VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: CALLIE ROBBINS, R.N.
License No.: 0001-201115

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 Board of Nursing ("Board") met on February 18, 2016, in Henrico County, Virginia, to inquire into evidence that Callie Robbins, R.N., may have violated certain laws and regulations governing nursing practice in Virginia. Ms. Robbins was present and was represented by Douglas Burtch, Esquire.

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

FINDINGS OF FACT

1. Callie Robbins, R.N., was issued License No. 0001-201115 to practice professional nursing in the Commonwealth of Virginia on June 7, 2006. Said license expires on June 30, 2016. Ms. Robbins' primary state of residence is Virginia.

2. By letter dated September 15, 2015, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Robbins notifying her that an informal conference would be held on October 14, 2015. The Notice was sent by certified and first class mail to 12121 Pervical Street, Chester, Virginia 23831, the address of record on file with the Board of Nursing. Ms. Robbins requested and received continuances on October 9, 2015, and December 1, 2015. The informal conference was rescheduled for February 18, 2016.

3. Between July 2014 and October 2014, Ms. Robbins asked two of her co-workers for their left-over pain medications, including Percocet (oxycodone-acetaminophen, C-II), that they had received from previous treatment. Ms. Robbins received the requested pain medications from two of her co-workers.

4. During the course of her employment with Bon Secours St. Francis Medical Center, Midlothian, Virginia, Ms. Robbins failed to accurately document administration and wastage of narcotic medications, as evidenced by the following:

a. On October 27, 2014, Ms. Robbins pulled two tablets of Percocet for Patient B; however, she failed to document the administration and/or wastage of the medication.

b. Between November 16, 2014 and November 17, 2014, Ms. Robbins pulled eight tablets of Percocet for Patient C. She documented wasting an unknown number of tablets and administering five tablets.

c. Between November 17, 2014 and November 19, 2014, Ms. Robbins pulled 16 tablets of Percocet for Patient D but she only documented administration of 12 of those tablets, leaving 4 tablets unaccounted for.

d. Between November 17, 2014 and November 20, 2014, Ms. Robbins pulled 17 tablets of Percocet for Patient E, but she only documented administering 11 tablets to the patient. In addition, Ms. Robbins pulled two tablets of Percocet for Patient E at 9:51 p.m., but she had administered two tablets to the patient at 8:00 p.m. The medication was ordered to be given two tablets every six hours as needed. Ms. Robbins then documented an unknown number of tablets as wasted at 11:18 p.m. but pulled another tablet approximately 30 seconds later.

e. Between November 16, 2014 and November 18, 2014, Ms. Robbins pulled 22 tablets of Percocet for Patient F; however, she only documented administration of 14 tablets to the patient. Ms.

Robbins also documented a medication waste on two occasions but did not indicate the quantity of the wastage.

f. Between November 30, 2014 and December 1, 2014, Ms. Robbins pulled 18 tablets of Percocet for Patient H; however, she only documented administration of 12 tablets to the patient.

g. On December 15, 2014 and December 17, 2014, Ms. Robbins pulled 15 tablets of Percocet for Patient I; however, she only documented administration of 10 tablets to the patient. Both the patient and her husband reported that Patient I did not receive any Percocet during her entire stay. Additionally, Ms. Robbins documented administering two tablets to the patient at least five times on December 16, 2014 and December 17, 2014.

h. On December 16, 2014 and December 17, 2014, Ms. Robbins falsely documented that she administered two tablets of Percocet to Patient J on three occasions during the evening and night hours. However, Patient J reported that she had only received one tablet of Percocet through the night and that her pain had not been well controlled.

i. On or about December 16, 2014 and December 17, 2014, Ms. Robbins falsely documented that she administered two tablets of Percocet to Patient K on three occasions, at approximately 8:13 p.m., 11:14 p.m. and 2:58 a.m. However, Patient K reported that she only received pain medication early in the evening on December 16, 2014.

j. On November 25, 2014, Ms. Robbins falsely documented that she administered two tabs of Percocet to Patient L at 3:13 a.m., but she did not pull the medication until 3:16 a.m.

k. Ms. Robbins frequently pulled Percocet tablets hours before they were due to be administered, withdrew Percocet but failed to document any action regarding the medication, and by her own admission and carried Percocet tablets around with her in her pockets.

5. Ms. Robbins admitted to the Committee her poor practice patterns. Ms. Robbins denied that she diverted any narcotic medications.

6. Ms. Robbins stated to the Committee that she resigned her position with St. Francis during the facility's investigation, to accept another position that does not involve direct patient care.

CONCLUSIONS OF LAW

Findings of Fact Nos. 4(a) through 4(k) constitute a violation of §54.1-3007(2), (5), and (8) of the Code and 18 VAC 90-20-300(A)(2)(e) and (f) of the Regulations Governing the Practice of Nursing.

ORDER

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

1. Callie Robbins, R.N., is hereby REPRIMANDED.

2. Ms. Robbins shall provide the Board with verification that she has completed the following NCSBN on-line courses: *Ethics of Nursing Practice; Documentation: A Critical Aspect of Client Care;* and *Professional Accountability & Legal Liability for Nurses* within 90 days of the date this Order is entered. These courses shall not be credited toward the continued competency requirements for the next renewal of her license.

3. Ms. Robbins shall maintain a course of conduct in her capacity as a professional nurse commensurate with the requirements of § 54.1-3000 *et seq.* of the Code and the Board of Nursing Regulations.

4. Any violation of the terms and conditions of this Order or of any law or regulation affecting the practice of nursing in the Commonwealth of Virginia shall constitute grounds for the suspension or revocation of the license of Ms. Robbins and an administrative proceeding shall be convened to determine whether such 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. Robbins may, not later than 5:00 p.m., on April 6, 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.

FOR THE COMMITTEE:

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

ENTERED: March 4th, 2016

This Order shall become final on April 6, 2016, unless a request for a formal administrative hearing is received as described above.