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STATE OF CONNECTICUT
BOARD OF EXAMINERS FOR NURSING

IN RE: Helen Horvath L.P.N., 015988

50 Ida Lane

West Haven, CT. 06516

Lic # 015988

MEMORANDUM OF DECISION

INTRODUCTION

The Board of Examiners for Nursing, (hereafter the "Board"), was presented by the Department of Health Services with a Statement of Charges dated June 30, 1986.

The Statement of Charges alleged violations of certain provisions of Chapter 378, Connecticut General Statutes. The Board issued a Notice of Hearing. The hearing took place on February 18, 1987, in room B 120/121, of the Department of Health Services, at 150 Washington Street, Hartford, Connecticut.

Each member of the Board involved in this decision attests that he/she has reviewed the record, and that this decision is based entirely on the record.

FACTS

Based on the testimony given and the exhibits offered into evidence at the above hearing, the Board made the following findings of fact:

1. Helen Horvath, hereafter referred to as the respondent, was at all pertinent times licensed to practice nursing as a licensed practical nurse in Connecticut, with registration number 015988.

2. Pursuant to Connecticut General Statutes, Section 4-182(c), the respondent was provided a full opportunity prior to the institution of agency action to show compliance with all the terms for the retention of her license.

3. The respondent was not present at the hearing nor was she represented by counsel. The respondent had sufficient notice of the time and location of the hearing, as specified in Department of Health Services Exhibits B, C, and D.

4. On or about March 4, 1986, the respondent was working as a licensed practical nurse at the Skyview Convalescent Home, Marc Drive, Wallingford Connecticut.

5. On or about March 4, 1986, while working at Skyview Convalescent Home, and providing nursing care to patient Frances Boyd, the respondent failed to adequately, completely or properly review the physician orders or medication Kardex prior to administration of medication. Specifically, on March 4, 1986, the respondent administered insulin orally whereas the physician's orders state the insulin was to be given subcutaneously.

6. On or about March 4, 1986 at approximately 5:00 P.M., while working at Skyview Convalescent Home, and providing nursing care to patient Frances Boyd, the respondent administered medication by the wrong route. Specifically, on March 4, 1986, at 5:00 P.M., the respondent had patient Frances Boyd drink insulin mixed with Osmolite contrary to physician's orders as provided for in the medication Kardex which stated that the insulin was to be administered subcutaneously.

7. On or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to administer physician ordered medication in a timely manner. Specifically, the physician's orders required insulin to be administered at 4:00 P.M. to patient Frances Boyd. The respondent did not administer the insulin to said patient until 5:00 P.M.

8. On or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to administer medication pursuant to a physician's order and failed to obtain a physician's order prior to administering medication by a route other than the route ordered. Specifically, on March 4, 1986, the respondent did not administer insulin subcutaneously to patient Francis Boyd at 4:00 P.M. as ordered by a physician but, administered it orally, mixed with Osmolite, at 5:00 P.M.

9. On or about March 4, 1986, at 5:00 P.M., while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent administered Osmolite

without a physician's order. Specifically, on March 4, 1986, the respondent administered to patient Francis Boyd insulin mixed with Osmolite without a physician's order.

10. On or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to adequately, completely or appropriately make documentation on hospital or medical records. Specifically, the physician's orders state that insulin be administered subcutaneously, at 4:00 P.M. On March 4, 1986, the respondent recorded insulin as given, orally with juice as a PRN medication. The insulin was administered with Osmolite, not juice, at 5:00 P.M.

DISCUSSION AND CONCLUSIONS

The First Count Subsection 4a alleges that on or about March 4, 1986 while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to adequately, completely or properly review the physician orders or medication Kardex prior to administration of medication. The respondent was not present at the hearing to admit or deny this charge.

The above described conduct is a violation of Connecticut General Statutes Section 20-99 (b). In pertinent part, Section 20-99 (b) forbids: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions.

Evidence was submitted at the hearing pertaining to the physician's orders and the incident report. Specifically, Department of Health Services Exhibit G evidenced that the physician's orders stated that insulin was to be administered subcutaneously at 4:00P.M. Exhibit H is an incident report which states that the respondent administered the insulin at 5:00P.M. by mouth.

The Board has determined that on or about March 4, 1986 while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to adequately, completely or properly review the physician orders or medication Kardex prior to administration of medication. The Board therefore concludes that the respondent has violated 20-99 (b), as specified in the First Count, Subsection 4a.

The First Count Subsection 4b alleges that on or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent administered medication by the wrong route. The First Count Subsection 4d alleges that on or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Francis Boyd, the respondent failed to administer medication pursuant to a physician's order. The First Count Subsection 4e alleges that on or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Francis Boyd, the respondent failed to obtain a physician's order prior to administering medication by a route other than the route ordered. The First Count Subsection 4f alleges that on or about March 4, 1986, while working at

Skyview Convalescent Home and providing nursing care to patient Francis Boyd, the respondent administered Osmolite without a physician's order. The respondent was not present at the hearing to admit or deny these charges.

The above mentioned conduct is a violation of Connecticut General Statutes Section 20-99 (b). In pertinent part, Section 20-99 (b) forbids: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions.

The follow-up document to the incident report, Department of Health Services Exhibit H, indicates that the insulin was given by mouth, rather than subcutaneously as ordered. The physician's order sheet in Department's Exhibit G indicated that 12 units NPH insulin U-100 were ordered to be given subcutaneously at 4:00 P.M. daily. The medication record in Exhibit G indicated that the insulin was given in juice at 5:00 P.M. The incident report in Department's Exhibit F indicated that the insulin was given by mouth, mixed with Osmolite, at approximately 5:00 P.M. A review of the physician's orders sheet evidences that there was no order for Osmolite at the time the respondent administered it.

The Board has determined that on or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent administered medication by the wrong route, failed to administer medication pursuant to a physician's order, failed to obtain a physician's order to administer a medication by a route other than that ordered, and administered Osmolite without a physician's order. The Board therefore concludes

that the respondent has violated Section 20-99(b) as specified in the First Count, Subsections 4b, 4d, 4e, and 4f.

The First Count Subsection 4c alleges that on or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to administer physician ordered medication in a timely manner. The respondent was not present at the hearing to admit or deny this charge.

The above mentioned conduct is a violation of Connecticut General Statutes Section 20-99 (b). In pertinent part, Section 20-99 (b) forbids: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions.

The medication record in Department's Exhibit G indicates the medication was administered at 5:00 P.M. though it was ordered to be administered at 4:00 P.M. The Board has determined that on or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to administer physician ordered medication in a timely manner. The Board therefore concludes that the respondent has violated Section 20-99(b) as specified in the First Count, Subsection 4c.

The First Count Subsection 4g alleges that on or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to adequately, completely or appropriately make documentation on hospital or medical records. The respondent was not present at the hearing to admit or deny this charge.

The above mentioned conduct is a violation of Connecticut General Statutes Section 20-99 (b). In pertinent part, Section 20-99 (b) forbids: (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions.

The medication record indicates that the respondent recorded insulin was given, by mouth in juice as a PRN medication, when the insulin was ordered to be given daily at 4:00 P.M. subcutaneously. It was given orally mixed with Osmolite, not juice. The Board has determined that on or about March 4, 1986, while working at Skyview Convalescent Home and providing nursing care to patient Frances Boyd, the respondent failed to adequately, completely or appropriately make documentation on hospital or medical records. The Board therefore concludes that the respondent has violated Section 20-99(b) as specified in the First Count, Subsection 4g.

ORDER

It is the unanimous decision of those members of the Board of Examiners for Nursing who were present and voting that:

- a. The respondent's license is to be suspended for a minimum period of six months to be determined as follows:
 - i. as to the First Count, Subsections 4a and 4d a concurrent six months probation and suspension;
 - ii. as to the First Count, Subsections 4b and 4e a concurrent six months probation and suspension;
 - iii. as to the First Count, Subsection 4c, a concurrent

six months probation and suspension;

iv. as to the First Count, Subsection 4f, a concurrent six months probation and suspension;

v. as to the First Count, Subsection 4g, a concurrent six months probation and suspension;

vi. the six month probations and concurrent suspensions referenced in (i), (ii), (iii), (iv) and (v) above are to run concurrently, for a total effective probation and suspension period of six months;

vii. that as a probationary condition the respondent is required to successfully complete a pharmacology course which would update her nursing knowledge and skills;

b. if the conditions referenced in (a), above, are not met the Board will place respondent on immediate summary revocation, with respondent having the right of appeal/review within sixty (60) days of the effective date of revocation.

c. The said periods of probation and suspension shall commence on August 1, 1988.

d. At the end of the six month probation and suspension specified in (a) above, the suspension and the probationary condition will be removed if the condition referenced in (a) above is met.

The Board of Examiners for Nursing herewith advises the Department of Health Services of the State of Connecticut of this decision.

Dated at *Hartford*, Connecticut, this *5th* day of *June*, 19*88*

BOARD OF EXAMINERS FOR NURSING

BY *Bette Jane M. Murphy R.N.*

Bette Jane M. Murphy R.N., Chairman