

Covenant School of Nursing
Disciplinary Action Summary Assignment
Instructional Module 2

Student Name: KADIE BERGMANN

Date: 08/23/2024

DAS Assignment # 1

Name of the defendant: DAVID J. RUBIN, RN

License number of the defendant: 1063013

Date action was taken against the license: 4/21/2023

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.*

David Rubin had multiple occurrences of unprofessional actions while in the clinical setting of Veterans Administration Medical Center ("VAMC") in Seattle, WA. These multiple occurrences included: signing for multiple doses of Oxycodone / acetaminophen and failed to document all administrations in medication records.

On another occasion, Rubin had signed for two doses of Oxycodone / acetaminophen and documented the administration four hours late in the patient's medication records.

On another occasion, Rubin had signed for three doses of Oxycodone / acetaminophen , documented the administration in patient's medication records, however, he failed to document the wastage of the remaining tablet.

On another occasion, Rubin had signed for two doses of acetaminophen / codeine and failed to document the administration in the patient's medication records.

On another occasion, Rubin signed for 1 mL of hydromorphone HCL and failed to document the administration in the patient's medication records.

On another occasion, Rubin signed for a 30 mL vial of morphine sulfate and failed to document the administration in the patient's records.

On another occasion, Rubin signed for 40 mg of methadone and failed to document the administration in the patient's medication records.

These occurrences all led to inaccurate medication being given due to the fact the next shift does not know what, if any, medications were given during the shift.

In conclusion, Nurse David Rubin was negligent of multiple occasions of failing to document and failing to document the wastage of a medication.

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.

The measures that could have been taken to prevent the action taken against the license, is simply documenting the medications that were administered. This would prevent the mistake of administering the medication again. Documenting after administering a medication should be done as soon as it is given at the bedside, to prevent any documentation errors.

- *Identify ALL universal competencies that were violated and explain how.*

Documentation- failure to document when medications were administered & when a medication was wasted and who was their witness. It could not have been proven that he actually wasted the medication, could easily be assumed he pocketed the medication.

Critical Thinking – nurse did not prioritize documenting that the medication was given. Nurse should have administered the medication and then documenting at bedside. Nurse should also have documented that the medication was wasted and who was their witness to wasting the medication.

Professional Role - Without documentation proving the patient received their medication, it is not proven that the patient received their medication so that would be considered a med error.

- *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.*

If I was the first person to discover these actions, I would report to the charge nurse and write him up. I would confront the nurse