VIRGINIA:

BEFORE THE COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE

IN RE: **SHELLEY HICKS, L.N.P.**
Virginia License No.: 0024-168229
Virginia Authority to Prescribe No.: 0017-139396

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 of the Virginia Committee of the Joint Boards of Nursing and Medicine ("Committee of the Joint Boards") met on October 7, 2015, in Henrico County, Virginia, to inquire into evidence that Shelley Hicks, L.N.P., may have violated certain laws and regulations governing the practice of nurse practitioners in Virginia. Ms. Hicks was present and was represented by Christopher Stevens, Esquire.

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

FINDINGS OF FACT

1. Shelley Hicks, L.N.P., was issued License No. 0024-168229 to practice as a licensed nurse practitioner in the Commonwealth of Virginia on March 10, 2009. Ms. Hicks also holds an authority to prescribe and a license to practice professional nursing in the Commonwealth of Virginia. Said licenses and authority are set to expire on January 31, 2017. Ms. Hicks' primary state of residence is Virginia.

2. By letter dated September 10, 2015, the Committee of the Joint Boards sent a Notice of Informal Conference ("Notice"), to Ms. Hicks notifying her that an informal conference would be held on October 7, 2015. The Notice was sent by certified and first class mail to Post Office Box 9, Kingsport, Tennessee, 37662, the address of record on file with the Board of Nursing. The Notice was also sent to 142 Hicks Lane, Castlewood, Virginia, 24224, a secondary address.

3. During the course of her employment with Family Health Care Associates, Lebanon, Virginia:

A. Between November 19, 2013 and December 31, 2013, Ms. Hicks failed to properly prescribe and monitor Patient A's narcotic pain medications and possible substance abuse and/or mental illness, as evidenced by the following:

i. Ms. Hicks prescribed narcotic medications to Patient A despite the following evidence of possible abuse or misuse from prior treatment providers:

a. Medical records from Southeastern Pain Management, Bristol, Tennessee, which were in Patient A's chart, revealed a history of non-compliance with prescribed medications. On April 18, 2013, Patient A indicated that she had taken two tablets of hydrocodone-acetaminophen (C-II) and that the medication did not provide any relief; however, the medication was ordered to be given one tablet every eight hours as needed for pain. Furthermore, between May 16, 2013 and August 8, 2013, at four office visits, it was noted that Patient A admitted that she had been non-compliant with her course of treatment and that she was self-medicating.

b. Medical records from C-Health of St. Paul, St. Paul, Virginia, which were in Patient A's chart, revealed that the patient displayed drug seeking behaviors. On January 29, 2013, Patient A requested a prescription for Lortab (hydrocodone, C-II), even though she was scheduled to see Dr. Roatsey, at another practice, the following week for a prescription for pain medications. The physician also noted that he suspected some of the patient's problems may be related to her alcohol use. The patient admitted that she continued to occasionally drink an alcoholic beverage. Moreover, on April 3, 2013, Patient A requested changes to her pain medication even though she was receiving treatment at Southeastern Pain Management.

B. Prior to prescribing narcotic mediations to Patient A:

i. Ms. Hicks failed to complete a detailed patient evaluation. In addition, Ms. Hicks failed to have the patient undergo any type of risk evaluation for depression or other mental health disorder. The patient's prior medical records indicated that she was previously diagnosed with depression and anxiety and Ms. Hicks documented that the patient had an anxiety disorder, for which she prescribed the patient medication.

ii. Ms. Hicks failed to consult with an addiction specialist despite knowing that Patient A had a history of substance abuse as documented in her medical records. Ms. Hicks also failed to consult with any of the patient's prior physicians.

iii. Ms. Hicks failed to notice and/or question the fact that Patient A's medical records showed evidence of "doctor shopping" in that Patient A repeatedly changed physicians after receiving care for less than one year.

C. While prescribing narcotic medications to Patient A:

i. On November 19, 2013, Patient A signed a Consent for Opioid Therapy agreement with Ms. Hicks as her prescriber. The agreement failed to address the prescriber's policies and expectations, reasons for discontinuing or changing drug therapy, and the responsibilities of the prescriber and the patient.

ii. Between November 19, 2013 and December 31, 2013, Ms. Hicks failed to have Patient A submit to random drug screens despite knowing that Patient A's prior medical records indicated a history of non-compliance and a history of self-medicating.

iii. On November 19, 2013, Ms. Hicks prescribed Patient A Dilaudid (hydromorphone, C-II) 4mg, one tablet every six hours as needed for pain, despite knowing that she was receiving oxycodone (C-II) from another provider and despite documenting that she used alcohol daily.

iv. On December 2, 2013, Ms. Hicks prescribed Patient A oxycodone and

Dilaudid, even though she documented that the patient used alcohol daily.

v. On December 31, 2013, Ms. Hicks again prescribed Patient A both Dilaudid and oxycodone, despite her report of intermittent alcohol use. Ms. Hicks also prescribed Patient A hydrocodone cough syrup (C-III). Furthermore, the patient presented at Ms. Hicks' office with a letter from the Department of Motor Vehicles ("DMV") indicating that her driver's license would soon be suspended, in part due to a diagnosis of alcohol-induced dementia. Ms. Hicks failed to research the matter and instead completed new paperwork indicating that Patient A was a "social drinker only" and that drug/alcohol treatment was "not applicable." At the informal conference, Ms. Hicks acknowledged that when Patient A presented DMV paperwork regarding a diagnosis of alcohol-induced dementia she did not contact the DMV to further explore the basis of the paperwork or the diagnosis.

vi. Ms. Hicks continued to prescribe the patient narcotic medications even though the patient had not displayed any progress with her treatment, and she failed to consult with a pain management specialist and/or to provide the patient with a referral to a pain management specialist.

vii. Ms. Hicks failed to assess Patient A's level of pain at each visit. The only time Ms. Hicks assessed and/or documented Patient A's pain level was at the first visit, when she documented a 9-10 on a 10 point pain scale. Thereafter, Ms. Hicks only documented that Patient A reported that the medications were not strong enough and that there was no change in her pain.

4. At the informal conference, Ms. Hicks acknowledged that she did not personally obtain each patient's Prescription Monitoring Program Report ("PMP") but stated that a nurse would pull the PMP for each patient to be seen each day and would put the record into the patient's room at check-in where she would review it.

5. At Patient A's first appointment, Ms. Hicks prescribed four new medications to the patient at relatively high doses. Ms. Hicks further acknowledged that Patient A had admitted to heavy alcohol use in the past and that she continued to use alcohol.

6. Between July 8, 2013 and January 1, 2014, Ms. Hicks practiced as nurse practitioner without a collaborative practice agreement with a physician.

7. At the informal conference, Ms. Hicks stated that she signed a collaborative practice agreement when she first began employment at Family Health Care Associates; however, she acknowledged that she did not date the document at the request of the practice administrator and that she did not obtain a copy of the agreement.

8. Ms. Hicks is currently employed at Community Medical Care, Castlewood, Virginia and has been employed there since August 3, 2015.

CONCLUSIONS OF LAW

1. Finding of Fact Nos. 3(A)(1)(a) and (b), Nos. 3(B)(i), (ii) and (iii), and Nos. 3(C)(i), (ii), (iii), (iv), (v), (vi) and (vii) constitute a violation of §§54.1-3007(5) and 54.1-2915(3), (12), (13), (17), and (18) of the Code and 18 VAC 90-30-220(4) and (6) of the Emergency Regulations Governing the Licensure of Nurse Practitioners ("Regulations").

2. Finding of Fact No. 6 constitutes a violation of §§54.1-2915(A)(18) and 54.1-2957(B) of the Code, 18 VAC 90-30-122(A) of the Regulations and 18 VAC 90-40-90(A) and (C) of the Emergency Regulations for Prescriptive Authority for Nurse Practitioners.

ORDER

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

1. Ms. Hicks is hereby REPRIMANDED.

2. Shelley Hicks, L.N.P., shall be placed on PROBATION for a period of 12 months of active practice in employment as a licensed nurse practitioner with prescriptive authority and subject to the following terms and conditions:

a. The nurse practitioner license of Ms. Hicks shall be reinstated without restriction at the completion of the probationary period without an administrative hearing unless there is a pending investigation or unresolved allegation involving a violation of law, regulation or any term or condition of probation. In that event, the period of probation shall be continued indefinitely or until such time as the Committee makes a case decision in accordance with the Administrative Process Act, §2.2-4000 et. seq. and §54.1-2400.9 et. seq. of the Code.

b. Written reports are required by this Order and, unless otherwise specified, shall be sent to Compliance at the Board offices with the first report(s) received in the Board office no later than 60 days from the date this Order is entered. Subsequent reports must be received quarterly by the last day of the months of March, June, September and December until the period of probation ends. Many of the required report forms are available on the Board of Nursing's website for your convenience.

c. Performance evaluations shall be provided to the Committee, at the direction of Ms. Hicks, by all practice employer(s), using the forms provided by Compliance and available on the Board's website.

d. Ms. Hicks shall submit "Self-Reports" which include a current address, telephone number, and verification of any and all current practice employment. These reports shall also include any change in practice employment status. Self-Reports must be submitted whether Ms. Hicks has current practice employment or not.

e. Ms. Hicks shall return all copies of her license to practice as a nurse practitioner and her prescriptive authority to the Board office within ten days of the date of entry of this Order, along with a

payment of a duplicate license fee as specified in the regulations governing nursing. Upon receipt, the Board of Nursing shall issue a replacement nurse practitioner license marked "Probation with Terms."

f. Ms. Hicks shall inform the Committee in writing within ten days of the date any practice employment begins, changes, is interrupted, or ends. Additionally, Ms. Hicks shall provide a contact name, address, and phone number for each practice employer to the Committee.

g. Ms. Hicks shall informal all current and future practice employers that the Committee has placed her on probation with terms and conditions and she shall provide each practice employer with a complete copy of this Order. If Ms. Hicks is employed through a staffing agency, she shall inform her supervisor in each facility where assigned that she is on probation with terms and conditions.

h. Ms. Hicks shall provide all current and future treating practitioners with a complete copy of this Order and shall execute an *Authorization for Disclosure of Information* form providing for unrestricted communication between the Committee, Compliance, and any treatment providers, court-appointed probation or parole officers, and any consultants designated by the Committee, if applicable.

3. Ms. Hicks shall provide evidence, within 60 days of the entry of this Order, of the following:

a. That she has read and understands Board of Medicine Guidance Document 85-24, *Guidance on the Use of Opioid Analgesics in the Treatment of Chronic Pain.*

b. That she has completed a course acceptable to the Committee regarding professional accountability and legal liability for nurse practitioners.

c. That she has completed an eight-CEU course acceptable to the Committee related to prescribing for the elderly.

d. These courses shall not be credited toward the continued competency requirements for the next renewal of her license.

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

5. Any violation of the terms and conditions of this Order or failure to comply with all terms of this Order within five years of the date of entry of the Order, shall be reason for the suspension or revocation of the license and/or authority of Ms. Hicks and an administrative proceeding shall be convened to determine whether such license and/or authority 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. Hicks may, not later than 5:00 p.m., on December 16, 2015, notify Jay P. Douglas, MSM, RN, CSAC, FRE, 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:

Gloria Mitchell-Lively

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

ENTERED: November 12, 2015

This Order shall become final on December 16, 2015 unless a request for a formal administrative hearing is received as described above.

Certified True Copy
By dgraham
Virginia Board Of Nursing