VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: CHRISTINA HOWELL, L.P.N.

ORDER

In accordance with §§2.2-4019, 2.2-4021 and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), an informal conference was conducted on behalf of the Board of Nursing ("Board") on November 30, 2010, in Henrico County, Virginia. Christina Howell, L.P.N., was present and was represented by Andrew J. Mulcunry, Esquire. Janet B. Younger, R.N., P.N.P., Ph.D., serving as Agency Subordinate for the Board, submitted a Recommended Decision for consideration.

On January 26, 2011, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Ms. Howell was not present nor was she represented by legal counsel.

Based upon its review of the Recommended Decision of the Agency Subordinate, the Board makes the following Findings of Fact and Conclusions of Law and issues the following Order.

FINDINGS OF FACT

1. Christina Howell, L.P.N., was issued License No. 0002-079155 to practice as a practical nurse in Virginia on September 26, 2008. The license is current and will expire on November 30, 2012. Ms. Howell's primary state of residence is Virginia.

2. By letter dated November 3, 2010, the Board sent a Notice of Informal Conference ("Notice") to Ms. Howell notifying her that an informal conference would be held on November 30, 2010. The Notice was sent by certified and first class mail to 6627 Quail Hollow Drive, Hayes Virginia 23072, the address of record on file with the Board.

3. On April 3, 2010, during the course of her employment with Riverside Convalescent Center ("Riverside"), Saluda, Virginia, Ms. Howell was assigned to conduct blood sugar tests and administer insulin to Residents A through E. At Riverside, nurses conduct blood sugar tests and determine the proper dose of insulin to administer through the use of a glucometer, a medical device for determining the approximate concentration of glucose in the blood. On April 3, 2010, Ms. Howell documented in Residents A through E's patient records (i) the resident's blood sugar test results and (ii) the amount of insulin administered to the resident. However, a colleague working the same shift reported to Riverside administrators that she did not observe Ms. Howell conduct any blood sugar test on any residents during the shift. Riverside administration's subsequent review of data retrieved from its glucometer device established that Ms. Howell did not conduct any blood sugar tests on Residents A through E on April 3, 2010. Riverside administrators could not interview the residents involved because each suffered from dementia and schizophrenia. However, there was no noticeable harm to any of the residents involved. At the conclusion of their investigation, Riverside administrators concluded that Ms. Howell had falsified the blood sugar test results. Riverside administrators could not determine whether Ms. Howell actually administered the insulin that she documented in each resident's patient record. As a result of this incident, Ms. Howell's employment was terminated on April 6, 2010.

4. At the informal conference, Ms. Howell described herself as a new graduate with limited preparatory experience for the clinical situation in which she found herself, having initially been licensed on September 26, 2008. Ms. Howell stated that she felt overwhelmed on the unit to which she was assigned and had asked to be transferred to unit of lower care intensity. Her requests were denied because she had not satisfactorily completed the orientation period. However, for a brief time only, she was assigned fewer patients.

5. Ms. Howell adamantly denied the allegation that she failed to conduct the blood sugar tests and falsified the residents' patient records. Ms. Howell disputed the veracity of her colleague's observations and the glucometer. Ms. Howell asserted that she used the glucometer properly to conduct blood sugar tests on Residents A through E and that she administered the proper amount of insulin (as determined by the glucometer) to each resident. Ms. Howell had no explanation why her user identification code or any of Residents A through E's identification codes were not stored in the glucometer for the shift at issue. Ms. Howell expressed uncertainty over the functioning of glucometers and had no idea what happened to the readings she took that day. However, Ms. Howell maintained that she accurately entered her identification code and all other necessary information into the glucometer device. Ms. Howell also maintained that she accurately documented in each patient record all of the data that she received from the glucometer (i.e., the blood sugar test results and the amount of insulin to be administered to each patient) and administered the proper amount of insulin to each patient. In support of her claim that she properly conducted the blood tests and administered insulin, Ms. Howell audited the patient records for Residents A through E and presented evidence that each patient's glucose levels later in the day after she had administered insulin showed no departure from their daily trends.

6. In the course of her employment with Walter Reed Convalescent and Rehabilitation Center ("Walter Reed"), Gloucester, Virginia, Ms. Howell committed numerous documentation errors involving controlled medications. Specifically:

a. On May 5, 2010, Ms. Howell administered two tablets of Tramodol to Resident F and only documented the administration of one tablet on the resident's Medication Administration Record ("MAR").

b. Between April 15, 2010, and April 28, 2010, Ms. Howell administered four doses of Darvocet (propoxyphene/acetaminophen - Schedule IV) to Resident G and in each case failed to document the administration on the resident's MAR.

c. On April 26, 2010, and April 30, 2010, Ms. Howell administered two doses of Darvocet to Resident H and failed to document the administration of either dose on the resident's MAR.

7. A Walter Reed administrator met with Ms. Howell and concluded that Ms. Howell did not recognize that improper documentation of controlled medications was a serious issue. Ms. Howell's employment was terminated on May 6, 2010.

8. At the informal conference, Ms. Howell admitted to making the documentation errors that were discovered and reported by Walter Reed. Ms. Howell confirmed that while she was employed by Walter Reed, she received a medication pass observation audit and received training on proper procedures for medication administration. Ms. Howell further acknowledged that she needs to improve in the area of documentation and time management. Ms. Howell is currently unemployed.

CONCLUSIONS OF LAW

1. Findings of Fact No. 3 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 Governing the Practice of Nursing.

2. Findings of Fact Nos. 6(a), 6(b), 6(c), 7, and 8 constitute violations of §54.1-3007(5) of the Code.

ORDER

WHEREFORE, it is hereby ORDERED as follows:

1. Christina Howell, L.P.N., is hereby REPRIMANDED.

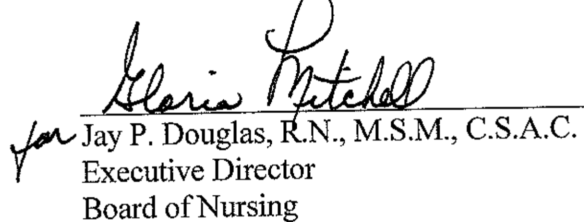
2. Ms. Howell shall provide the Board with verification that she has successfully completed the online National Council of State Board of Nursing ("NCBSN") course: *Documentation: A Critical Aspect of Client Care* within 30 days of the date the Order is entered.

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

This Order is subject to appeal to the Board. If Ms. Howell desires a formal administrative hearing before the Board pursuant to §§ 2.2-4020 and 2.2-4021 of the Code, she must notify Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, Perimeter Center, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing, within thirty-three (33) days from the date of service of this Order. Upon the filing of a request for the hearing with the Executive Director, this Order shall be vacated.

Pursuant to §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 a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD



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

Entered: February 3, 2011