

# Covenant School of Nursing

## Disciplinary Action Summary Assignment

### Instructional Module 2

Student Name: Hope Robnett      Date: 4/4/23      DAS Assignment # \_\_\_3\_\_\_ (1-4)

Name of the defendant: Rufina Wroblewski      License number of the defendant: 767222

Date action was taken against the license: 14 – Nov - 12

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.*

From July 2010 to September 2010, Ms. Wroblewski had several incidents of failure to accurately and/or inappropriately document her medications correctly. Ms. Wroblewski would dispense medications multiple medications for multiple patients then would either document incorrectly, saying she gave this medication in multiple doses simultaneously to a single patient and then have no documentation on another patient she pulled pain medication for. In the later months, Ms. Wroblewski almost stopped documenting all together on the medications she was pulling, putting her patients at risk for overdose and other complications if other staff members were unaware if she really had or didn't give those medications. A few more similar incidents occurred between March and April of 2012, showing that she hadn't documented correctly and/or fully on the patient, whether if she wasted the remaining amount.

*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.*

Measures that should have been taken to help prevent this kind of situation from happening should include a mandatory co-signature of another nurse verifying that the assigned nurse had accurately measured the appropriate dose and then wasted the unneeded amount. Many of the systems were already electronic at that time, so I feel it's appropriate that the system should have had a certain set of required information that is filled out before a medication can be pulled out of a pyxis and then before it can be scanned into the computer as "given". On the records, it shows that some medications were dispensed without indicating the dosage that was taken out, so another protocol that should be implemented would have been to block the medication from dispensing until the correct dose was inputted into the computer.

*Identify which universal competencies were violated and explain how.*

From the report, we can see that the nurse probably didn't provide proper safety and security to the patient in terms of not providing all 7 Rights for Medication Administration, by not providing the dose and proper documentation. Another universal competency, documentation, the nurse blatantly ignored proper documentation on several accounts by not recording the administered amount, making note of why a patient received the medication and improper wasting of the excess amounts. This in turn also violates the universal competency of human caring by putting her patients at risk of possible drug overdose because of there being no history of the medication being administered prior.

*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.*

Most of the medications that were drawn up were drugs that required co-signage of wastage which should have been an indication that the nurse was falsely pulling medications or cause alert. I would have reported the incident to a supervisor because it's a major risk for the patients and other staff members. If I was the nurse that was getting report from this nurse, I would diffidently question her because it would look like she hadn't given medications appropriately, then it might look bad on yourself as well. You have to be an advocate for both yourself and your patients in this situation because you don't want them at risk because of another nurse's negligence.