

BEFORE THE VIRGINIA BOARD OF NURSING

IN RE: SONIA DIONNE BARNETT-KETTER, R.N.
License Number: 0001-254643
Case Number: 169860

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11), a panel of the Virginia Board of Nursing ("Board") held a formal administrative hearing on March 23, 2017, in Henrico County, Virginia, to inquire into evidence that Sonia Dionne Barnett-Ketter, R.N., may have violated certain laws and regulations governing the practice of professional nursing in the Commonwealth of Virginia.

Sonia Dionne Barnett-Ketter, R.N., appeared at this proceeding and was represented by Eileen M. Talamante, Esquire.

NOTICE

By letter dated February 23, 2017, the Board sent a Notice of Formal Hearing ("Notice") to Ms. Barnett-Ketter notifying her that a formal administrative hearing would be held on March 23, 2017. The Notice was sent by certified and first class mail to the legal address of record on file with the Board.

Upon consideration of the evidence, the Board adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT

1. On September 29, 2015, the Board issued License Number 0001-254643 to Sonia Barnett-Ketter to practice professional nursing in the Commonwealth of Virginia. Said license is

scheduled to expire on May 31, 2018. At all times relevant hereto, said license was in full force and effect. Her state of residence is Virginia.

2. During the course of her employment, while participating in a new graduate residency program with Chesapeake Regional Medical Center, Chesapeake, Virginia (“CRMC”), an audit of Ms. Barnett-Ketter’s medication overrides and patient documentation from April 2015 through September 2015, revealed that of the 181 medication overrides entered by Ms. Barnett-Ketter, 150 were inappropriate. Specifically, Ms. Barnett-Ketter repeatedly documented that she verified overrides when, in fact, she failed to have fellow nurses verify and co-sign. Ms. Barnett-Ketter also repeatedly failed to document the reasons for the overrides or for failing to administer medications as ordered in the patient assessment records and Medication Administration Records (“MAR”). For example:

a. On September 2, 2015, just prior to leaving her shift, Ms. Barnett-Ketter was told by her supervising nurse to administer Arixtra (fondaparinux, a “high-risk” medication) to Patient A, who was under Ms. Barnett-Ketter’s care. Ms. Barnett-Ketter obtained the Arixtra from another patient’s medication drawer (Patient B), entered an electronic override of the medication, and administered it to Patient A. Ms. Barnett-Ketter failed to document a reason for the override and failed to obtain the required validation and signature from another nurse before performing the override. In doing so, Ms. Barnett-Ketter delayed the administration of Patient B’s ordered medication.

b. On June 18, 2015 and June 19, 2015, Ms. Barnett-Ketter failed to give Patient C heparin, which was ordered to be administered every 12 hours. Ms. Barnett-Ketter charted in Patient C’s MAR that “medication [was] refused.” Ms. Barnett-Ketter failed to document a reason for the refusal in Patient C’s daily assessment record and failed to notify the physician of the refusal. On June 18, 2015, Ms. Barnett-Ketter also failed to administer ordered lisinopril to Patient C, giving the reason as “held for

Low BP/HR.” Ms. Barnett-Ketter failed to document the “Low BP/HR” parameters in Patient C’s daily assessment record and failed to document that she notified the physician of the “hold.”

c. On May 28, 2015, Ms. Barnett-Ketter failed to administer ordered hydrochlorothiazide and temazepam to Patient D. Ms. Barnett-Ketter failed to document the reason these medications were not given in Patient D’s daily assessment records and MAR.

3. Ms. Barnett-Ketter testified that she was trained that it was “best practice” to have another nurse sign off on an override, but that she believed she was handling the overrides properly in light of the computer system in use at the time. She told the Board that she has learned that if a medication does not scan, then she can call the pharmacy and get the medication issue resolved.

4. Ms. Barnett-Ketter testified that she understands that the system is there for patient safety and that she has learned she must verify everything prior to administering medications. She also told the Board that she has learned to make sure that her documentation is specific as to why a patient may refuse medication, to be more specific in her assessment, and to always follow up with the doctor so he or she is aware of a patient’s refusal of his medication.

5. Ms. Barnett-Ketter holds two jobs, one in a long term care facility, and one in a home health setting. She submitted a letter and six-month evaluation from Personal Touch Home Health, which were positive. Ms. Barnett-Ketter also submitted evidence that she completed two continuing education courses on medication errors and documentation.

6. No evidence of patient harm was presented.

CONCLUSIONS OF LAW

1. Findings of Fact Nos. 2(a) through 2(c) constitute a violation of Virginia Code § 54.1-3007(5) and (8).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Nursing hereby ORDERS as follows:

1. Sonia Dionne Barnett-Ketter, R.N., is REPRIMANDED.
2. Sonia Dionne Barnett-Ketter, R.N., shall comply with all laws and regulations governing the practice of professional nursing in the Commonwealth of Virginia.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD


Jay Douglas, M.S.M., R.N., C.S.A.C., F.R.E.
Executive Director
Virginia Board of Nursing

ENTERED AND MAILED ON: March 30th, 2017

NOTICE OF RIGHT TO APPEAL

As provided by Rule 2A:2 of the Supreme Court of Virginia, you have 30 days from the date you are served with this Order in which to appeal this decision by filing a Notice of Appeal with Jay Douglas, M.S.M., R.N., C.S.A.C., F.R.E., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.

Certified True Copy

By 
Virginia Board Of Nursing