

Covenant School of Nursing  
Disciplinary Action Summary Assignment  
Instructional Module 2

Student Name: Payton Conger

Date: 08/31/2023

DAS Assignment # 2

Name of Defendant: Sarah Nell Albrecht  
948882

License Number of the Defendant:

Date Action was Taken Against the License: March 23<sup>rd</sup>, 2021.

Type of action taken against the license: Warning with Stipulations and Fine

On or about May 28<sup>th</sup>, 2019, RN Sarah Albrecht committed the following violations while working at University Hospital, located in San Antonio, Texas. The first violation includes inaccurately documenting and scanning the administration of Synthroid, Protonix, and Oxycodone to a patient. The RN committed a second violation on or about June 23<sup>rd</sup>, 2019, by failing to follow a physician's order to administer 500mL of normal saline before and after the administration of the antibiotic, Amikacin. The RN's final violation occurred on or about July 29<sup>th</sup>, 2019, by knowingly misleading a patient by stating to the patient that she administered as-needed intravenous Dilaudid and Phenergan for pain and nausea.

There are several measures that could have been taken to prevent the first violation, stated above, from taking place. Miss Albrecht failed to accurately scan and document the administration of Synthroid, Protonix, and Oxycodone. The RN also only administered the Oxycodone to the patient, leaving the other two medications in the patient's medication drawer. Because of the lack of documentation regarding the non-administration of the above medications, harm was caused to the patient. The RN stated her reasoning for not administering / documenting these medications was due to her being called out of the patient's room to tend to another patient. Prevention of this error could have been made, simply by Miss Albrecht completing her work with the patient she was administering medications to first, before stepping out of the room. Had this interruption been unavoidable, the RN should have documented why there was a pause in the administration of the other two medications. After sorting out the issue with the other patient, Miss Albrecht should have made more of an effort to complete the medication administration, instead of stating that she simply forgot.

Miss Albrecht's second violation of failing to follow a physician's order could have also been easily avoided. The RN was ordered to administer 500mL of Normal Saline before and after the administration of an antibiotic, Amikacin, to protect said patient's renal function. However, Miss Albrecht went against the order given and administered 1,000mL of Normal Saline before the administration of the antibiotic, and nothing after. This error could have resulted in non-efficacious treatment of the patient's renal condition and altered the patient's response to the antibiotic. The RN tried justifying her actions by stating when she opened the Pyxis, she grabbed and opened a 1,000mL bag of Normal Saline and decided to use it instead, since the patient's renal function was very poor. This violation should not have occurred and could have been easily avoided by Miss Albrecht performing the three checks of medication administration. She should have also corrected her actions when pulling the incorrect medication from the drawer and notified the floor's Charge Nurse or Nurse Manager about her mistake instead of following through.

The final violation committed by Miss Albrecht is probably the most unethical. The RN knowingly misled a patient by stating to them that she did, in fact, administer the patient's as-needed intravenous Dilaudid and Phenergan for the patient's pain and nausea. Instead of administering the correct medications, the RN chose to administer Normal Saline to the patient. Miss Albrecht stated her reasoning for this violation was because she could not get in touch with the on-call physician to renew the patient's prescription for Dilaudid. She also stated that she had seen other RNs on the floor administer Normal Saline to patients as a sort-of placebo effect when they could not get orders renewed as fast as the patient's wanted / needed them. This violation exposed the patient to a risk of harm from untreated pain and nausea. This violation could have been prevented by Miss Albrecht simply knowing what is acceptable, and what is not. Instead of improvising when she couldn't reach the on-call physician, Miss Albrecht should have tried explaining the situation to the patient and continued to try to reach the physician. There is no circumstance in which it is acceptable to lie to a patient about their plan of care, nor is it acceptable to deceive them by making them believe they are being treated with the care they deserve.

Miss Albrecht violated several universal competencies in the case described. Of the eight universal competencies provided to us, Miss Albrecht broke the following five:

- Failure to properly complete the **Documentation** needed when administering several medications, in the first violation, potentially caused harm, both present and future. Had the RN properly documented the reasoning for giving / not giving the medications stated above, this violation would not have occurred.
- Failure to comply with the patient's rights to **Physical Safety and Security** occurred in the second violation when the RN failed to review the seven rights of medication administration. Had this been checked before administration, the RN would have seen the dosage on the order did not match what had been pulled, and the proper steps to correct this error would have been taken.
- The patient's **Emotional Safety and Security** was broken during the third violation, when the RN decided to deliberately lie to the patient about which medication was being administered. This action broke any and all trust and respect that was had between the RN and patient at this time.
- The RN failed to provide the patient in the third violation with any type of **Human Caring** when a decision was made to give a placebo-effect medication against any type of orders. By doing this, the RN did not listen to the patient's needs, nor was the patient treated with the respect and dignity they deserved.
- The RN did not use the appropriate **Critical Thinking** skills she was provided during all three violations. For the first violation, the RN did not stop, prioritize, and complete the current task. Instead, she left a patient during medication administration, and failed to return to finish said administration. During the second violation, the RN failed to use ethical decision-making skills, by deciding to administer a medication against physician's orders. For the third violation, the RN, again, used improper decision-making skills by administering a placebo medication to the patient without orders to do so.

As a prudent nurse, witnessing the occurrence of the violations stated above, on each separate account, a move to report Miss Albrecht would have been executed immediately. Although some violations are honest mistakes, I do not believe any of the violations stated above can be ruled as accidents. These violations made by the RN were each deliberately made against any and all higher judgement Miss Albrecht should have had. The one action that stands out above all others is the lying done by the RN to a patient. Again, as stated above, there is no situation that lying to a patient is justifiable.