Covenant School of Nursing

Disciplinary Action Summary Assignment

Instructional Module 2

Student Name: Misti Damron Date: 03-28-2024 DAS Assignment # 1 (07/2023)

Name of the defendant: Sarah Nell Albrecht, RN License number of the defendant: 9488882

Date action was taken against the license: 04-20-2023

Type of action taken against the license: Reprimand with Stipulations

- *Sarah Nell Albrecht, RN had a plethora of unethical mishaps that lead to the Board of Nursing giving her a warning with stipulations and a fine of $250.00 that was ordered to be paid within 45 days of the order. First, Ms. Albrecht inaccurately documented the administration of Synthroid and Protonix. She did, however, give the patient the Oxycodone that was ordered by the physician. She stated that "she was called away to another patient's room". However, she did document that she gave the Synthroid and Protonix prior to leaving the room, the medication was found in the patient's med drawer unopened. Ms. Albrecht also administered 1000ml of NS instead of following the doctors' orders. The order stated 500ml prior to giving the patient her antibiotics. She scanned the medication and documented that she gave the 1000ml for the patients' poor renal function when the order stated to only give 500ml. While treating another patient she had knowingly and purposely gave the patient normal saline (placebo) for the pain instead of the Dilaudid that was ordered with the two prn meds anxiolytics and anti-emetics due to the order expiring. She did reach out to the physician several times; however, he did not get back to her until 0330. She then administered the patients Dilaudid and Phenergan without documenting due to witnessing seasoned nurses provide a patient placebo in the past.*

- *Sarah Nell Albrecht could have caused the patient harm by not administering the patient's medications from the physicians' orders correctly and timely. This causing the patient not to have the desired effect of the medications and could also cause negative and incorrect lab values. The action of her poor documentation would not be accurate. She documented that she gave the two medications at bed side, however, she did not do this, and this action negatively affected the patients' overall health.*

- *As far as the universal competencies that were violated: Safety and Security (Physical) (Emotional), Critical Thinking, Communication, Documentation, Human caring, and Professional Role.*

- *Safety and Security: Ms. Albrecht broke this by not giving the patient the right drug, dose, time, and documentation. Ms. Albrecht also broke the trust of the patient by giving placebo instead of the correct*

medication. She did pull the wrong medication. Did not check the fluids 3 times prior to administering. She also falsified her documentation.

- *Documentation: Ms. Albrecht left the patient medication in the med drawer and documented that she had given it to the patient. She also documented the wrong dose of iv fluids. She did not document that she gave the patient Dilaudid at 0330.*

- *Communication: Ms. Albrecht deceived the patient about the order of Dilaudid being approved at 0200 and administered placebo instead. Did not explain to the patient that the orders had expired and was waiting on the physician to call with a new one.*

- *Critical Thinking: Ms. Albrecht did not prioritize her time with the patient and forgot to give medication. She also decided to administer placebo because she had seen other nurses do it. She left the patient alone after giving an opioid. The patient could have had an allergic reaction which could have caused extreme harm or even death to the medication and she was in another patient's room.*

- *Human Caring: The nurse did not listen to the patient's needs and gave no medication when he/she needed it.*

- *Professional Role: The RN did not make sure her patient had their medications properly and forgot to administer others. She also was deceitful and exposed the patient to harmful side effects of not getting the proper dose. She is also supposed to check the medications 3 times prior to giving.*

- *If I was the nurse on duty or the first prudent person to witness her actions. I would speak with her about it and then speak to the charge nurse if she wouldn't report her own mistakes. I would also ask if I could take over her patients. I would try to re-establish trust with the patient. The patient with poor renal function I would have given the 500ml instead of the 1000ml bag and documented that I did not have a 500ml bag and used the 1000ml and gave half. This would be after calling the pharmacy to see if they had the 500ml solution on hand. I would not want to defy the physicians' orders. I would also have better communication with the patient regarding the pain medication. Explain the process of having to wait for the physician to rewrite the order and offer him or her a different type of pain medication.*