VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: **AMANDA MARSHALL, R.N.**
a.k.a. Amanda Guth, R.N.
License No.: 0001-174830

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 August 4, 2014, in Henrico County, Virginia, to inquire into evidence that Amanda Marshall, R.N., may have violated certain laws and regulations governing professional nursing practice in Virginia. Ms. Marshall was present and was 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. Amanda Marshall, R.N., was issued License No. 0001-174830 to practice professional nursing in the Commonwealth of Virginia on October 25, 2001. Said license expires on May 31, 2016. Her primary state of residence is Virginia.

2. By letter dated June 26, 2014, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Marshall notifying her that an informal conference would be held on August 4, 2014. The Notice was sent by certified and first class mail to 2442 Denniston Avenue, Roanoke, Virginia, 24015, the address of record on file with the Board of Nursing. The Notice was also sent to 4809 Celtic Circle, Salem, Virginia, 24153, a secondary address.

3. During the course of her employment with Carilion Roanoke Memorial Hospital, Roanoke, Virginia:

a. On July 10, 2013, Ms. Marshall failed to administer Patient A's medications as ordered. Ms. Marshall administered fentanyl 50mcg (Schedule II) at 1619 hours and oxycodone (Schedule II) at 1627; however, Patient A was ordered oxycodone two tablets every four hours as needed and fentanyl 50mcg by intravenous every two hours as needed and if oral analgesics were ineffective 45 minutes after given.

b. On August 8, 2013, Ms. Marshall failed to administer Patient B's medications as ordered. Ms. Marshall administered fentanyl 50mcg and oxycodone at 0956 hours; however, Patient B was ordered oxycodone every three hours to be used first, as needed for pain and fentanyl 50mcg by intravenous every hour as needed for pain on a scale of 7 to 10 and if oral analgesics were ineffective 45 minutes after given.

c. On August 20, 2013, at 1552 hours, Ms. Marshall withdrew morphine 4mg for Patient C and documented administration of 4mg; however, the patient only had orders for 2mg and 3mg.

d. On September 6, 2013, Ms. Marshall failed to administer a Lovenox (enoxaparin, Schedule VI) injection to Patient D within 30 minutes of stopping the patient's heparin drip, as ordered.

e. On September 10, 2013, Ms. Marshall failed to administer Patient G's 0900 medications until approximately 1031 hours. Also, at 1415 hours, Ms. Marshall silenced Patient G's oxygen saturation alarm, which had a reading of 77%, and walked away without assessing the situation.

f. On August 7, 2013, at 1408 hours, Ms. Marshall withdrew fentanyl 100mcg for Patient B and documented administering 50mcg at 1413 hours. Ms. Marshall failed to document wasting the remaining 50mcg.

g. On August 20, 2013, at 0809 hours, Ms. Marshall withdrew morphine (Schedule II) 4mg for Patient C and documented administering 3mg; however, she failed to document any wastage.

h. On August 20, 2013, at 1136 hours, Ms. Marshall withdrew morphine 10mg using Patient F's name, and documented administering 3mg to Patient C and wasting 7mg.

i. On August 25, 2013, at 0954 hours, Ms. Marshall withdrew fentanyl 100mcg using Patient G's name; however, she failed to document administration or wastage.

4. On September 30, 2013, Ms. Marshall had a psychological evaluation conducted by a licensed clinical psychologist. His diagnostic impression was major depression, recurrent, moderate-severe; and alcohol abuse. Ms. Marshall had two follow-up appointments, which she failed to keep.

5. On August 29, 2013, in an email to her unit manager, and on February 25, 2014, during an interview with an investigator from the Department of Health Professions, Ms. Marshall reported having a lot of personal stressors. At the informal conference, Ms. Marshall also acknowledged having multiple stressors involving close family members. She is currently not employed, but is caring for her grandmother. Ms. Marshall stated that previously she could not understand how people could get stressed out and not be able to cope, but now she understands not being able to cope.

6. Ms. Marshall's last place of employment was Gentiva Home Health. She reported not being able to keep up with the charting of her home health clients.

CONCLUSIONS OF LAW

1. Findings of Fact Nos. 3(a)-(f) 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 Governing the Practice of Nursing.

2. Findings of Fact Nos. 3(g)-(i) constitute a violation of § 54.1-3007(5) and (8) of the Code.

3. Based on Findings of Fact Nos. 4 and 5, there is probable cause to believe that Ms. Marshall may be unable to safely practice nursing due to substance abuse and/or mental illness.

ORDER

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

1. Amanda Marshall, R.N., is hereby REPRIMANDED.

2. Pursuant to § 54.1-2400(15) of the Code, Ms. Marshall shall have an evaluation by a mental health/chemical dependency specialist satisfactory to the Board and shall have a written report of the evaluation, including a diagnosis, recommended course of therapy, prognosis, and any recommendations sent to the Board within 120 days after the date that this Order is entered. Upon receipt of the required information, the Board may request that Ms. Marshall reappear before a Special Conference Committee in order to consider the specialist's recommendations and to make a final disposition of the matter.

3. Ms. Marshall 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 Amanda Marshall, R.N., 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. Marshall may, not later than 5:00 p.m., on **September 28, 2014,** 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:

Gloria Mitchell

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

ENTERED: August 26, 2014

This Order shall become final on September 28, 2014, unless a request for a formal administrative hearing is received as described above.

Certified True Copy
By U. Robinson-Howard
Virginia Board of Nursing