



20-300(A)(2)(f) of the Board of Nursing Regulations, in that during the course of his employment at INOVA Mount Vernon Hospital, Alexandria, Virginia (“INOVA Mt. Vernon”), he failed to provide proper care for two patients. Specifically:

- a. Between September 23 and 24, 2005, he was assigned to care for Patient A, who was suffering from a gastrointestinal bleed. The physician orders required monitoring of the patient’s hemoglobin and hematocrit levels; if the hematocrit level fell below 9.0 the patient was to receive an immediate blood transfusion. Blood tests performed at 8:09 p.m. and 9:50 p.m. on the 23rd indicated hematocrit levels of 8.9 and 8.2 respectively, but he did not begin a blood transfusion on either occasion. At approximately 2:20 a.m. on the 24th the patient experienced an acute bleed resulting in the first transfusion being performed at approximately 2:30 a.m. The patient was rushed to the Critical Care Unit (“CCU”) shortly afterwards. As a result of the incident, Mr. McLinden was sent home immediately and terminated from his employment on September 30, 2005.
- b. On September 15, 2005, Mr. McLinden was assigned to care for Patient B, who was admitted to his department at 12:30 a.m. Among the physician orders was an order for one dose of Digoxin (Schedule VI) immediately with another dose four hours later, and six units of fresh frozen plasma (“FFP”) “now.” The first blood transfusion did not begin until 4:45 a.m. When he was asked why the patient was supposed to receive six units of FFP Mr. McLinden could not give the reason. When the patient was admitted to his department, his heart rate was in the 120’s and irregular; Mr. McLinden had to be prompted by other staff to address the rapid and


irregular heartbeat. After contacting the attending physician, Mr. McLinden received orders to provide Cardizem (benzothiazepine, Schedule VI) to the patient to treat the irregular heartbeat. When preparing the Cardizem, he began to mix the wrong size bag and he did not know how to operate the medication pump. Finally, when Mr. McLinden was asked why a second dose of Digoxin had not been administered after four hours, he replied that the Cardizem would be better for the patient. Mr. McLinden was then ordered to administer the second dose of Digoxin.

2. Mr. McLinden may have violated § 54.1-3007(2) and (5) of the Code, and 18 VAC 90-20-300(A)(2)(e) of the Board of Nursing Regulations in that he made multiple false statements on job applications. Specifically:

- a. On his application for employment to INOVA Mt. Vernon dated May 27, 2004, he was asked to list his reasons for leaving his previous places of employment. Mr. McLinden did not state his reasons for leaving the Reston Hospital Association, Reston, Virginia (“Reston”) and the Virginia Hospital Center, Arlington, Virginia, which were that he had resigned from both positions after being involved in patient care issues. When interviewed by the Investigator with the Department of Health Professions, Mr. McLinden stated that he “forgot about it and did not want to elaborate about anything negative.”
- b. On his application for employment to Reston dated June 20, 2001, he was asked to list his reasons for leaving his previous places of employment. Mr. McLinden failed to list his reason for leaving INOVA Cameron Glen, Reston, Virginia, which was that he agreed to leave the facility due to an incident involving a patient on a

respirator.

FOR THE BOARD

  
Jay E. Douglas, R.N., M.S.M., C.S.A.C.  
Executive Director

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