patient care and failed to communicate with the physician.

- ***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 was the first person to discover the patient after the nurse left them on the floor, I would have reported it to the charge nurse and ensured the physician was notified of the patient's condition. I would have helped the patient into bed and performed vital signs, a respiratory assessment, and a neuro assessment based on the patient's signs and symptoms. I would have implemented interventions to prevent respiratory distress; such as, sitting HOB up and starting the patient on oxygen. I would assess for other injuries, ensure all the patients' needs were met, and I would have implemented fall precautions and a sitter to ensure the patients safety.