COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Nursing

Nancy K. Durrett, R.N., M.S.N.
Executive Director
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July 31, 2002

Sandra Chester
Rt. 5 Box 571
Grundy, Virginia 24614

CERTIFIED MAIL
7160 3901 9844 7518 3844

Dear Ms. Chester:

Enclosed is a certified true copy of the Order entered by the Virginia Board of Nursing indefinitely suspending your license to practice as a professional nurse in the Commonwealth of Virginia.

Please, return both the large and small sections of your license to the Board office upon receipt of this letter.

If you have any questions, please contact us.

Sincerely,

Nancy K. Durrett

Nancy K. Durrett, R.N., M.S.N.
Executive Director

NKD/klb
Enclosure

cc: Robert A. Nebiker, Director, Department of Health Professions
James L. Banning, Director, Administrative Proceedings Division
Emily O. Wingfield, Assistant Attorney General
Ann L. Tiller, Senior Adjudication Analyst
Jennifer E. Baker, R.N., Division of Enforcement (82095/82696/84047)
Donna P. Whitney, L.P.N., C.S.A.C., Intervention Program Manager

VIRGINIA:

BEFORE THE BOARD OF NURSING

RE: SANDRA CAROL STEVENSON CHESTER, R.N.

ORDER

Pursuant to § 2.2-4020, § 2.2-4021, § 54.1-110 and § 54.1-2400(11) of the Code of Virginia (1950), as amended (the "Code"), a formal administrative hearing was held before a panel of the Board of Nursing (the "Board") on July 17, 2002, in Henrico County, Virginia, to receive and act upon evidence that Sandra Carol Stevenson Chester, R.N., a.k.a Sandy Duncan Chester, may have violated certain laws and regulations governing the practice of nursing in Virginia. The case was presented by Ann L. Tiller, Senior Adjudication Analyst, Administrative Proceedings Division. Howard M. Casway, Assistant Attorney General, was present as legal counsel for the Board. Ms. Chester was not present and was not represented by counsel. The proceedings were recorded by a certified court reporter.

Upon consideration of the evidence presented, the Board adopted the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Sandra Carol Stevenson Chester, R.N., held License No. 0001-136680 to practice professional nursing in the Commonwealth of Virginia.
2. Based upon the representations of Ms. Tiller and the admission of Commonwealth's Exhibit # 1, the affidavit of mailing, the presiding officer ruled that adequate notice was provided to Ms. Chester and the hearing proceeded in her absence.
3. During the course of Ms. Chester's employment with Tazewell Community Hospital, Tazewell, Virginia:

A. On or about June 18 through 19, 2001, while on duty from 7:00 p.m. to 7:00 a.m.:

1) Patient A, who was assigned to Ms. Chester, became combative and attempted to get out of bed. Ms. Chester was on break, and when paged to return to the Intensive Care Unit immediately, did not respond to the page and return to the unit.

2) By her own admission, Ms. Chester self-injected Lidocaine NS (Schedule VI), into her toe in the absence of a physician's order.

3) Ms. Chester documented that she administered Morphine 4 mg (Schedule II), to Patient B at 0200 hours and 0615 hours. She documented the administration of both doses of the Morphine on the Medication Administration Record ("MAR"); however, she failed to document completely the 0615 dose on the MAR, and did not document administration of the medication in the nurse's notes.

4) At 0600 hours, Ms. Chester signed out Morphine 2 mg for administration to Patient C; however, she failed to document its administration on the MAR or on the patient's recovery note.

5) Ms. Chester signed out eleven (11) doses of Ativan 2 mg for administration to Patient A. The narcotics control sheet indicates that Ms. Chester made many corrections and changes in time, and is unclear as to exactly when she may have removed the medication for administration to Patient A. Further, Ms. Chester documented administration of only nine (9) doses of Ativan to Patient A on the MAR.

6) At the conclusion of Ms. Chester's shift, she fell asleep when giving report, and could not find the appropriate line on which to sign her name on the narcotics count sheet. Additionally, although she was shown by her coworker where to sign her name, Ms. Chester did not sign her name on the proper line.

B. On or about June 15, 2001, while on duty, Ms. Chester altered Patient B's physician order for Morphine. Specifically, the physician wrote a new order for Morphine 2 mg IV every 4 hours as needed. Ms. Chester altered the MAR in that she changed the dosage from 2 mg to 4 mg.

C. From approximately June 8 through June 13, 2001, Ms. Chester documented that she administered Morphine, in a higher dosage, on more occasions than the day shift to Patient B. During this period, Patient B was only administered Morphine 2 mg by the day shift on June 9, 2001. Ms. Chester documented that she administered Morphine 4 mg on nine (9) occasions while on duty.

D. On or about June 21, 2001, Ms. Chester's employment was terminated for acting outside the scope of her practice and license, specifically, injecting Lidocaine into her own toe and altering a physician's order for Morphine.

4. During the course of Ms. Chester's employment with Lewis Gale Medical Center, Salem, Virginia:

A. On or about July 26, 2001, Ms. Chester falsified her application for employment in that she failed to disclose her previous employment with Tazewell Community Hospital. As a result of the falsification, Ms. Chester's employment was terminated on December 11, 2001. On or about December 12, 2001, when

staff cleaned out Ms. Chester's locker, the following was discovered:

1) One syringe containing Morphine;

2) One syringe containing Lidocaine;

3) Two (2) Ultram tablets; and

4) One Benadryl Allergy and Sinus Tablet.

5) It was noted that items 3 and 4 above were in unit dose packaging with lot numbers that matched those of the hospital pharmacy.

B. On or about October 29, 2001, during her shift, Ms. Chester signed out Morphine 2mg three (3) times, and Percocet 10mg once for Patient D. During the following shift, the patient received only Morphine on two (2) occasions.

C. On or about October 9, 2001, Patient E was given intravenous ("IV") fentanyl (Schedule II) via PCA pump at approximately 1100 hours. Ms. Chester changed the IV bag of fentanyl at midnight when 38 cc remained. It is unclear why Ms. Chester changed the medication early, and why she wasted, with a witness, the remaining 38 ccs.

D. From approximately October 9 through October 11, 2001, during her shifts, Ms. Chester signed out approximately 54mg of Morphine for Patient E. The patient had not received any pain medications, other than fentanyl via PCA pump, since October 6, 2001, and was not administered any pain medications other than fentanyl when Ms. Chester was not on duty. Further, on or about October 11, 2001, Ms. Chester failed to document the administration on the MAR of Morphine 10mg she signed out for the patient at 0000 hours.

5. On October 2, 2000, Ms. Chester signed a Participation Contract with the Health

Practitioners' Intervention Program ("HPIP"). This was pursuant to Chapter 25.1 of Title 54.1 of the Code of Virginia (1950), as amended, and 18 VAC 76-10-10, et seq., of the Regulations Governing the Health Practitioners' Intervention Program, with the understanding that the program is to assist those persons who have an impairment, defined as "a physical or mental disability, including, but not limited to substance abuse, that substantially alters the ability of a practitioner to practice his profession with safety to his patients and the public." On December 6, 2000, Ms. Chester signed a Recovery Monitoring Contract with the HPIP. On June 15, 2001, Ms. Chester was dismissed from the HPIP due to her:

A. Failure to enter and complete treatment as recommended;

B. Failure to call for or submit to urine drug screens;

C. Failure to respond to telephone messages and to written correspondence regarding non-compliance;

D. Failure to send in monthly self-reports; and

E. Failure to call her case manager weekly pursuant to her Recovery Monitoring Contract.

6. On or about August 15, 2001, the investigator from the Department of Health Professions interviewed Ms. Chester with regard to her dismissal from the HPIP. During the interview, Ms. Chester advised the following:

A. She had not been employed since September 2000;

B. She denied use of narcotics;

C. She stated that Dr. Sutherland initially diagnosed her as being depressed with suicidal tendencies, and placed her on Prozac;

D. She is not in treatment;

E. She attended Aftercare meetings two (2) times a week at Highlands Community, Abingdon, Virginia;

F. She did not comply with the terms of her contract with the HPIP.

7. During the course of investigation into the above allegations, it was discovered that Ms. Chester failed to notify the HPIP of her employment with Tazewell Community Hospital, and did not inform this hospital of her contract with the HPIP.

CONCLUSIONS OF LAW

Based upon the Findings of Fact, the Board concludes that Sandra Carol Stevenson Chester, R.N., has violated § 54.1-3007(2), (3), (5) and (6) of the Code of Virginia (1950), as amended, and 18 VAC 90-20-300(A)(2)(a), (c), (e) and (f) of the Regulations of the Board of Nursing.

ORDER

WHEREFORE, the Virginia Board of Nursing, effective upon entry of this Order, hereby ORDERS that License No. 0001-136680, issued to Sandra Carol Stevenson Chester, R.N., to practice professional nursing in the Commonwealth of Virginia, be and hereby is INDEFINITELY SUSPENDED. Ms. Chester may petition the Board after not less than two (2) years from the date of entry of this Order for reinstatement of her license to practice professional nursing, at which time a meeting will be convened to receive evidence satisfactory to the Board that Ms. Chester is able to resume the safe and competent practice of nursing.

Pursuant to § 2.2-4023 of the Code of Virginia (1950), as amended, 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.

Upon entry of this Order, the license of Sandra Carol Stevenson Chester, R.N., will be

recorded as indefinitely suspended and no longer current. Consistent with the terms of this Order, in the event that Ms. Chester seeks reinstatement of her license, she shall be responsible for any fees that may be required for the reinstatement and renewal of her license prior to issuance of her license to resume practice.

As provided by Rule 2A:2 of the Supreme Court of Virginia, Ms. Chester has thirty (30) days from the service date in which to appeal this decision by filing a Notice of Appeal with Nancy K. Durrett, R.N., M.S.N., Executive Director, Board of Nursing, 6606 W. Broad Street, Fourth Floor, Richmond, Virginia 23230-1717. The service date shall be defined as the date Ms. Chester actually received this decision or the date it was mailed to her, whichever occurred first. In the event this decision is served upon her by mail, three (3) days are added to that period.

FOR THE BOARD

Nancy K. Durrett

Nancy K. Durrett, R.N., M.S.N.
Executive Director for the
Board of Nursing

July 31, 2002

ENTERED

SANDRA CAROL STEVENSON CHESTER, R.N.

Certificate of Service

I hereby certify that a certified true copy of the foregoing Order was mailed on this day to Sandra Carol Stevenson Chester, R.N., at Rt. 5 Box 571, Grundy, Virginia, 24614.

Nancy K. Durrett

Nancy K. Durrett, R.N., M.S.N.
Executive Director for the
Board of Nursing

July 31, 2002
DATE

Certified True Copy
By DD 7/31/02
Virginia Board of Nursing