BEFORE THE VIRGINIA BOARD OF NURSING

IN RE:

ASHLEY DANIELLE BROUILLIARD SINOZICH, R.N.

License Number: 0001-226678

Case Number:

163395

RATIFICATION AND ORDER

On July 20, 2016, a panel of the Board met to receive and act upon the Recommended Decision

of the Agency Subordinate. ASHLEY DANIELLE BROUILLIARD SINOZICH, R.N. was not present

nor was she represented by legal counsel.

In consideration whereof, the Board of Nursing ACCEPTS the attached Recommended

Findings of Fact and Conclusions of Law of the Agency Subordinate and ADOPTS the Recommended

Order in its entirety.

Pursuant to Virginia Code § 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.

Pursuant to Virginia Code § 54.1-2400(K), the Board considered whether to disclose or not

disclose Ms. Sinozich's health records or health services.

Pursuant to Virginia Code § 54.1-2400(10), Ms. Sinozich may, not later than 5:00 p.m., on

August 29, 2016, notify Jay P. 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.

Certified True Copy

Executive Director

Virginia Board of Nursing

300-2

ENTERED AND MAILED ON:

ly 27, 2016

This Order shall become final on August 29, 2016, unless a request for a formal administrative hearing

is received as described above.

**Certified True Copy** 

Virginia Board of Nursing

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IN RE:

ASHLEY DANIELLE BROUILLIARD SINOZICH, R.N.

**License Number: 0001-226678** Case Number:

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REPORT AND RECOMMENDATION OF AGENCY SUBORDINATE

Jurisdiction and Procedural History

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), Jane Elliott, R.N., Ph.D., serving as

Agency Subordinate of the Virginia Board of Nursing ("Board"), held an informal conference on April

20, 2016 in Henrico County, Virginia, to inquire into evidence that ASHLEY DANIELLE

BROUILLIARD SINOZICH, R.N. may have violated certain laws and regulations governing the

practice of professional nursing in the Commonwealth of Virginia.

Ms. Sinozich appeared at this proceeding and was not represented by legal counsel.

Upon consideration of the evidence, the Agency Subordinate makes the following Findings of

Fact and Conclusions of Law and recommends that the Board adopt the following Order.

Notice

By letter dated March 22, 2016, the Board of Nursing sent a Notice of Informal Conference

("Notice") to Ms. Sinozich notifying her that an informal conference would be held on April 20, 2016.

The Notice was sent by certified and first class mail to the legal address of record on file with the

Board of Nursing.

Recommended Findings of Fact and Conclusions of Law

ASHLEY DANIELLE BROUILLIARD SINOZICH, R.N. was issued License Number 1.

0001-226678 to practice professional nursing on August 16, 2010, which is scheduled to expire on

August 31, 2017. At all times relevant to the allegations herein, said licenses was in full force and effect. Her primary state of residence is Virginia.

- 2. By Consent Order entered July 29, 2010, the Board reprimanded Ms. Sinozich and approved her application for licensure to practice professional nursing. This action was based on findings that Ms. Sinozich had been convicted of driving under the influence in 2005 and 2010.
- 3. ASHLEY DANIELLE BROUILLIARD SINOZICH, R.N. violated Virginia Code § 54.1-3007(5) and (8) in that during the course of her employment as night shift unit coordinator/permanent charge nurse on the Telemetry Unit of Sentara CarePlex Hospital, Hampton, Virginia, in April 2015, she made numerous errors with respect to the withdrawal, administration, and documentation of narcotic medications, as evidenced by the following:
- a. For Patient A, who had an order for fentanyl 25mcg every two hours as needed for anxiety and pain, she withdrew fentanyl from the Omnicell system without any documentation of administration, with conflicting documentation, and/or less than two hours after the last withdrawal:
- i. On April 2, 2015, she withdrew fentanyl at 06:15 without documenting any pain assessment or administration of the medication.
- ii. On April 7, 2015, she withdrew fentanyl at 13:45 and documented administering it at 14:07 along with hydrocodone and lorazepam, but at 15:00, another nurse documented that the patient was still complaining of pain.
- iii. On April 8, 2015, she withdrew fentanyl at 19:04 and documented administering it at 19:27, but she failed to document any complaint of pain. She then withdrew fentanyl again at 20:17 without documenting administration or complaint of pain, and when she had just documented that the patient was asleep at 20:00.

- iv. On April 9, 2015, at 01:48; 02:29, 02:58, and 04:14, she withdrew fentanyl and documented administering it to the patient without documenting any complaint of pain. In addition, during this time, the patient was noted to be calm and tranquil.
- v. On April 10, 2015, she withdrew fentanyl at 21:12 and 21:53. She failed to document any complaint of pain or administration of the medication after the 21:53 withdrawal. Further, another nurse had documented the patient's pain at 4/10 at 21:06.
- vi. Between 23:48 on April 10, 2015 and 03:26 on April 11, 2015, she withdrew fentanyl four times. She only documented administration three times, and failed to document any complaint of pain. Further, another nurse had documented the patient's pain at 2/10 at 22:49 on April 10.
- vii. On April 11, 2015, between 05:58 and 23:47, there is documentation that she administered fentanyl to Patient A four times; however, she failed to document any complaint of pain or administration of the medication on the patient's flowsheet.
- viii. On April 12, 2015, between 17:36 and 23:15, she withdrew fentanyl six times; however, she documented complaints of pain and administering the medication only three times.
- ix. On April 13, 2015, she withdrew fentanyl once at 00:04, twice at 02:12 and once at 03:35. However, she only documented complaints of pain and administering the medication twice during this time period.
  - b. For Patient B, who had an order for fentanyl 50mcg every four hours:
- i. On April 5, 2015, she documented administering fentanyl at 02:01, though she documented at 02:00 that the patient was calm and denied pain. Further, there was no withdrawal of the medication until 02:39.

- ii. On April 5, 2015, at 04:00, she documented that the patient was resting without distress, and at 04:15, she documented that he was asleep, but she also noted that his pain was 7/10 and that she medicated him with hydrocodone at 04:14.
- iii. On April 5, 2015, at 06:35, she withdrew fentanyl but failed to document any complaint of pain or administration of the medication.
- iv. On April 5, 2015, she withdrew fentanyl at 18:54 and documented administering it to the patient at 19:22. She then withdrew fentanyl at 20:06 with no documentation of pain or administration.
- v. She withdrew fentanyl at 23:55 on April 5 but failed to document pain or administration.
- vi. On April 6, 2015, she withdrew fentanyl at 03:13 and 04:22, but failed to document any complaint of pain, and documented administering the medication only at 04:26.
  - c. For Patient C, who had an order for fentanyl 50mcg every hour:
- i. On April 18, 2015, she withdrew fentanyl at 03:30 but failed to document administering the medication until 05:31.
- ii. On April 18, 2015, at 0630, she documented an absence of nonverbal indicators of pain, but she withdrew fentanyl at 06:34 and documented administering the medication at 06:53.
- iii. On April 18, 2015, at 17:08, she withdrew fentanyl but failed to document pain or administration.
- 4. At the informal conference, Ms. Sinozich denied diverting any of the medication. She stated that she became overwhelmed with responsibilities in April 2015 and took numerous shortcuts with regard to medicating her patients. She stated that she often removed multiple doses of narcotics at

the beginning of a shift and carried the doses around with her until it was time to administer them, then had another nurse witness any wastages at the end of her shift. She acknowledged that her practice and documentation were very poor during this time.

- 5. Ms. Sinozich's employment was terminated on May 15, 2015. She was not counseled or given an opportunity to remediate her practice. The facility did not find Ms. Sinozich showed any signs of impairment and did not ask her to submit to a urine drug screen during its investigation of possible drug diversion. Ms. Sinozich had been employed at Sentara CarePlex for five years. This was her first nursing employment. She had received average performance reviews and had been promoted during this time.
- 6. On June 10, 2015, Ms. Sinozich submitted to a urine drug screen as requested by an investigator for the Department of Health Professions. The screen was negative.
- 7. Ms. Sinozich has been employed with Riverside Hospital System Health Communications Office since August 2015. In this position, she answers patient queries over the telephone. She does not have hands-on patient contact. Her employer is not aware of this matter before the Board.

## Recommended Order

Based on the foregoing Findings of Fact and Conclusions of Law, the Agency Subordinate recommends that the Board issue an Order as follows:

- 1. ASHLEY DANIELLE BROUILLIARD SINOZICH is REPRIMANDED.
- 2. Within 60 days from the date of entry of this Order, ASHLEY DANIELLE BROUILLIARD SINOZICH shall provide written proof satisfactory to the Board of successful completion of the following NCSBN online courses:
  - a. Documentation: A Critical Aspect of Client Care;

ASHLEY DANIELLE BROUILLIARD SINOZICH, R.N. Page 6 of 6

b. Professional Accountability & Legal Liability for Nurses.

3. Continuing education obtained through compliance with Term No. 2 shall not be used

toward licensure renewal.

4. ASHLEY DANIELLE BROUILLIARD SINOZICH shall comply with all laws and

regulations governing the practice of nursing in the Commonwealth of Virginia.

5. Any violation of the foregoing terms and conditions of this Order or any statute or

regulation governing the practice of professional nursing shall constitute grounds for further

disciplinary action.

Reviewed and approved on May 3, 2016

By Jane Elliott, R.N., Ph.D.

Agency Subordinate

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Virginia Board of Nursing