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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SHANE DENMAN BRYAN 47 N. W. Memorial Ft. Walton, FL 32548 Registered Nurse License No. 666429 Respondent.	Case No. 2011-80 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about September 26, 2005, the Board of Registered Nursing issued Registered Nurse License Number 666429 to Shane Denman Bryan (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

8. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

REGULATORY PROVISIONS

9. Title 16, California Code of Regulations, section 1442, provides:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

11. Morphine is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and is a dangerous drug pursuant to Business and Professions Code section 4022.

12. Vicodin, a brand name for acetaminophen and hydrocodone bitartrate, is a Schedule III controlled substance as designated by Health and Safety Code Section 11056, and is a dangerous drug pursuant to Business and Professions Code section 4022.

13. Vicodin ES, a brand name for hydrocodone and acetaminophen, is a Schedule III controlled substance as designated by Health and Safety Code Section 11056(c), and is a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

14. Respondent was employed as a registered nurse with NurseFinders, a nursing registry. From January 11, 2008 through January 12, 2008, Respondent was assigned to Saint Louise Regional Hospital (Saint Louise) in Gilroy, California. Respondent received orientation at

NurseFinders on or about December 24, 2006. Prior to his shift, Respondent also received orientation at Saint Louise. Respondent signed his orientation paperwork, acknowledging that he was aware of all of the policies and that he did not have any unanswered questions. During his shift at Saint Louise from January 11, 2008 at 3:00 p.m. through January 12, 2008 at 7:00 a.m., Respondent made inconsistent and or unintelligible entries in hospital and patient records as follows:

15. Patient 3:

a. On January 8, 2008 at 0930 hours, this patient had a physician's order for 1 tablet of Vicodin every six hours as needed for pain.

b. On January 12, 2008 at 0017 hours, Respondent withdrew from the Pyxis[1] machine, 1 tablet of Vicodin. Respondent documented administration of the drug on the patient's pre-printed MAR at 0005 hours, 12 minutes before the drug was withdrawn from the Pyxis machine. Respondent failed to document the patient's pain levels before and after he administered the drug on the patient's MAR. The Shift Assessment Report at 0005 hours indicated that the patient was resting quietly and denied pain.

c. On January 12, 2008 at 0305 hours, Respondent withdrew from the Pyxis machine, 2 tablets of Vicodin. The patient's pre-printed MAR listed 1 tablet of Vicodin, to which Respondent documentated administration at 0300 hours. There is no indication in the patient's medical administration record (MAR) that the other tablet of Vicodin withdrawn by Respondent was administered to the patient. There is no record of wastage for the other tablet of Vicodin withdrawn by Respondent. One tablet of Vicodin was unaccounted for. Respondent failed to document the patient's pain levels before and after he administered the drug and he withdrew the medication prior to the six hour interval between doses, as ordered by the patient's physician.

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[1] Pyxis is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witnessed by another authorized user and is also recorded by the Pyxis machine.

d. On January 12, 2008 at 0623 hours, Respondent withdrew from the Pyxis machine, 2 tablets of Vicodin. The patient's pre-printed MAR listed 1 tablet of Vicodin, to which Respondent documentated administration at 0630 hours. There is no indication in the patient's medical administration record (MAR) that the other tablet of Vicodin withdrawn by Respondent was administered to the patient. There is no record of wastage for the other tablet of Vicodin withdrawn by Respondent. One tablet of Vicodin was unaccounted for. Respondent failed to document the patient's pain levels before and after he administered the drug and he withdrew the medication prior to the six hour interval between doses, as ordered by the patient's physician.

e. On January 12, 2008, the patient reported to another registered nurse that she had not received any Vicodin that day.

16. Patient 4: This patient was 62 years of age, stood 5'5", and weighed 170 pounds.

a. On January 10, 2008 at 1540 hours, this patient had a physician's order for 1 tablet of Vicodin every four hours as needed for pain.

b. On January 12, 2008 at 0105 hours, Respondent withdrew from the Pyxis machine 2 tablets of Vicodin. The patient's pre-printed MAR listed 1 tablet of Vicodin, to which Respondent documented administration at 0100 hours. There is no indication in the patient's medical administration record (MAR) that the other tablet of Vicodin withdrawn by Respondent was administered to the patient. There is no record of wastage for the other tablet of Vicodin withdrawn by Respondent. One tablet of Vicodin was unaccounted for. Respondent also failed to document the patient's pain levels before and after he administered the drug.

c. On January 12, 2008 at 0359 hours, Respondent withdrew from the Pyxis machine 2 tablets of Vicodin. The patient's pre-printed MAR listed 1 tablet of Vicodin, to which Respondent documented administration at 0400 hours, 3 hours after the previous administration of Vicodin, which was inconsistent with the physician's order. There is no indication in the patient's medical administration record (MAR) that the other tablet of Vicodin withdrawn by Respondent was administered to the patient. There is no record of wastage for the other tablet of Vicodin withdrawn by Respondent. One tablet of Vicodin was unaccounted for. Respondent failed to document the patient's pain levels before and after he administered the drug.

d. Respondent also initialed on the patient's MAR that he administered Morphine 4 mg IV and Promethazine 12.5 mg IV. There was no accompanying documentation to justify that this amount of medication was required. Respondent's overuse of narcotic medication resulted in a delay in the patient's planned discharge from Saint Louise.

17. On January 12, 2008 at 1500 hours, Respondent reported for work at Saint Louise. Another registered nurse at Saint Louise reported that Respondent appeared "sluggish" at the start of his shift. Respondent was sent home early from his assignment at Saint Louise on January 12, 2008. On January 14, 2008, Saint Louise issued a "do not return" request for Respondent to NurseFinders, due to his inconsistent and/or unintelligible entries in records.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Falsify or Make Grossly Incorrect or Inconsistent Entries)

18. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2762(e) for falsifying or making grossly incorrect, inconsistent and/or unintelligible entries in the hospital records of Saint Louise Regional Hospital by withdrawing medication from the Pyxis system, charging the withdrawal to patients who did not receive the drugs or for whom Respondent did not document administration or wastage of the drug as is more particularly set forth in paragraphs 14 through 17 above, which are incorporated herein as though set forth in full.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence)

19. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during his employment at Saint Louise, Respondent was grossly negligent in his repeated failure to medicate patients at the correct interval with the correct dosage of medication and in overmedicating an older patient to the point that her discharge was delayed, as is forth in paragraphs 14 through 17 above, which are incorporated herein as though set forth in full.

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THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

20. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a) of the Code in that he failed to declare to his staffing agency or hospital officials that his level of fatigue was negatively impacting his ability to appropriately care for his patients and administered Vicodin at a frequency greater than ordered and twice in excess of what was ordered for patients #3 and #4, as is set forth in paragraphs 14 through 17 above, which are incorporated herein as though set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Obtain Controlled Substances Unlawfully)

21. Respondent is subject to disciplinary action for unprofessional conduct under section 2762(a) for unlawfully obtaining and possessing Vicodin, a controlled substance, as is more particularly set forth in paragraphs 14 through 17 above, which are incorporated herein as though set forth in full.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 666429, issued to Shane Denman Bryan;

2. Ordering Shane Denman Bryan to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/29/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant