Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Mindy Ojeda Date: 04/05/24 DAS Assignment # 2

Name of the defendant: Sherry Lee Amaechiokonji-Alford License number of the defendant: 553670

Date action was taken against the license: 07/24/2019.

Type of action taken against the license: Voluntary Surrender

- *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.*

Sherry Lee had multiple disciplinary actions that led to her surrendering her own license due to not completing corrective actions issued by the board. Sherry had multiple unprofessional actions that included subsequent failure to document doses on medication drips, failed to follow physicians medication orders, was increasing patients drip without physician orders, failed to document, failed to document patients vital signs, failed to notify physician when patient was having critical hypotension, did not provide accurate information on patients that where experiencing critical event when doing morning round which was causing other nurses to complete accurate care to the patient, also had a verbal argument with a physician in front of the patient in a not so professional manner. Was not discontinuing IV meds as ordered by the physician.

- *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.*

Looking back at Shelly Lee's nursing mishaps, there are multiple things that she could have done differently for the safety of her patient. I think if the Nurse would have documented her IV drips, documented correct times, labeled them correctly and gone over physician orders the patient would have not been put in a critical situation that the nurse implementing the patient in. Checking vital signs as ordered would have given the nurse signs that the patient had hypotension and could have given the physician an early indication that something was wrong. The nurse should have gone back to the early stages of what she had learned in nursing school. A lack of communication with the physician and other nurses during her morning rounds could have prevented our other nurses checking how accurate her documentations where on the patient.

Identify ALL universal competencies were violated and explain how.

Safety and Security

The nurse was increasing IV medication without a Physicians order and documenting that IV meds where discontinued when they were found to be still infusing in the patient's room. Failed to notify physician in a timely manner when patient was experiencing hypotension.

Documentation

The nurse failed to document the times medications were given. She failed to document vital signs, she never documented critical events that patients were experiencing throughout the night.

Communication

The nurse failed to communicate with the physician on patients care. She failed to communicate with the other nurses during the morning shift change.

Critical Thinking

The RN failed to review physicians' orders and was increasing meds without permission. She was just not documenting and pretty much doing as she pleased. She was not evaluating her patients to make sure they were ok before and after meds were given.

Professional Role

The RN was acting in an unprofessional manner when she engaged in a verbal argument with the physician in front of her patient. Very unprofessional when she was not taking her role as a RN seriously and not keeping her patient's safety as a number one priority.

- *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.*

My first action that I would take if I was the one that noticed many things not adding up in her documentation in the patient's chart is informing the charge nurse and all physicians. I would inform them that way we could reevaluate all patients in her care to make sure all meds where given properly and to check vitals to make sure patients there were affected by her negligence.