VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: FELICIA DONAVANT, R.N.
License No.: 0001-227929

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 June 8, 2015, in Henrico County, Virginia, to inquire into evidence that Felicia Donavant, R.N., may have violated certain laws and regulations governing nursing practice in Virginia. Ms. Donavant was present and was not represented by Margaret Hardy, Esquire.

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

FINDINGS OF FACT

1. Felicia Donavant, R.N., was issued License No. 0001-227929 to practice professional nursing in the Commonwealth of Virginia on November 3, 2010. Said license expires on October 31, 2015. Ms. Donavant's primary state of residence is Virginia.

2. By letter dated May 13, 2015, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Donavant notifying her that an informal conference would be held on June 8, 2015. The Notice was sent by certified and first class mail to 71 Tupelo Circle, Hampton, Virginia 23666, the address of record on file with the Board of Nursing.

3. During the course of her employment with Sentara CarePlex Hospital ("Sentara CarePlex"), Hampton, Virginia, by her own admission, Ms. Donavant failed to properly administer medications as evidenced by the following:

a. On April 12, 2014, Ms. Donavant administered IV Lasix (furosemide, C-VI) to a patient instead of a continuous IV infusion of Protonix as ordered.

b. On September 22, 2014, Ms. Donavant administered Percocet to Patient C, while the patient was also receiving IV morphine and Dilaudid (hydromorphone, C- II).

c. On October 6, 2014, Ms. Donavant administered Tylenol 650mg and two tablets of Percocet to Patient E at the same time.

4. By her own admission, during the course of her employment with Sentara CarePlex, Ms. Donavant failed to administer and properly document narcotic medications as evidenced by the following:

a. On June 22, 2014, at 0811 hours and 0812 hours, Ms. Donavant removed one tablet of Norco from the Omnicell machine for Patient A, but only documented administration of one tablet at 0901 hours.

b. On September 6, 2014, at 0811 hours and 0812 hours, Ms. Donavant removed one tablet of Percocet (acetaminophen and oxycodone, C-II) from the Omnicell machine for Patient B, but only documented administration of one tablet at 0859 hours.

c. On September 21, 2014, at 0949 hours, Ms. Donavant removed two tablets of Percocet from the Omnicell machine for Patient C, but there was no documentation of administration.

d. On September 22, 2014, at 1008 hours, Ms. Donavant removed two tablets of Percocet from the Omnicell machine for Patient C, but there was no documentation of administration.

e. On September 29, 2014, at 1004 hours, Ms. Donavant removed 10mg IV morphine (C-II) from the Omnicell machine for Patient D. She documented administration of 6mg IV morphine, but did not document wastage of the remaining 4mg of morphine.

f. On September 29, 2014, at 1004 hours, Ms. Donavant removed two tablets of Percocet from the Omnicell machine for Patient D, but there was no documentation of administration.

5. By her own admission, during the course of her employment at Sentara CarePlex, on June 21, 2014, at 0715 hours, Ms. Donavant documented administration of one tablet of Norco (acetaminophen and hydrocodone, C-II) to Patient A, but there was no record that the medication was dispensed from the Omnicell machine until 0821 hours.

6. By her own admission, during the course of her employment at Sentara CarePlex, on June 21, 2014, Ms. Donavant documented administration of one tablet of Norco to Patient A at 1115 hours and 1515 hours, but there was no record that the medication was dispensed from the Omnicell machine until 1651 hours and 1652 hours.

7. Ms. Donavant stated to the Committee that her practice was to pull narcotic medications in anticipation of her patients' needs prior to assessing them. She stated that many times she did not scan the medications and her patients' armbands contemporaneously with administration. Ms. Donavant stated that at the end of her shift, she documented the events of the day in her patients' records, including medications given. She acknowledged that her documentation may not have been accurate.

8. During the course of her employment with Sentara CarePlex, Ms. Donavant failed to follow physicians' orders as evidenced by the following:

a. On September 13, 2013, Ms. Donavant failed to follow a physician's order to get a post-surgery patient out of bed, with assistance, for meals.

b. On September 19, 2013, Ms. Donavant failed to follow a physician's order for a stat lab in a timely manner.

9. On April 18, 2011, during the course of her employment with Riverside Regional Memorial Hospital, Ms. Donavant failed to timely respond to a patient's request for assistance. Ms. Donanvant also failed to assess the patient every two hours as required, but documented in the patient's record that she had

assessed the patient's IV site every two hours by utilizing a copy and paste method of documenting in the patient's record.

10. Ms. Donavant stated to the Committee that she was working with a critical patient and had delegated a patient care partner to check on the patient. Ms. Donavant stated that she checked on the patient approximately one hour later.

11. On her applications for employment with Eastern State Hospital, Williamsburg, Virginia, dated on or about November 15, 2011, and on or about March 15, 2012, Ms. Donanvant stated that her reason for leaving her employment with Riverside Regional Medical Center, Newport News, Virginia, was due to "lack of communications," when, in fact, her employment was terminated on September 16, 2011, due to attendance issues.

12. On her application for employment with Sentara CarePlex Hospital, dated January 9, 2013, Ms. Donavant stated that her reason for leaving her employment with Riverside Regional Medical Center was due to "family/personal-moved out of state," when, in fact, her employment was terminated as referenced in Finding of Fact No. 14.

13. Ms. Donavant stated that she knew she was overwhelmed at Sentara CarePlex and that she was not following the safety precautions related to medication administration and documentation.

14. On September 16, 2011, Ms. Donavant's employment with Riverside Regional Medical Center was terminated as a result of poor attendance.

15. On October 9, 2014, Ms. Donavant's employment with Sentara CarePlex was terminated for poor clinical judgment, unsatisfactory job performance, and failure to properly document, administer and/or dispense medications including controlled medications.

16. Ms. Donavant has been employed by four facilities since being licensed to practice professional nursing.

17. Ms. Donavant stated that she began employment with an emergent care center on March 19, 2015. She stated that this position is less stressful and allows her to document patient records in real-time. Ms. Donavant stated that she did not disclose to her current employer about her terminations from Sentara CarePlex and Riverside Regional Medical Center, because they did not ask. Further, she did not reveal that she had an informal conference before the Board scheduled for June 8, 2015.

CONCLUSIONS OF LAW

1. Findings of Fact Nos. 3(a) through 3(c) constitute a violation of § 54.1-3007(5) and (8) of the Code.

2. Findings of Fact Nos. 4(a) through 4(f) constitute a violation of § 54.1-3007(2), (3), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(e) of the Regulations Governing the Practice of Nursing ("Regulations").

3. Findings of Fact Nos. 5 and 6 constitute a violation of § 54.1-3007(5) of the Code.

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

5. Finding of Fact No. 9 constitutes 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.

6. Findings of Fact Nos. 11 and 12 constitute a violation of § 54.1-3007(2), (3) and (5) of the Code and 18 VAC 90-20-300(A)(2)(e) of the Regulations.

ORDER

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

1. Felicia Donavant, R.N., is hereby REPRIMANDED.

2. Ms. Donavant shall provide the Board with verification that she has completed the following NCSBN Courses: *Professional Accountability & Legal Liability for Nurses; Medication Errors: Detection &*

Prevention; and *Documentation: A Critical Aspect of Client Care* 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.

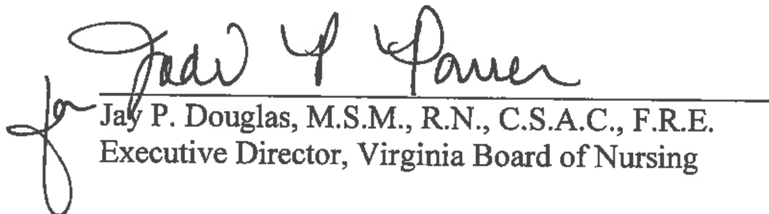
3. Ms. Donavant shall maintain a course of conduct in her capacity as a professional nurse commensurate with the requirements of § 54.1-3000 *et seq.* of the Code and the Board of Nursing Regulations.

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. Donavant 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. Donavant may, not later than 5:00 p.m., on August 9, 2015, 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: July 7, 2015

Certified True Copy
By________
Virginia Board of Nursing

This Order shall become final on August 9, 2015, unless a request for a formal administrative hearing is received as described above.