VIRGINIA:

BEFORE THE COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE

IN RE: AMANDA MOORE, L.N.P.
License Nos.: 0024-170245
0017-140593
0001-196531

ORDER

Pursuant to §§ 2.2-4019, 2.2-4021, and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), a Special Conference Committee ("Committee") of the Virginia Committee of the Joint Boards of Nursing and Medicine ("Committee of the Joint Boards") met on October 7, 2015 in Henrico County, Virginia, to inquire into evidence that Amanda Moore, L.N.P. may have violated certain laws and regulations governing nurse practitioner practice in Virginia. Ms. Moore was present and was represented by William Moffett, Esquire

Upon consideration of the evidence, the Committee adopts the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Amanda Moore, L.N.P. was issued License No. 0024-170245 to practice as a nurse practitioner in the area of family practice in the Commonwealth of Virginia on July 31, 2012. Said license expires on November 30, 2016. She also holds License No. 0017-140593 for prescriptive authority and License No. 0001-196531 to practice professional nursing in Virginia.

2. By letter dated September 10, 2015, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Moore notifying her that an informal conference would be held on October 7, 2015. The Notice was sent by certified and first class mail to P.O. Box 143, Clintwood, Virginia 24228, the address of

record on file with the Board of Nursing. The Notice was also sent to 201 Hampton Street, Clintwood, Virginia 24228, a secondary address.

3. During the course of her employment as a nurse practitioner with Community Medical Care, Lebanon, Virginia:

a. In her care and treatment of Patient A, a female in her mid-40's diagnosed with generalized osteoarthritis, degenerative joint disease, migraines, insomnia due to chronic pain and anxiety with depression (among other things), from approximately December 2012 until the patient's death in October 2014 due to acute combined oxycodone (C-II), alprazolam (C-IV), and cyclobenzaprine intoxication:

i. Beginning on December 5, 2012, when Ms. Moore took over the patient's care from another provider in the practice, she prescribed controlled substances for the treatment of her pain, anxiety with depression, and insomnia, including narcotics, benzodiazepines, sedative-hypnotics, and muscle relaxants, without attempting to treat the patient with non-narcotic modalities and despite the following indicia of drug seeking and substance misuse or abuse being noted in her record:

(a). On July 16, 2012, it was noted that the patient called the practice stating that "she went to the eye doc [sic] today that he stated that the reason she was seeing black dots is because her stress is too high. Patient needs you to increase her dose of Klonopin, put her on Lortab, and send her in a sleeping pill …"

(b). On March 11, 2013, when the patient visited Wellmont Medical Center, Norton, Virginia, complaining of ankle pain, the physician who examined her noted that the patient required surgery but that "at this time she is taking heavy doses of narcotics. This will be a problem. She cannot even stand up without holding onto the wall. She cannot even open her eyes … I think it is going to be a problem to take care of her."

(c). On June 20, 2013, Patient A's urine toxicology screen was negative for her prescribed Xanax (alprazolam, C-IV), yet Ms. Moore continued to prescribe Xanax to her.

(d). On August 17, 2014, Patient A's urine toxicology screen was negative for her prescribed oxycodone, yet Ms. Moore continued to prescribe oxycodone to her.

ii Despite the fact that Patient A's condition did not improve under her care, Ms. Moore continued to prescribe narcotics, benzodiazepines, sedative-hypnotics, muscle relaxants, ropinirol, and Neurontin (gabapentin) without any further referrals to specialists after March 2013 or any indication that she consulted with Patient A regarding the possibility that continued use of narcotics could make her pain worse.

iii. Despite requiring Patient A to sign a controlled medications policy in May 2013, there is no indication in the record that Ms. Moore conducted pill counts at each visit, required Patient A to submit to random urine toxicology screens, or reviewed the patient's Prescription Monitoring Report to determine whether she was taking her medications as prescribed by her or whether she was being prescribed controlled medications by other providers.

b. In her care and treatment of Patient B, a male in his mid-50's diagnosed with degenerative joint disease, osteoarthritis, degenerative spondylolisthesis, anxiety, and insomnia (among other things), from approximately July 2012 until the patient's death in September 2014:

i. Beginning on November 7, 2012, when Ms. Moore took over the patient's care from another provider in the practice, she continued to prescribe controlled substances for the treatment of his pain, anxiety, and insomnia, including hydrocodone, oxycodone, sedative-hypnotics, and muscle relaxants, without attempting to treat the patient with non-narcotic modalities and despite the following indicia of substance misuse or abuse being noted in his record:

(a). August 7, 2009: "patient has failed UTOX in the past, not comfortable writing controlled meds."

(b). December 9, 2009: "patient did not keep appointment with referrals to pain clinic."

(c) June 8, 2011: "call from … Total Home Care states that she went to admit patient to home health and patient became irate and refused. She discharged him but she received a phone call from patient's insurance stating that they requested patient meds be monitored because they have concerns about his narcotics. Also wanted us to know the patient is traveling to Washington DC to get methadone."

(d). July 10, 2012: "patient missed his appointment with pain management with Dr. Gutti. Also patient is [sic] not been here for > 6 months … patient has missed several appointments with neurosurgery, pain management … referral initiated to a chronic pain specialist … due to previous hx of noncompliance, also please refer to previous UTOX report, will hold off on controlled meds for now, patient also has been on methadone, will refer him to pain management …" It was further noted that the provider recommended that Patient B decrease his consumption of alcohol.

(e). July 12, 2012: "patient is refusing to go to appointment with Dr. Gutti states he has been there before and they cannot do anything for him."

(f). July 27, 2012: "Southeastern Pain management refusing to see patient because of noncompliance."

(g). December 10, 2012: A note from Pain Medicine Associates, Kingsport, Tennessee, stated "he was previously seen at a pain clinic in Washington, D.C. … evidently on methadone 10mg as well as oxycodone … he is no longer being seen at the clinic … he says he called there for an

appointment and they told him they were not available … will need to obtain records from previous pain clinics for review prior to deciding whether to accept the patient for care here."

(h). On January 10, 2013, Ms. Moore noted "UTOX today – keep follow up with pain management. Instructed I would no longer write his pain medication after this month."

(i). On January 10, 2013, Patient B's urine toxicology screen was positive for oxymorphone (C-II), which Ms. Moore did not prescribe.

(j). On April 26, 2013, after having surgery at Highlands Neurosurgery, Bristol, Tennessee, Patient B was prescribed MS Contin (morphine, C-II) 30mg, 1 tab bid #60 (a 30-day supply) and oxycodone 10mg 1 q 6 hours #90 (a 22.5-day supply), yet Ms. Moore prescribed oxycodone 20mg #120 nine days later, on May 7, 2013.

(k). On August 30, 2013, Patient B's urine toxicology screen was positive for morphine and oxymorphone, which Ms. Moore did not prescribe. She noted "morphine 15mg from pain clinic Southeast Pain Clinic;" however, there is no record in Patient B's chart that Southeast Pain Clinic was treating Patient B, and Southeast Pain Clinic had refused to treat Patient B in July 2012.

ii. From August 2013 until September 2014, despite the fact that Patient B's condition did not improve under her care, Ms. Moore continued to prescribe oxycodone, Flexeril (cyclobenzaprine, C-IV), Klonopin (clonazepam, C-IV), Ambien, and Neurontin, and to inject Patient B with Toradol (ketorolac), without any further referrals to specialists or any indication that she consulted with Patient B regarding the possibility that continued use of narcotics could make his pain worse. Further, on April 30, 2014, she increased Patient B's dosage of oxycodone from 20mg every 6 hours to 30mg every 4-6 hours without explanation.

iii. Despite requiring Patient B to sign a controlled medications policy in December 2012 and August 2013, there is no indication in the record that Ms. Moore conducted pill counts

at each visit, required Patient B to submit to more than one random urine toxicology screen, or reviewed the patient's Prescription Monitoring Report to determine whether he was taking his medications as prescribed by her or whether he was being prescribed controlled medications by other providers.

c. In her care and treatment of Patient C, a male in his early 70's diagnosed with COPD, degenerative joint disease with chronic low back pain, osteoarthritis, and anxiety (among other things), from approximately October 2012 until the patient's death in August 2014:

i. Beginning on February 6, 2013, Ms. Moore prescribed Patient C narcotic medications, including Lortab and fentanyl, even though she knew or should have known that Patient C had entered into a controlled medication contract with Dr. Gutti of the Pain Management Center in June 2012 and she noted on December 6, 2012 that the patient was receiving OxyContin and Percocet from "pain management."

ii. Between March 13, 2014 and July 9, 2014, Ms. Moore increased Patient C's transdermal fentanyl (C-II) dose despite the following:

(a). On April 10, 2014, she increased his dosage from 25mcg to 50mcg every 72 hours without documenting an adequate rationale.

(b). On July 9, 2014, she increased his dosage from 50mcg to 75mcg every 72 hours despite his telling her that narcotics helped with his pain level and he was "stable on fentanyl and norco."

iii. Ms. Moore continued to prescribe potentially dangerous drugs or combinations of drugs to Patient C despite the following:

(a). Although a drug utilization note dated November 12, 2012, indicated that using SSRI's and tramadol together may lead to an increased risk of seizures and serotonin syndrome, which is marked by hypertension, hyperthermia, and mental status changes, as well as a decrease in analgesic

efficacy, she prescribed fluoxetine and tramadol to Patient C (or noted that he was currently taking these medications) at 14 monthly follow-up visits thereafter.

(b). Although a drug utilization note dated June 4, 2012, indicated that the concomitant use of benzodiazepines and muscle relaxants increased the risk of seizure and/or serotonin syndrome, she prescribed benzodiazepines and muscle relaxants to Patient C (or noted that he was currently taking these medications) at 16 monthly visits beginning in October 2012.

(c). Although drug utilization notes dated January 16, 2012 and January 15, 2013, indicated that the use of muscle relaxants in elderly patients created the high risk of anticholinergic adverse effects, sedation, disorientation, and weakness, and although Patient C's previous provider indicated that he would discontinue muscle relaxants on January 16, 2012, she prescribed muscle relaxants to Patient C (or noted that he was receiving muscle relaxants) in 18 monthly visits beginning in October 2012.

(d). On November 21, 2013, a note in Patient C's record indicated that the patient's wife had called stating that the patient was refusing to take his medications and exhibiting unusual, violent behavior, potential side effects of the medications she was prescribing him.

iv. Ms. Moore failed to adequately monitor Patient C for compliance with his treatment plan, in that she failed to document performing pill counts randomly or at each visit or accessing his Prescription Monitoring Program report, and she required only one urine drug screen, which was taken in the month of his death.

d. In her care and treatment of Patient D, a female in her mid-50's being treated for chronic low back pain and depressive disorder (among other things) from approximately November 2012:

i. Ms. Moore failed to adequately monitor Patient D for compliance with her Controlled Medications Contract, in that she failed to document performing pill counts randomly or at each visit or accessing her Prescription Monitoring Program report. Further, when Patient D tested negative for

her prescribed Ultram (tramadol) on November 19, 2013, she failed to review this result with her and continued to prescribe Ultram to her.

ii. Ms. Moore continued to prescribe narcotics, including Percocet and tramadol, to Patient D for treatment of her low back pain, despite the following:

(a). On June 3, 2013, Ms. Moore sent a letter of referral to Center East Tennessee Brain & Spine, and on July 16, 2013, she noted "refer to neurosurgery" for Patient D's low back pain. However, there is no indication that Patient D was examined with regard to her pain until she was seen at Pikeville Medical Center on October 27, 2014.

(b). On October 2, 2014, she prescribed Percocet to Patient D even though she noted, "she has been to neurosurgery" and "patient agrees to go to pain management" but that her "pain is uncontrolled with Percocet and Ultram. Percocet and Ultram causes decreased analgesia per genetic testing performed in July. Patient agrees to go to pain management and states her arthritis pain is worse too…. She would be unable to work without her Percocet even though it is not helping with her pain very much."

(c). On November 3, 2014, she prescribed Percocet to Patient D even though she noted, "refer to pain management due to pharmacogenetics testing stating patient will have reduce [sic] analgesic to Percocet."

4. At the informal conference, Ms. Moore stated that she was a new nurse practitioner and had taken over a practice from a physician who had made the determination that these patients needed pain medications. She stated that she treated these patients differently than she would have treated new patients. She acknowledged that she did not review their charts carefully. She acknowledged that she did not review the patients' Prescription Monitoring Program reports, but relied on the practice's nurses to check the reports and alert her if there were any problems. She acknowledged that she did not adequately document her reasons for increasing patients' doses of narcotic medications. She stated that she did refer patients to pain

management physicians and neurosurgeons but acknowledged that she did not monitor their compliance with these referrals. She acknowledged not conducting pill counts. She acknowledged that she should have made psychiatric referrals because she could not help the patients with their psychiatric problems. She acknowledged that she did not appropriately respond when patients' drug tests revealed that they were not taking medications as prescribed or were taking medications that she did not prescribe.

5. Ms. Moore stated that her practice as a professional nurse had taken place on a med-surg. intensive care unit at a hospital. She had not worked in a family practice setting before beginning her position as a nurse practitioner at Community Medical Care. She stated that in her nurse practitioner program, she learned how to take care of chronic conditions such as diabetes, but not chronic pain. She did not feel that she was adequately trained in pain management.

6. Ms. Moore stated that she was now working under the stricter supervision of her collaborating physician, Dr. Yousuf. She gets Dr. Yousuf's approval every time she needs to prescribe a narcotic medication. Dr. Yousuf now reviews her charts more carefully and sends feedback. Ms. Moore sends complex patients to Dr. Yousuf if she is unable help them. Her patient load has been decreased from 24 patients a day to 12-15 patients a day. She has more staff to help her.

7. Ms. Moore stated that Dr. Yousuf enacted a pain management policy after the investigation into Ms. Moore's practice started; she follows it carefully. She requires patients to sign informed consent forms and discusses the risks before prescribing narcotics. She refers patients out more frequently. She uses different modalities for pain including NSAIDs, referrals to physical therapy, and relaxation techniques.

CONCLUSIONS OF LAW

Findings of Fact Nos. 3(a) – 3(d) constitute a violation of §§ 54.1-2915(A)(3), (13), (17), and (18), 54.1-3007(2), (5), and (8), 54.1-3303(A), and 54.1-3408(A) of the Code, 18 VAC 90-20-300(A)(2)(b) and (f)

of the Regulations Governing the Practice of Nursing, and 18 VAC 90-30-220(4) of the Regulations Governing the Licensure of Nurse Practitioners.

ORDER

On the basis of the foregoing, the Committee hereby ORDERS as follows:

1. Amanda Moore, L.N.P. is hereby REPRIMANDED.

2. Ms. Moore shall be placed on PROBATION for a period of 12 months of actual nurse practitioner practice subject to the following terms and conditions:

a. The period of probation shall begin on the date that this Order is entered and shall end at such time as Ms. Moore has completed 12 months of active practice in employment as a licensed nurse practitioner ("practice employment"). The nurse practitioner license of Ms. Moore shall be reinstated without restriction at the completion of the probationary period without an administrative proceeding unless there is a pending investigation or unresolved allegation involving a violation of law, regulation or any term or condition of probation. In that event, the period of probation shall be continued indefinitely or until such time as the Committee of the Joint Boards makes a case decision in accordance with the Administrative Process Act, § 2.2-4000 et seq. and § 54.1-2400.9 et seq. of the Code.

b. Written reports are required by this Order and, unless otherwise specified, shall be sent to Compliance at the Board of Nursing offices with the first report(s) received in the Board of Nursing office no later than 60 days from the date this Order is entered. Subsequent reports must be received quarterly by the last day of the months of March, June, September and December until the period of probation ends. Many of the required report forms are available on the Board of Nursing's website for your convenience.

c. Performance Evaluations shall be provided to the Committee of the Joint Boards, at the direction of Ms. Moore, by all practice employer(s), using the forms provided by Compliance and available on the Board of Nursing's website.

d. Ms. Moore shall provide evidence, within 60 days of the entry of this Order, of the following:

i. That she has read and understands Board of Medicine Guidance Document 85-24, Guidance *on the Use of Opioid Analgesics in the Treatment of Chronic Pain.*

ii. That she has completed a course acceptable to the Committee of the Joint Boards regarding professional accountability and legal liability for nurse practitioners.

e. Ms. Moore shall submit "Self-Reports" which include a current address, telephone number, and verification of any and all current practice employment. These reports shall also include any changes in practice employment status. Self-Reports must be submitted whether Ms. Moore has current practice employment or not.

f. Ms. Moore shall inform the Committee of the Joint Boards in writing within ten days of the date any practice employment begins, changes, is interrupted, or ends. Additionally, Ms. Moore shall provide a contact name, address, and phone number for each practice employer to the Committee of the Joint Boards.

g. Ms. Moore shall inform all current and future practice employers that the Committee of the Joint Boards has placed her on probation and shall provide each practice employer with a complete copy of this Order. If Ms. Moore is employed through a staffing agency, she shall inform her supervisor in each facility where assigned that she is on probation.

h. Ms. Moore shall return all copies of her license to practice as a nurse practitioner to the Board of Nursing office within ten days of the date of entry of this Order, along with payment of a duplicate license fee as specified in the regulations governing nurse practitioners. Upon receipt, the Board of Nursing shall issue a replacement nurse practitioner license marked "Probation with Terms."

i. The Committee of the Joint Boards shall review Ms. Moore's Prescription Monitoring Program profile quarterly and shall evaluate the profile for appropriate prescribing of controlled substances. Ms. Moore shall provide the Committee of the Joint Boards with any requested patient documentation in furtherance of such review.

j. Ms. Moore shall conduct herself as a licensed nurse practitioner in compliance with the requirements of Title 54.1, Chapters 29 and 30 of the Code and the Committee of the Joint Boards' Regulations.

k. Any violation of the stated terms and conditions contained in this Order, or failure to comply with all terms of this Order within five years of the date of entry of the Order, shall be reason for suspending or revoking the license of Ms. Moore, and an administrative proceeding may be held to determine whether her license shall be suspended or revoked.

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

Pursuant to Section 54.1-2400(10) of the Code, Ms. Moore may, not later than 5:00 p.m., on December 2, 2015, notify Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that she desires a formal administrative hearing before the Committee of the Joint Boards. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

FOR THE COMMITTEE:

for Gloria Mitchell-Lewis
Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director, Virginia Board of Nursing

ENTERED: October 29, 2015

This Order shall become final on December 2, 2015 unless a request for a formal administrative hearing is received as described above.

Certified True Copy
By dgraham
Virginia Board Of Nursing