

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: Edward Rodriguez

Date: 1/26/2025

DAS Assignment # 2

Name of the defendant: Sarah Nell Albrecht

License number of the defendant: 948882

Date(s) and action(s) taken against the license: 3/23/2021, 4/20/2023

Type of action(s) taken against the license: Warning with stipulations and fine, Reprimand with stipulations

- *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 each of them, e.g. drug diversion, HIPAA violation, abandonment, etc.*
- Sarah Albrecht has produced multiple violations within a two-year time frame that led to two separate cases being filed against her. The violations stated in the first case include: Scanning three medications, Synthroid, Protonix, and Oxycodone but only giving Oxycodone, failing to complete required charting for a patient, neglecting physician orders to flush saline before and after the administration of an antibiotic, and knowingly deceiving her patient by administering IV fluids to her patient for pain instead of the ordered Dilaudid. The second case violations include: Locking patients in a seclusion room without physician orders failing to document those actions, and failing to document emergency medication telephone orders in the medical record. These unprofessional acts endangered the health and safety of Sarah's patients and would ultimately lead to disciplinary actions in the form of a Warning with stipulations and fine for case #1, and a Reprimand with stipulations for case #2.

Case #1: University Hospital, San Antonio, Texas

On or about May 28, 2019, Sarah inaccurately documented the administration of medications by scanning Synthroid, Protonix, and Oxycodone. Unfortunately, Sarah only gave the Oxycodone and placed the other medications in her patient's medication drawer. This gave her patient the potential to develop a worsening condition based on the fact that the full prescribed dose was not given and therefore could not be effective in her patient's treatment. Also, falsely documenting medication administration may lead subsequent caregivers to make incorrect and possibly dangerous decisions for the patient based on the false documentation. Lastly, Sarah failed to complete her charting for this patient which resulted in an incomplete and inaccurate medical record. By giving incomplete and incorrect data to the medical record, Sarah once again put her patient at risk for inadequate care based on her documentation.

On or about June 23, 2019, Sarah received physician orders to flush 500 ml of Normal saline before and after the administration of the antibiotic, Amikacin, which was to protect the patient's renal function. Instead, Sarah incorrectly administered 1000ml of Normal Saline only before administration of the antibiotic. Sarah would later state in her response that the reason for her giving it that way was because the Pyxis only opened for a 1000ml bag instead of the ordered 500ml. Not only is this malpractice but it is also negligent to the physician's orders. This resulted in the patient not receiving the correct treatment from the RN which may have led to detrimental health effects based on improper treatment.

On or about July 29, 2019, Sarah knowingly committed an act of deception when she misled her patient into believing that she was giving them the pain medications, Dilaudid and Phenergan, when in fact the patient was only receiving IV Normal saline for their pain. Sarah stated in her response that she only administered the Normal saline because her patient was constantly demanding it and that the current orders for the pain medication had expired. Sarah attempted to call the physician three times but when no response was given she took it upon herself to administer the normal saline. Afterward, she did receive an updated order for Dilaudid and administered it at a later time, but did not document that she gave the saline because she stated to have seen multiple nurses give a placebo before. Sarah not only endangered her patient for untreated pain but also willingly conducted unethical malpractice that violated the trust in the relationship between the patient and the nurse. In addition, not documenting the administration of any fluid or medication can have extremely negative consequences for the health and safety of the patient.

Case # 2: Laurel Ridge Treatment Center, San Antonio, Texas

On or about April 11, 2022, Sarah, on two separate occasions, locked her patients in a seclusion room without receiving valid physician orders. She also failed to complete the required documentation of the seclusion of the patients. The actions committed by the nurse in this situation were completely unethical and put the patients at risk of potentiating any underlying ailment they may have had or developing new physical, emotional, and mental harm. Also, by not documenting this act the nurse failed to take responsibility for her actions, endangered the health and safety of her patients, and misled her peers into believing this situation never occurred.

On or about May 11, 2022, Sarah inappropriately documented emergency medication telephone orders in the patient's medical record for the medication, Zyprexa 5mg IM. Her failure to correctly document the medication put her patient at risk for misguided care by any subsequent caregiver.

In conclusion, Sarah had a multitude of documentation errors, unprofessional conduct, and unethical behaviors which put her patient's directly at risk for adverse treatment and potential harm.

For case #1, Sarah received a Warning with stipulations and a fine of two hundred and fifty dollars. Sarah was also ordered to complete remedial courses which included: A Board – approved course in Texas nursing jurisprudence and ethics(6 hours in length), A Board - approved course in medication administration(6 hours in length), A Board - approved course in nursing documentation(6 hours in length), the course "Sharpening Critical Thinking Skills"(6 hours in length), and the online course "Understanding Board Orders". Sarah would also have to undergo future employment requirements

including: Notifying Present and Future Employers, Notification of Employment forms, Indirect Supervision, and Nursing Performance Evaluations.

For case #2, Sarah received a Reprimand with stipulations and was required to meet all of the same education and employment requirements stated in case #1 with the addition of the remedial online course, "Righting a Wrong"(3 hours in length).

- *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.*

These are the measures Sarah should've taken to prevent the risk of harm to her patients. In her response to the findings, Sarah stated that she was called to another patients room before administering the remainder of the medications. Sarah also left those medications in the patient's medication drawer before leaving to another room which creates an enormous safety risk for the patient. Firstly, Sarah should've prioritized the immediate safety of her patient by completing the administration of all the medications to prevent any medication error or harm to the patient. Secondly, if the other patient's situation was urgent, then Sarah could've paused the medication if the process could be safely paused and explained to her patient why the rest of the medication would not be administered at that time. Then she could secure the unused medication, document what was given and what was not, and safely take it back to the medication room or a secure storage if the policy allows and return to it at a later time after dealing with the urgent patient. She could've also called for assistance from another nurse or aid to handle the task of seeing the other patient. To ensure that false documentation did not take place Sarah should've documented the reason for not administering the already scanned medication and called the physician to explain the reason for the delay in the administration. To prevent further risk and errors from other caregivers, Sarah should've completed her charting of the patient before handing off her report.

Sarah did not follow safety protocol by neglecting physician orders when she administered the incorrect dose of Normal Saline to her patient. If the Pyxis only opened for a 1000ml bag then Sarah should've double-checked the inventory and then contacted the pharmacy informing them of the issue if the correct dose was not found. From there, she could order the appropriate dose and have it delivered to the floor or if was urgent ask for a stat delivery. Sarah could've also contacted the physician to explain the issue and obtain any alternate orders for the treatment. Documenting the initial issue and detailing the necessary actions to resolve it is also crucial for maintaining a correct narrative of the situation. If there was any necessary delay in the administration, Sarah should've also communicated with her patients to reassure them that the problem would be resolved. Furthermore, if the 1000ml bag was the only option for her then she should've administered it in 500ml before and after the antibiotic and not just before. This could've prevented any residual antibiotic from remaining in the line. This would've also prevented the risk of any blockage forming in the line.

In the instance of deceiving her patient, Sarah could've avoided the entire situation if she had used her critical thinking by using all of her available resources. This could've included contacting her charge nurse or nurse manager to try and resolve the issue. She also should've communicated with her patient to explain the delay for the medication. Assessing the current status of the patient should've also

happened to determine if the expired order posed an immediate risk. Accurate documentation of each action taken and each attempt to call the physician should've also been made to avoid any potential risk of a breach in safety protocol for the nurse and patient.

Secluding any patient should only be utilized if it's the last resort and through a physician's order only. Before doing this, Sarah could've tried to talk with her patients and empathize with them to try and de-escalate the situation. By using therapeutic techniques like physical activities, creating a safe environment, deep breathing exercises, and even calming distractions (movies or books), Sarah could've maintained the physical and mental health of her patients. The nurse could've also consulted with the physician to update them on the patient status to see if any orders were to be implemented. Documenting the events accurately even if mistakes were made is a nurse's responsibility to uphold for the safety of the patient and should not be falsified no matter how severe the error.

Reading back the order to the prescriber and having them validate it is the technique that is implemented to prevent inaccurate documentation when receiving an order over the phone. The nurse should've used this technique to prevent false documentation and incorrect medication administration.

- Identify ALL universal competencies (4-5) that were violated and explain how.

Safety and Security – was violated when the nurse incorrectly scanned all three medications when she only administered one which directly violates one of the 7 rights. Secondly, the nurse violated this by not adhering to physician orders and administered the wrong dose of saline before administration. The nurse was also in violation when she gave her patient Normal saline fluids instead of the prescribed pain medication. This puts the patient at direct risk of harm due to ineffective treatment for pain. This also violated the trust and respect aspect because the nurse intentionally lied to her patients instead of being honest and direct with them. This aspect was also violated when the nurse secluded without an order which may have caused emotional and physical harm to her patients. Lastly, by the nurse not correctly documenting a telephone order for medication, she directly put her patient at harm for subsequent false administration of the medication.

Communication – was violated when the nurse failed to establish communication with her peers by not asking for assistance to help her tend to a patient while she finished her medication administration. The nurse also violated this when she did not utilize her resources and did not contact the pharmacy or charge nurse when she drew up an incorrect dose of Normal saline. Sarah was also in violation when she failed to communicate with her charger nurse and nurse manager to resolve the issue of not having an updated order of pain medication. Sarah also failed to utilize the correct communication technique when documenting a telephone medication order.

Critical Thinking – was violated when the nurse did not prioritize her tasks correctly by failing to finish her medication administration for her patient. She also violated her decision-making when she decided to administer normal saline instead of the prescribed pain medication. She also failed to exhaust every resource and option before making the incorrect decision to seclude her patients.

Documentation – was violated multiple times throughout these findings. Firstly, Sarah scanned three medications but only gave one. She also failed to finish her charting for that same patient which led to false and incorrect documentation for subsequent caregivers. Secondly, she did not document that she gave her patient Normal saline which put her patient at risk for detrimental care by following caregivers. Thirdly, Sarah did not take the responsibility to document that she secluded her patients which provided a false record of the actions that occurred. Lastly, Sarah incorrectly documented telephone medication orders which could've led to an error in medication administration.

Human caring – was violated when the nurse neglected to treat her patients with respect and dignity by deceiving them into thinking that Normal saline was their prescribed pain medication. She also violated this by not listening to her patient's needs and instead left them in a seclusion room.

Professional role – was violated when the nurse failed to manage her supplies when she did not secure her unused medication from the patient's room. She also did not interact with staff and patients appropriately when required to absolve any issues that she was dealing with.

- *Use the space below to describe what actions 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.*

As the nurse first nurse to discover these events, I first assess any patient for adverse effects on their physical and mental health. I would then call the physicians involved to report the situation and status of each patient. From there, I would obtain any new order and collaborate with the charge nurse to rectify and prevent any physical or mental harm done to the patient. I would assess the patient who did not receive their full round of medication, then call the physician to explain the situation and administer those medications if they were still required. Then, I would assess the patient and their tubing to assess any detrimental effects. Then, I would call the physician to explain the situation and receive any new orders required for the treatment of that patient. If I could intervene before Sarah administered the Normal Saline I would've helped her to try and obtain the correct medication by collaborating with the charge nurse and nurse manager. If I were to see Sarah try and seclude her patients, I would stop her to confirm whether or not she had a physician's order to do so. Upon finding that she did not have that order, I would explain to her that secluding a patient without an order is malpractice and that therapeutic communication should've been implemented first. Lastly, I would assess the patient for adverse effects, check the medical record for incorrect documentation, then report my findings to the charge nurse to rectify the issue. If I were to witness any potential mistakes from Sarah I would

communicate with her to understand the rationale behind her decisions and work with her to utilize safer options for the health and safety of her patient.