

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Chelsie Callesen

Date: 8/1/2021

DAS Assignment # 1 (1-4)

Name of the defendant: Alysha Michele Alexander

License number of the defendant: 701399

Date action was taken against the license: 7/25/2019

Type of action taken against the license: Reprimand with Stipulations

Use the space below to describe the events which led to action 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.

The nurse in question, Alysha Michele Alexander, had multiple incidences involving an “incomplete and/or inaccurate medical record.” The events in question initially took place on November 22nd, 2016, but these events continued occurring in multiple other incidences through May 17th, 2017. The incidences in question involve Mrs. Alexander failing to ensure her patient had a signed consent form before going in for a specific procedure, failing to ensure she properly and completely labeled a blood specimen before sending it off to another unit, failing to document vital signs and Aldrete scores every five minutes for patients in the PACU following procedures under general anesthesia, failing to assess and or/document assessments for patients following procedures under general anesthesia, failing to reassess a patient who was on physical restraints, failure to accurately document a patient’s oxygen rate and method of delivery, and failure to accurately document a patient’s dermatome levels.

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.

In a situation where a mistake is made, much like the many situations stated above, we, as humans, would typically try to learn from it and ensure that it never happened again. Unfortunately, for whatever reason, Mrs. Alexander, failed to do this. However, in the instance that one realized they made a mistake, such as failing to properly document vital signs, etc. one should go through the proper channels to not only fix their mistake, but to also figure out why the mistake happened in the first place, so that to ensure it didn’t happen again. Moreover, to ensure that something of this nature doesn’t occur in the first place, we as nurses, need to slow down enough to think about what we may or may not have missed. In the many instances stated above, Mrs. Alexander failed to document a wide array of important information for her patients. If she would’ve stopped what she was doing long enough to say, “did I do all the necessary things for this patient?” she just might’ve caught her discrepancy in time to correct it. In order to help remember all the necessary things that need to be completed for a patient, especially one returning from a procedure, one could make a small checklist of the important things. This way they could go over it with every patient to ensure that nothing is being missed. Patient safety is at the core of what we do as practicing medical professionals, it’s a big reason why we have

so many different rules and why we do things in such specific ways. Remembering this and always keeping it in the back of our minds, could ensure that we never put our patients in harm's way.

Use the space below to describe what action you think a prudent nurse would take as the first 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.

In the situation's stated above, if I were the first to find Mrs. Alexander failing to do as she should in the initial offense, I would approach her with the question, "are you forgetting something?" If she realized what she had forgotten and/or failed to do and corrected it, then we would go through the necessary channels from that point forward to fully correct her mistakes and ensure it didn't happen again, e.g., bringing it to the charge nurses' attention, etc. However, if Mrs. Alexander had been made aware of her mistakes and continued to do them, I would go by the chain of command and immediately bring it to my charge nurse's attention, as well as potentially my nurse manager. Although the mistakes Mrs. Alexander made may have initially seemed minor, when looking at the picture in its entirety, even the smallest of mistake could put your patient at an extreme risk. Mrs. Alexander's failure to correct her mistakes, time after time, involved complete negligence and needed to be stopped as soon as the first offense occurred.