

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Brock Fitzgerald

Date: 4/4/2025

DAS Assignment #1

Name of the defendant: Susan Dawn Ferguson, RN License number of the defendant: 789084

Date(s) and BON decision(s) taken against the license: 6/9/2020

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

Susan Ferguson committed multiple infractions against professional and state codes during her employment as a registered nurse at Senior Care of Western Hills located in Temple, Texas. The date(s) these offenses were committed was on or about November 28, through November 29, 2019, due to the negligence of Susan Ferguson the timeline is ambiguous between these dates. Three formal charges were accrued and implemented against Susan Ferguson. The charges go as follows: **Charge 1**, failed to notify a health care provider of a serious change in the status of a patient, the patient became agitated and confused (neurological change), this resulted in injury of the patient, who fell several times (this violated Section 301.452(b)(10)&(13), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.11 (1)(A),(1)(B),(1)(M)&(1)(P), and 22 TEX. ADMIN. CODE §217.12 (1)(A),(1)(B)&(4)), **Charge 2**, failed to assess any vital signs of the patient after falling at 0100 (11/29/19), Susan Ferguson left the patient lying on the floor until staff observed the patient in question, unresponsive and experiencing respiratory distress at 0240 (11/29/19) (this violated Section 301.452(b)(10)&(13), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.11 (1)(A),(1)(B), (1)(M)&(3)(A), and 22 TEX. ADMIN. CODE §217.12 (1)(A),(1)(B)&(4)), and **Charge 3**, knowingly violated the patient's DNR and performed CPR over the span of two minutes (this violated Section 301.452(b)(10)&(13), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.11 (1)(A),(1)(B)&(3)(A), and 22 TEX. ADMIN. CODE §217.12 (1)(A)&(1)(B)). The accumulation of these actions without regard to professional, legal or

humanitarian ethics led to the revocation of Susan Ferguson's license, based on the evidence the Board's decision is irrefutably justified.

Failing to notify the physician in any scenario regarding a patient's change in status can be detrimental, especially when the patient experiences repeated falls. The patient Susan Ferguson was assigned, displayed evident alterations to mental status ranging from disorientation to disrobing. It is imperative that the physician be notified of changes as soon as they are observed to accurately assess and make changes to the plan of care for the patient in a timely manner. Susan Ferguson deliberately withheld medical findings, which opened the patient up to unnecessary harm that could have been prevented.

Failing to assess vital signs or oxygenation of a patient is clear negligence, and these assessments are of greater significance after sustaining a fall, injury or status change. Susan Ferguson did not attempt to assess any vitals after finding her patient on the floor at 0100 on 11/29/19. Allegedly, Susan Ferguson assessed her patient for injuries and documented incontinent care. However, this is contraindicated by the fact that the patient was left on the floor and found by staff almost two hours later at 0240 on 11/29/19. Unfortunately, the patient was unresponsive and in respiratory distress. These failures by Susan Ferguson put the patient in substantial danger, increased risk for injury and death, and were intentionally malicious.

Knowingly disregarding an advanced directive or DNR is wrong for a multitude of reasons, but most importantly it betrays the patient's wishes. In addition, it opens up liability to the nurse/provider, as well as pursuant legal action by the representative of the patient with the DNR or their family. Susan Ferguson knew there was a posted DNR on this patient, and still recklessly chose to perform CPR anyways. The patient lost their ability to have autonomy in their care and their rights as a patient were completely voided by Nurse Susan Ferguson.

Overall, Susan Ferguson's multi-faceted situation filled with erroneous medical and professional decisions, allowed for great harm to the patient that could have been avoided by abiding by universal competencies.

- 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 was an abundance of measures that could have been taken to ensure the safety and health of the patient, maintenance of professional conduct and integrity, and prevent any unnecessary risk. The first measure that should have been taken was properly recording and documenting abnormal findings when Susan Ferguson initially observed the status change in the patient. The findings should have been immediately reported to the provider. Due to the severity of disorientation the patient should not have been left alone, and at minimum strictly monitored until the mentation was restored. There should have been a focused neurological assessment

performed and documented. The injuries and falls sustained by the patient could have been decreased or avoided all together.

Based on the findings, when the patient was found on the floor at 0100 on 11/29/19 by Susan Ferguson, the incident should have been reported right away. Vital signs should have been assessed and a physical assessment to follow to denote any injuries sustained then recorded and documented. The respiratory status should have been checked, as well as the pulse-ox to confirm there were no abnormalities. Leaving the patient on the floor after finding them there is inexcusable. The patient should have been assisted by nurse Susan Ferguson with assistance from staff to their bed. Had any of this been done the patient could have avoided falling into respiratory distress, further injuries and becoming unresponsive.

The blatant, conscious inattention to the DNR caused more trauma and harm to the patient and their rights. The appropriate response would be to honor the DNR as ordered, while immediately notifying the provider. Violating the DNR goes directly against the patient's wishes in this situation. Had Nurse Susan Ferguson been diligent in any capacity for her role as a registered nurse, the entire ordeal could have been prevented, instead of the rapid deterioration of the patient.

- Identify ALL universal competencies (4-5) that were violated and explain how in detail to reflect your understanding and importance of the universal competencies.

Documentation was breached when Nurse Susan Ferguson repeatedly refused to record and document abnormal findings. The information could have allowed the provider to order patient specific interventions. Forgetting this crucial universal competency opens the nurse to malpractice.

Communication was violated when Susan Ferguson did not notify the doctor or staff of the status change or falling incidents that occurred on her watch. Failure to communicate and excluding providers and other staff leads to confusion and hinders affective patient care. Protocol within the agency is broken at this point and disrupts the professional and ethical dynamic.

Critical Thinking is violated in this case when Susan Ferguson did not prioritize assessing vital signs and oxygenation, as well as poor decision making. Abandoning this universal competency led to the patient's declining health. Thorough assessments would have revealed adventitious values, and decisive interventions could have rectified the patient's status. Also, the decision to conduct CPR with a DNR in place displayed the absence of critical thinking.

Human Caring was by far the most egregious violation that occurred in this case. The patient being left on the floor injured and with abnormal vital signs, after being observed by Susan Ferguson shows a complete lack of respect and dignity. Throughout the timeline in question

Susan Ferguson shows ill intent and apathy towards the patient's physical and mental well-being along with their rights.

Safety and Security in this case was ignored on several instances. Nurse Susan Ferguson failed to provide any interventions related to the fall bundle, which allowed for numerous falls and injuries. Additionally, in the entirety of the incident Susan Ferguson violated the patient's trust and respect. By not promoting these qualities, the patient's rights and level of care suffers.

Professional Role was violated by Susan Ferguson when she failed to uphold her role under her license as a registered nurse. She did not make patient care a priority, broke protocol, undermined the facility and providers, and deliberately allowed harm to fall upon the patient.

- 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.

The first action I would take if I found myself observing a situation like this, is to immediately report to the nursing supervisor at the care facility and notify the provider of the patient. Assess the patient's status change and obtain vitals signs along with a focused neurological assessment. I would also begin a physical inspection of any injuries associated with the numerous falls that occurred. I would ensure the patient's safety and health is achieved before moving on to other assigned tasks. Once the patient is stabilized, I would find Susan Ferguson to obtain her reasoning for her neglecting protocol and care. I would file an incident report with the facility and turn Susan Ferguson (or any other nurse who I observed in this manner) into the Board of Nursing.