

Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: [Ashlynn Cunningham](#) Date: [08/01/2021](#) DAS Assignment # 1 (1-4)

Name of the defendant: [Michelle Casey Brownlow](#) License number of the defendant: [880249](#)

Date action was taken against the license: [1/24/2019](#)

Type of action taken against the license: [Revoked](#)

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.

I. [FAILURE TO DOCUMENT:](#)

[Michelle Casey Brownlow, a NVICU nurse in Dallas, Texas at the time, had her license revoked due to her lack of charting and documentation. Brownlow "failed to complete and/or document assessments, neurological checks, and narrative notes \[leading to\] an incomplete medical record and was likely to injure the patient from subsequent care decisions made without the benefit of accurate and complete care information."](#)

II. [FAILURE TO DOCUMENT/REPORT:](#)

[Brownlow did not only fail to document assessments and narrative notes, but also failed to notify the physician of "significant neurological changes in condition" of her patient. The patient suffered an acute ischemic stroke in the left middle cerebral artery. This lack of documentation "was likely to injure the patient from ineffective treatment by depriving the patient's physician the opportunity to institute timely medical intervention."](#)

III. [MEDICATION ERROR/FALSIFYING DOCUMENTATION:](#)

[Brownlow administered \(IV\) 3% saline to infuse at 20 cc/hour instead of at 50 cc/hour which was ordered by the physician. Brownlow also failed to administer IV Precedex at titrated levels according to the RASS scale. This error "was likely to injure the patient from ineffective treatment." Brownlow also "incorrectly documented that she increased the 3% saline to infuse at 50 cc/hour." This was also likely to injure the patient as a result of an inaccurate medical record.](#)

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.

Proper documentation would have lead to proper medical invention. If Brownlow would have documented her assessments, neurological checks and narrative notes, the Medical Record would have been accurate which other members of the care team would have responded to. Brownlow also should have documented and reported the changes in the patient's status (i.e. stroke.) By failing to report to the physician, Brownlow delayed medical intervention and endangered the patient. Furthermore, Brownlow should have ensured she followed the orders correctly, or at the very least should have documented and rectified her mistake upon realization. She also should have corrected her error, when she falsely reported that she did.

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.

Upon discovering the failure to document I would have instructed Brownlow to chart immediately, noting that all instances were late entries, and to include all details that she could remember. I would immediately visit the patient in question and do assessments of my own. I would let the charge nurse know about the error and ask that Brownlow's patients be reassigned to other nurses, if relief for Brownlow was unavailable. In the case of failure to report, I would notify the physician myself and follow the given orders. I would no longer trust Brownlow to make decisions that are in the best interest of the patient. Upon discovering her medication errors, I would make sure the saline was increased to the proper infusion rate. I would note the errors in the patients chart and if I did not know how to rectify the issue, I would call the physician.