

BEFORE THE VIRGINIA BOARD OF NURSING

IN RE: DENISE HARDEY, R.N.
A.K.A. Denise Rusk Ballard Dunham
A.K.A. Denise Rusk Ballard
License Number: 0001-110995
Case Number: 170011

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Nursing (“Board”) held an informal conference on October 6, 2016, in Henrico County, Virginia, to inquire into evidence that Denise Hardey, R.N., may have violated certain laws and regulations governing the practice of professional nursing in the Commonwealth of Virginia.

Denise Hardey, R.N. appeared at this proceeding and was represented by Michael Goodman, Esquire.

NOTICE

By letter dated May 13, 2016, the Board sent a Notice of Informal Conference (“Notice”) to Ms. Hardey notifying her that an informal conference would be held on June 9, 2016. The Notice was sent by certified and first class mail to the legal address of record on file with the Board. Ms. Hardey requested a continuance, which was granted. By letter dated September 8, 2016, the Board sent an Amended Notice of Informal Conference (“Amended Notice”) to Ms. Hardey notifying her that an informal conference would be held on October 6, 2016. The Amended 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 Committee adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Denise Hardey, R.N., was issued License Number 0001-110995 to practice professional nursing on August 23, 1988, which is scheduled to expire on February 28, 2018. At all times relevant to the findings contained herein, said license was current and active. Her primary state of residence is Virginia.

2. Denise Hardey, R.N. violated Virginia Code § 54.1-3007(2), (5) and (8) and 18 VAC 90-20-300(A)(2)(c) and (e) of the Regulations Governing the Practice of Nursing in that during the course of her employment with Chesapeake Regional Medical Center, Chesapeake, Virginia, she participated with another nurse (“Nurse B”) who Ms. Hardey supervised, in the diversion of oxycodone (C-II), Percocet (oxycodone and acetaminophen, C-II), and hydrocodone (C-II), as evidenced by the following:

a. Ms. Hardey and Nurse B often pulled medications for a patient and then minutes later pulled the same medication for the same patient. Administration of the medications was often not documented. The medications were frequently wasted immediately after being vended, with each nurse witnessing the waste for the other nurse’s vends. Some medications were vended after the patient was discharged. For example:

i. On June 4, 2015, Nurse B pulled four tabs of oxycodone (20mg) at 14:27 for Patient A. Ms. Hardey documented the administration of 10 mg of oxycodone to Patient A at 14:32. Nurse B documented the waste of two tabs at 16:08, witnessed by Ms. Hardey. Nurse B also pulled two tabs of Percocet at 14:28 for Patient A. There is no record of administration. Nurse B wasted two tabs at 16:08, witnessed by Ms. Hardey.

ii. On June 5, 2015, Nurse B pulled two tabs of Percocet at 12:57 for Patient A, for which there is no documentation of administration, return, or waste. Ms. Hardy then

pulled two tabs of Percocet at 13:30:50 for Patient A, for which there was no documentation of administration, return, or waste. Additionally, Patient A was discharged at 13:30.

iii. On June 29, 2015, Ms. Hardey pulled four tabs of oxycodone for Patient B at 16:03, for which there was no documentation of administration, return, or waste. Patient B was discharged at 15:59.

iv. On June 26, 2015, Ms. Hardey pulled one tab of hydrocodone/acetaminophen at 13:37 for Patient C, for which there was no documentation of administration, return, or waste.

v. On July 1, 2015, Ms. Hardey pulled four tabs of oxycodone at 11:20 for Patient D, for which there was no record of administration, return, or waste.

vi. On July 1, 2015, Nurse B pulled two tabs of Percocet at 09:55 for Patient D, for which there is no documentation of administration. Ms. Hardey pulled two tabs of Percocet at 10:19, for which there is no documentation of administration. Nurse B pulled two tabs of Percocet at 12:36, for which there is no record of administration. Ms. Hardey pulled two tabs of Percocet at 13:25, for which there is no record of administration. Ms. Hardey pulled two tabs of Percocet at 16:26, for which there was no record of administration. Patient D had been discharged at 16:23. Nurse B recorded the waste of two tabs of Percocet at 14:02:40, witnessed by Ms. Hardey. Nurse B recorded the waste of two tabs of Percocet at 14:02:41, witnessed by Ms. Hardey. Nurse B recorded the waste of two tabs of Percocet at 14:02:42, witnessed by Ms. Hardey.

vii. On July 20, 2015, Nurse B pulled two tabs of oxycodone for Patient E at 12:17, for which there is no record of administration. Nurse B documented the waste of two tabs of oxycodone at 13:59, witnessed by Ms. Hardey. Ms. Hardey pulled two tabs of oxycodone at 14:03, for which there is no record of administration, return, or waste. At 15:50 Nurse B pulled two tabs of

oxycodone, for which there is no record of administration. Nurse B recorded the waste of two tabs of oxycodone at 15:52:54, witnessed by Ms. Hardey. Nurse B also recorded the waste of two tabs of oxycodone at 15:52:55, witnessed by Ms. Hardey.

viii. On July 21, 2015, Nurse B pulled two tabs of oxycodone at 10:07 for Patient E, for which there is no record of administration. Nurse B recorded the waste of two tabs of oxycodone at 10:16, witnessed by Ms. Hardey. Nurse B pulled two tabs of oxycodone at 11:20 for Patient E, for which there is no record of administration. Nurse B recorded the waste of two of tabs of oxycodone at 15:30, witnessed by Ms. Hardey.

ix. On July 23, 2015, Nurse B pulled two tabs of oxycodone at 12:41 for Patient E, for which there is no record of administration. Nurse B recorded the waste of two tabs of oxycodone at 12:45, witnessed by Ms. Hardey.

x. On July 24, 2015, Nurse B pulled two tabs of oxycodone at 10:42 for Patient E, for which there is no record of administration. Nurse B recorded the waste of two tabs of oxycodone at 10:49, witnessed by Ms. Hardey.

xi. On August 13, 2015, Nurse B pulled two tabs of Percocet at 12:44 for Patient F, for which there is no record of administration, return, or waste. Ms. Hardey pulled two tabs of Percocet for Patient F at 13:15, for which there is no record of administration. Ms. Hardey recorded the waste of two tabs of Percocet at 13:16, witnessed by Nurse B.

xii. On September 9, 2015, Nurse B pulled two tabs of Percocet for Patient G at 15:13:25 which was recorded as administered at 15:13. Nurse B pulled two tabs of Percocet at 15:27, for which there was no record of administration, return, or waste. Ms. Hardy pulled two tabs of Percocet at 17:22, for which there is no record of administration. Ms. Hardey documented the waste of

two tabs of Percocet at 17:22:14, witnessed by Nurse B. Ms. Hardey documented the waste of two tabs of Percocet at 17:22:57, witnessed by Nurse B.

xiii. On October 4, 2015, Nurse B pulled two tabs of Percocet for Patient H at 14:03, for which there is no record of administration. Nurse B recorded the waste of two tabs of Percocet at 14:33:34, witnessed by Ms. Hardey. Nurse B pulled two tabs of Percocet at 14:04, for which there is no record of administration. Nurse B recorded the waste of two tabs of Percocet at 14:33:35, witnessed by Ms. Hardey.

b. Ms. Hardey admitted that she had not witnessed all of Nurse B's wastes. Nurse B admitted to diverting medications for three or four months, and to wasting empty packages in the sharps container when Ms. Hardey witnessed, believing the medication was in the package.

3. During the informal conference, Ms. Hardey denied diversion but said that looking back at the situation she should have realized what Nurse B was doing.

4. Ms. Hardey was allowed to resign from her employment with the Chesapeake Regional Medical Center in lieu of termination on October 5, 2015.


ORDER

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

1. Denise Hardey, R.N., is REPRIMANDED.
2. Denise Hardey, 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: November 8th, 2016

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), Ms. Hardey may, not later than 5:00 p.m., on November 26, 2016, notify 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, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated. This Order shall become final on November 26, 2016, unless a request for a formal administrative hearing is received as described above.

Certified True Copy

By 
Virginia Board of Nursing