VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: DARLENE M. MELLEN, R.N.
License No.: 0001-247137

ORDER

In accordance with §§ 2.2-4019, 2.2-4021 and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), an informal conference was conducted on behalf of the Board of Nursing ("Board") on October 7, 2015, in Henrico County, Virginia. Ms. Mellen was present and was not represented by legal counsel. Jodi Power, R.N., J.D., serving as Agency Subordinate for the Board, submitted a Recommended Decision for consideration.

On November 18, 2015, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Ms. Mellen was not present nor was she represented by legal counsel.

Based upon its review of the Recommended Decision of the Agency Subordinate, the Board makes the following Findings of Fact and Conclusions of Law and issues the following Order.

FINDINGS OF FACT

1. Darlene M. Mellen, R.N. was issued License No. 0001-247137 to practice professional nursing in Virginia on August 27, 2013. The license is scheduled to expire on October 31, 2017. Ms. Mellen's primary state of residence is Virginia.

2. By letter dated September 9, 2015, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Mellen notifying her that an informal conference would be held on October 7, 2015. The Notice was sent by certified and first class mail to 321 Persimmon Drive, Yorktown, Virginia 23693, the address of record on file with the Board of Nursing. By letter dated September 21, 2015, the Board of Nursing sent an Amended Notice of Informal Conference ("Amended Notice") to Ms.

Mellen notifying her that an informal conference would be held on October 7, 2015. The Amended Notice was sent by certified and first class mail to 321 Persimmon Drive, Yorktown, Virginia 23693, the address of record on file with the Board of Nursing.

3. During the course of her employment with Envoy of Williamsburg, Williamsburg, Virginia, on December 19, 2014, Ms. Mellen failed to properly administer and document administration of medication to an alert and oriented patient, who was scheduled to receive one tablet of hydromorphone HCL 4mg (C-II) every six hours as needed for pain and one tablet of morphine sulfate 60mg every eight hours. Ms. Mellen withdrew the resident's medication, but instead of giving the resident morphine sulfate, she gave the resident ibuprofen, that she retrieved from the facility's supply and was intended for resident use, to treat her own headache. At the informal conference, Ms. Mellen stated that she was a new nurse with six months experience at the time of this incident. Ms. Mellen stated that she pulled medications for three to four residents in advance and then stacked the unlabeled cups in her pocket along with the two ibuprofen tablets. Ms. Mellen claimed that the cups spilled, and, as a result, she gave the resident the incorrect medication. Ms. Mellen admitted that she mistakenly switched an ibuprofen tablet with the morphine sulfate tablet, but claimed that she gave the resident his hydromorphone tablet and any patient deprivation was inadvertent. Ms. Mellen incorrectly documented administration of both medications. Ms. Mellen reported that she threw away the patient's morphine sulfate tablet, which had spilled in her pocket.

4. As a result of this incident, Ms. Mellen's employment was terminated on December 23, 2014, after approximately one month of employment. Ms. Mellen previously received a disciplinary write-up on December 17, 2014 for failure to administer medication and poor work performance, which Ms. Mellen claimed was related to holes in her documentation related to medication administration records and treatment administration records.

5. Ms. Mellen's employment was terminated from all three nursing positions she has held since her nursing licensure in 2013. At the informal conference, Ms. Mellen stated that she was not currently employed in nursing but wished to return to nursing after this matter was resolved.

6. Ms. Mellen acknowledged that her practice of pulling, documenting, and administering medications for multiple residents concurrently was not a safe practice, but she stated that she had learned from this matter. Ms. Mellen reported that going forward she would ensure she was well-orientated and prepared for nursing positions, practice "by the book," and put patient safety first.

CONCLUSIONS OF LAW

Finding of Fact No. 3 constitutes a violation of § 54.1-3007(2), (5), and (8) of the Code and 18 VAC 90-20-300(A)(2)(c) and (e)of the Regulations Governing the Practice of Nursing.

ORDER

WHEREFORE, it is hereby ORDERED as follows:

1. Darlene M. Mellen is hereby REPRIMANDED.

2. Ms. Mellen shall provide the Board with verification that she has completed the National Council of State Boards of Nursing courses *Medication Errors: Detection and Prevention* and *Documentation: A Critical Aspect of Client Care* within 60 days of the entry of this Order. These courses shall not be credited toward the continued competency requirements for the next renewal of her license.

3. Ms. Mellen 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 Darlene M. Mellen, R.N., and an administrative proceeding shall be convened to determine whether such license shall be suspended or revoked.

Pursuant to § 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 a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Section 54.1-2400(10) of the Code, Ms. Mellen may, not later than 5:00 p.m., on January 17, 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 BOARD:

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

ENTERED: December 15th, 2015

This Order shall become final on January 17, 2016, unless a request for a formal administrative hearing is received as described above.

Certified True Copy
By _____
Virginia Board of Nursing