

**STATE OF NORTH CAROLINA
NORTH CAROLINA BOARD OF PHARMACY**

IN THE MATTER OF

**JACQUELYN HALLECK SISK
(Applicant to Reciprocate Georgia
License No. RPH013820)**

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FINAL ORDER

THIS MATTER was heard on November 21, 2017, by the North Carolina Board of Pharmacy (“Board”) located at 6015 Farrington Road, Suite 201, Chapel Hill, North Carolina, pursuant to an application by Jacquelyn Halleck Sisk (“Sisk”) for a license by reciprocity. Board President Gene Minton and Board Members Robert A. Graves and Keith A. Vance conducted this hearing. Board Member J. Andrew Bowman was present at the Board meeting and provided a quorum, but he recused himself from any participation in the hearing. Additionally, Board Vice President L. Stan Haywood was recused from any participation in the hearing, though he was also absent from the Board meeting. Sisk was present at the hearing and had the opportunity to be represented by counsel but represented herself. After hearing the testimony of witnesses, adjudging the credibility of the witnesses, and receiving evidence, the Board makes the following:

FINDINGS OF FACT

1. The North Carolina Board of Pharmacy is a body duly organized under the laws of North Carolina and is the proper body for this proceeding under the authority granted it in Chapter 90 of the General Statutes of North Carolina, and the rules and regulations promulgated thereunder.

2. All parties are properly before the Board, the Board has jurisdiction of the parties and of the subject matter, and Sisk received all required notice of the hearing.

3. Since July 28, 1982, Sisk has been licensed as a pharmacist in the State of Georgia, with license number RPH013820.

4. On February 10, 2017, Sisk executed an application for licensure in North Carolina by reciprocity.

5. In Sisk's license application, she answered "yes" to the question that asked whether she had ever been discharged or forced to resign from any position as a pharmacist. She further explained that those terminations were because she was "[o]ver threshold on errors" and "[d]id not meet test requirements."

6. Upon request from Board staff for further details, Sisk provided a letter stating that she had been terminated from two positions as a pharmacist: A position with Tanner Health System ("Tanner") that she held from November 5, 2007 to March 15, 2013; and a position with Emory Healthcare ("Emory") that she held from June 29, 2015 to October 25, 2016. This letter shall be referred to as the "Application Letter."

Tanner

7. During her employment at Tanner, Sisk worked doing night shift dispensing and medication entry for multiple hospitals in the Tanner system. She worked on a seven-day-on-seven-day-off schedule.

8. In the Application Letter, Sisk stated that, after initially performing well at Tanner for a few years, her "reported error rate started to increase." Although she claimed that many of the errors were "procedural in nature" instead of actual medication errors, she admitted to an unspecified number of medication errors at Tanner.

9. In the Application Letter, Sisk admitted to only one specific medication error: She said that, in late February 2013, a physician had entered an order increasing the bupivacaine concentration of a bupivacaine/fentanyl epidural from 0.15% to 0.25%, but Sisk continued to dispense the standard 0.15% concentration, contrary to the order.

10. In the Application Letter, Sisk acknowledged that, when she was terminated from Tanner in March 2013, she was shown “several pages of errors,” but Sisk denied that she made some of the errors, and she contended that some were errors that co-workers had made that Sisk reported to Tanner.

11. Dr. Lynn Barrett testified at the hearing. Dr. Barrett was the pharmacist-manager at Tanner and was Sisk’s supervisor during Sisk’s entire tenure at Tanner.

12. Dr. Barrett testified that Sisk’s error rate was within the normal range of her peers from her hiring on November 5, 2007 until May 2009. Between May 2009 and December 2009, Sisk’s error rate was consistently higher than her co-workers, and, most of those months, her error rate was multiples of the next highest error rate among the Tanner pharmacists. In particular, Dr. Barrett testified that, in November 2009, Sisk made errors on 0.44% of her orders, and, in December 2009, Sisk made errors on 0.48% of her orders. In November 2009, Sisk made over 30 errors, six of which were medication errors that reached the patients. In December 2009, Sisk made over 40 errors, ten of which were medication errors that reached the patients. Dr. Barrett further testified that Sisk’s average time to verification had risen from 26 minutes to 38 minutes at the end of 2009, causing delays in patient treatment. On January 28, 2010, Dr. Barrett and Sisk discussed these errors, and Dr. Barrett required that Sisk bring her accuracy rate within the range of her peers within ten days.

13. Dr. Barrett testified that Sisk's error rate improved after that meeting, but it began to rise again in 2012. Dr. Barrett testified that, each month, Tanner provided each pharmacist with his or her error rate, along with a description of medication errors. Dr. Barrett testified about one medication error in March 2012, in which Sisk incorrectly increased the dosage of a dilaudid drip so that the patient was receiving 30 mg/hr instead of the prescribed 3 mg/hr. Dr. Barrett testified that the patient did not suffer any permanent effects, only because the patient had high opioid tolerance.

14. For most of the months between October 2011 and January 2013, Sisk's error rate was the highest of all of Tanner's pharmacists. Her error rate was the highest of any Tanner pharmacist for every month from September 2012 to January 2013, and, in January 2013, Sisk's error rate spiked back to about 0.40% of all of her orders. Dr. Barrett testified that these were all errors on which Sisk was the verifying or dispensing pharmacist. Furthermore, Dr. Barrett testified that she reviewed Sisk's time for entry of two types of orders (medication reconciliation admission orders and new antibiotic orders), and Sisk's time for entry and verification was longer than other pharmacists, including being longer than the other pharmacist working the same night shift seven-day-on-seven-day-off schedule. For example, Sisk's time for verifying new antibiotic orders was 55 minutes, while her night shift counterpart's time for those orders was less than 30 minutes.

15. Dr. Barrett testified that Sisk's response to the errors was to provide excuses for the errors and to fail to take responsibility for them. On March 15, 2013, Tanner terminated Sisk due to poor work performance and loss of confidence in her.

16. The Board credits Dr. Barrett's testimony regarding the number and nature of the errors made by Ms. Sisk.

17. In testimony before the Board, Sisk attributed some of her errors to working tired as a result of her night shift seven-day-on-seven-day-off schedule.

Cardinal

18. Between September 26, 2013 and April 1, 2015, Sisk worked as a pharmacist for Cardinal Health. At Cardinal Health, Sisk worked a seven-day-on-seven-day-off schedule as a night shift pharmacist, as she had at Tanner. Sisk provided remote medication order entry for Cardinal Health's client hospital pharmacies in Georgia.

19. In her Application Letter, Sisk did not disclose that she was terminated from Cardinal Health; however, she was – in fact – terminated from Cardinal Health due to medication errors.

20. Dr. Ronnie Strickland testified at the Board hearing. Dr. Strickland became Sisk's supervisor at Cardinal in February 2014. Dr. Strickland testified that, after he became Sisk's supervisor, he tracked her errors and became concerned about the number of those errors. While many of these errors were "procedural errors" in dispensing medications in conformity with the client hospitals' procedures, about 25 percent of her errors were actual medication errors. Dr. Strickland testified that, around the start of 2015, he addressed with Sisk the need to decrease her errors.

21. By March 2015, Cardinal was only servicing one hospital in Georgia: Upson Regional Medical Center.

22. On March 4, 2015, Sisk made an error by entering that she had completed an order for vancomycin, when she had -- in fact -- left the order on hold. This error resulted in a delay in the patient receiving the prescribed medication until the next day, when Sisk's error was

discovered. Sisk further told the pharmacist-manager at Upson that the error occurred as a result of Sisk working tired.

23. On March 29, 2015, Sisk made an error with respect to a patient in Upson Regional Medical Center's emergency room with a suspected overdose. The physician ordered Romazicon, a reversal agent for a patient overdosing on benzodiazepines. Instead, Sisk dispensed Pavulon, a paralytic designed to permit intubation. Dr. Strickland testified that Sisk would have received stark warnings from the pharmacy system about the dispensing of the Pavulon and that, if the Pavulon had been administered, it could easily have killed the patient.

24. After the error on March 29, 2015, the pharmacist-manager at Upson Regional Medical Center asked Cardinal not to allow Sisk to perform remote medication entry for Upson in the future. Because Cardinal did not have any other client hospitals in Georgia, Cardinal could not assign Sisk to any other remote medication entry. On April 1, 2015, Cardinal terminated Sisk. Dr. Strickland testified that, due to the seriousness of the March 2015 errors, Cardinal would have terminated Sisk, even if Cardinal had other Georgia hospitals to which it could have assigned Sisk.

25. The Board credits Dr. Strickland's testimony regarding the number and nature of the errors made by Ms. Sisk.

26. In testimony before the Board, Sisk attributed some of her errors to working tired as a result of her night shift seven-day-on-seven-day-off schedule.

Emory

27. During her employment at Emory, Sisk worked on the night shift on a seven-day-on-seven-day-off schedule, similar to her schedule at Tanner and Cardinal.

28. In the Application Letter, Sisk attributed her termination to failing a competency test and errors in recordkeeping on two prescriptions. In the Application Letter and at the hearing, Sisk failed to take full responsibility for the errors, blaming (among other things) the fact that the pharmacist in charge of training went on maternity leave a month after Sisk started, purported late feedback on errors, and purported contrary instructions on how to dose vancomycin. Ms. Sisk attributed the failure on at least one administration of the competency test to being tired from her seven-day-on-seven-day-off schedule.

29. Dr. Beth DelRossi testified at the hearing. Dr. DelRossi was the pharmacist-manager at Emory and was Sisk's supervisor during Sisk's entire tenure at Emory.

30. Dr. DelRossi testified, and the Board finds, that there were opportunities for Sisk to be trained at Emory that Sisk did not take advantage of. Sisk cancelled meetings with the training pharmacist that were scheduled during the month before the training pharmacist went out on maternity leave, and there were other pharmacists assigned to train Sisk during the maternity leave by reviewing Sisk's dosing sheets, but Sisk left few dosing sheets for them to review. Once the training pharmacist returned from maternity leave, Sisk continued to cancel meetings with the trainer and to fail to take advantage of opportunities to meet with the trainer.

31. In March 2016, Emory administered a vancomycin dosing competency test to all of its pharmacists. Thirty-six pharmacists took the test, and only five (including Sisk) failed the test on the first administration. This is contrary to Sisk's representation in her Application Letter that "not many of the staff passed" the test. Emory required all those who failed (including Sisk)

to retake the test and pass by the end of April. The failing pharmacists could pick any date during April to take the test.

32. During April 2016, Sisk failed to get the required training and was given an extension to May 2016 to retake the competency test. Sisk finally took the test on May 2 and failed again. Only two of the five who took the retest failed on that second administration. While Sisk claimed in her Application Letter that there was a specific time that Sisk was required to take the second test, Dr. DelRossi testified – and the Board finds – that Sisk could have taken the test at any time in April and was only taking it on May 2 because she had failed to take it in a timely fashion during April.

33. Of the two pharmacists who failed the retest, the other pharmacist chose to resign from Emory rather than to undergo additional training. Sisk was placed on a Performance Improvement Plan containing a number of requirements to improve her competency in vancomycin dosing. That Performance Improvement Plan had to be extended because Sisk failed to meet with the training pharmacist during the first month of the plan, as required.

34. Dr. DelRossi testified that, at the conclusion of the Performance Improvement Plan in August 2016, Dr. DelRossi reviewed all 27 of Sisk's vancomycin dosing regimens entered during the course of the Performance Improvement Plan. Of those 27 regimens, only five were dosed correctly and had a completely accurate note. Sixteen regimens had incorrect doses, and eleven had inaccuracies in the notes. Due to Sisk's continuing medication errors, Emory gave Sisk a final written warning on September 12, 2016.

35. Both Sisk and Dr. DelRossi testified that there were two further errors after the final warning that led to Sisk's termination on October 24, 2016. However, they disagreed as to the nature of those errors. In her Application Letter and testimony, Sisk minimized these errors

by describing them as inconsistencies between the computer-entered regimens and the hard copy forms. Dr. DelRossi testified that both errors were instead significant medication errors. Dr. DelRossi testified that the first error occurred when the physician ordered dosing to start in 12 hours, but Sisk incorrectly entered that the dosing should start in 48 hours, which would have led to a dangerous delay in treatment. Dr. DelRossi testified that the second error occurred when a patient had impaired kidney function and was supposed to receive an initial dose and then be tested to determine any future doses. Instead, Sisk entered a recurring dose every 12 hours which far exceeded the dose that the patient's kidneys could eliminate. The Board credits Dr. DelRossi's testimony about the nature of the errors.

36. In her Application Letter and testimony, Sisk minimized the nature of the errors by testifying that Dr. DelRossi told Sisk that she would be eligible to be rehired one year after the error. Dr. DelRossi testified, and the documents showed, that Sisk was not eligible for rehire by Emory, and Dr. DelRossi did not tell Sisk that she was eligible for rehire (since she was not). The Board credits Dr. DelRossi's testimony.

Gordon

37. Between December 2, 2016 and the date of the hearing, Sisk has worked for Gordon Hospital in Calhoun, Georgia ("Gordon"). At Gordon, Sisk has worked a seven-day-on-seven-day-off schedule as a night pharmacist, as she had at Tanner, Cardinal and Emory. Sisk provided medication order entry for Gordon and remote medication order entry for other hospitals in the Adventist Health System.

38. Dr. Karen Guerreso testified at the hearing. Dr. Guerreso is the pharmacy director at Gordon and was Sisk's supervisor during Sisk's entire tenure at Gordon.

39. Dr. Guerreso testified that during Sisk's time at Gordon, Sisk's performance has been good, Sisk has not had an unusual error history, and Dr. Guerreso could not recall any specific errors. The Board credits Dr. Guerreso's testimony that Sisk's performance at Gordon has satisfied appropriate professional standards.

General Findings

40. Based on the testimony of all of the witnesses, the Board finds that Sisk meets the standards of professional competency to proceed with the process of getting a license in North Carolina, if certain restrictions are placed on any license that she ultimately receives and if she is placed on a stayed suspension that will provide a probationary period during her initial licensure. The facts previously found demonstrate a history of errors that justify both restrictions on Sisk's practice in order to ensure her safe practice, as well as monitoring requirements so that the Board can ensure that Sisk continues to practice competently and to preserve the health, safety and welfare of the people of North Carolina. The Board finds that the restrictions set forth below are reasonable and necessary for these purposes. In particular, Sisk has attributed prior errors to instances of her working tired as a result of her schedule as a night pharmacist working a seven-day-on-seven-day-off schedule. The Board finds that a schedule in which Sisk works more than 40 hours a week poses an unreasonable risk of danger to the health, safety and welfare of the people of North Carolina.

CONCLUSIONS OF LAW

1. Based on the above findings, the Board concludes as a matter of law that Sisk has been negligent in the practice of pharmacy and that this negligence resulted in medication errors between May 2009 and October 2016 that were unacceptable in both their number and severity.

2. The Board concludes that this negligence does not justify denying Sisk the ability to proceed with a license under North Carolina General Statutes § 90-85.38(a)(9), so long as restrictions are placed on that license to ensure the health, safety and welfare of the people of North Carolina and so long as Sisk is placed on a stayed suspension that will provide a probationary period during her initial licensure.

Based upon the foregoing, IT IS THEREFORE ORDERED that Jacquelyn Halleck Sisk's application to be allowed to proceed with the process of licensure in North Carolina, including authorization to take the Multistate Pharmacy Jurisprudence Exam, is hereby GRANTED. If Sisk ultimately meets the other standards for licensure in North Carolina (including passing the Multistate Pharmacy Jurisprudence Exam), and is licensed in North Carolina, that license shall immediately be SUSPENDED INDEFINITELY. That suspension is STAYED for THREE (3) YEARS from the date of her licensure in North Carolina, upon the following conditions:

- i. Sisk shall advise the Board promptly in writing of any change of address or change in practice status;
- ii. Sisk shall obtain prior approval of all employment as a pharmacist from the Board's Executive Director;
- iii. Sisk shall not serve as pharmacist manager of any pharmacy;
- iv. Sisk shall not be employed as a pharmacist for more than forty (40) hours per week or eight (8) hours per day, on average;
- v. Sisk shall violate no laws governing the practice of pharmacy or the distribution of drugs;
- vi. Sisk shall violate no rules or regulations of the Board;

- vii. Sisk shall promptly provide documentation of any known or suspected errors to the Board's Executive Director within five (5) business days of learning of such error;
- viii. Sisk shall complete a live error reduction course within six (6) months of the date of her licensure in North Carolina, and within thirty (30) days of completing such course, Sisk shall submit a short report to the Board's Executive Director describing what Sisk learned from the course; and
- ix. If Sisk fails to comply with any terms or conditions of this Final Order, the three-year stay described above shall be lifted and Sisk may be subject to additional disciplinary action by the Board.

Nunc pro tunc to the 21st day of November, 2017.

NORTH CAROLINA BOARD OF PHARMACY

By:



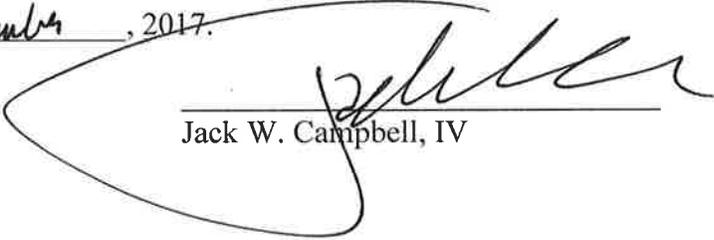
Jack W. Campbell, IV
Executive Director

CERTIFICATE OF SERVICE

I certify that, today, I served the foregoing Final Order on the following by U.S. Mail:

Jacquelyn Halleck Sisk
207 Greenhill Drive
Dallas, GA 30157

This, the 6th day of December, 2017.



Jack W. Campbell, IV