VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: HEATHER K. WIDGEON, R.N.
License No.: 0001-228637

NOTICE OF HEARING

Pursuant to §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), Heather K. Widgeon, R.N., who holds License No. 0001-228637, which expires on July 31, 2016, is hereby given notice that a formal administrative hearing will be held in the presence of a panel of the Board of Nursing. The hearing will be held on November 18, 2015, at 1:00 p.m., at the offices of the Department of Health Professions, Board of Nursing, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia 23233, at which time Ms. Widgeon will be afforded the opportunity to be heard in person or by counsel.

At the hearing, Ms. Widgeon has the following rights, among others: the right to representation by counsel; the right to have witnesses subpoenaed and to present witnesses on her behalf; the right to present documentary evidence; and the right to cross-examine adverse witnesses. If Ms. Widgeon desires any witnesses to appear on her behalf, she must notify the Director of Administrative Proceedings, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in accordance with the Instructions for Requesting Subpoenas.

The purpose of the hearing is to inquire into evidence that Heather K. Widgeon, R.N. may have violated certain laws and regulations governing nursing practice in Virginia, as more fully set forth in the Statement of Particulars below.

STATEMENT OF PARTICULARS

The Board alleges that during the course of her employment with Children's Hospital of the King's Daughters, Norfolk, Virginia:

1. Ms. Widgeon may have violated §54.1-3007(2) and (5) of the Code and 18 VAC 90-20-300(A)(2)(f) of the Regulations Governing the Practice of Nursing ("Regulations") in that:

a. On or about January 10, 2014, Ms. Widgeon failed to assess and/or document the results of respiratory assessments for Patient A.

b. On or about January 17, 2014, and January 18, 2014, Ms. Widgeon failed to assess and/or document the results of respiratory and pain assessments, as well as vital signs taken with regard to Patient B.

c. On or about February 14, 2014, Ms. Widgeon failed to assess and/or document the results of Patient C's vital signs, as well as respiratory and pain assessments.

d. On or about February 21, 2014 and February 22, 2014, Ms. Widgeon failed to assess and/or document the results of respiratory assessments for Patient D.

e. On or about February 21, 2014 and February 22, 2014, Ms. Widgeon failed to assess and/or document the results of respiratory assessments for Patient E.

f. On or about February 27, 2014, Ms. Widgeon failed to assess and/or document the results of vital signs and pain assessments for Patient F.

g. On or about March 3, 2014, Ms. Widgeon failed to assess and/or document the results of vital signs, as well as pain and respiratory assessments for Patient G.

h. On or about March 7, 2014, Ms. Widgeon failed to assess and/or document the results of vital signs and pain assessments for Patients H, I and J.

i. On or about January 17, 2014, January 18, 2014 and January 19, 2014, Ms. Widgeon failed to assess and/or document the results of vital signs and respiratory assessments for Patient K.

2. Ms. Widgeon may have violated §54.1-3007(2) and (5) of the Code and 18 VAC 90-20-300(A)(2)(e) of the Regulations in that:

a. On or about April 4, 2014 and April 5, 2014, Ms. Widgeon documented IV fluid rate values prior to fluid being administered to Patient L on five occasions.

b. On or about April 20, 2014 and April 21, 2014, Ms. Widgeon documented IV fluid rate values prior to fluid being administered to Patient M on ten occasions.

c. On or about April 26, 2014 and April 27, 2014, Ms. Widgeon documented IV fluid rate values prior to fluid being administered to Patient N on six occasions.

d. On or about April 26, 2014, and April 27, 2014, Ms. Widgeon documented IV fluid rate values prior to fluid being administered to Patient O on eight occasions.

e. On or about April 4, 2014 and April 5, 2014, Ms. Widgeon documented IV fluid rate values prior to fluid being administered to Patient Q on six occasions.

3. Ms. Widgeon may have violated §54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(a), (e) and (f) of the Regulations in that on or about May 2, 2014, Ms. Widgeon performed an in and out catheterization on Patient P without a physician's order and she failed to inform the physician of the procedure. Ms. Widgeon also documented IV fluid rate values prior to the fluid being administered on May 2, 2014 and May 3, 2014, on five occasions. Additionally, Ms. Widgeon documented on Patient P's medical record that he had voided and there was no documentation related to fluid retention or a bladder scan.

4. Ms. Widgeon may have violated §54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(e) and (f) of the Regulations in that on or about May 13, 2014, Ms. Widgeon gave Patient Q, a four-year-old, newly diagnosed diabetic, an inappropriate amount of carbohydrates as a snack. The patient's insulin dosage was only appropriate for 30 grams of carbohydrates. By her own admission, Ms. Widgeon gave the patient 59 grams of carbohydrates; however, by the parents' report of what the patient ingested, the patient received approximately 148 grams of carbohydrates. In addition, by her own admission, Ms. Widgeon failed to check the patient's blood sugar prior to giving the patient her snack, Ms. Widgeon's

calculations were incorrect with regard to carbohydrate grams, Ms. Widgeon incorrectly documented "cola" for a drink, and Ms. Widgeon failed to document giving the patient two juice boxes. Furthermore, based on the incorrect carbohydrate calculation, Ms. Widgeon administered an incorrect dose of insulin.

Please see confidential Attachment I for the names of the patients referenced above.

FOR THE BOARD

Gloria Mitchell-Lively

for Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director for the
Board of Nursing

ENTERED: October 15, 2015