License Details

The Department of Consumer Affairs encourages you to verify the license statuses of any licensees that may appear in a 'Related License' section below. You can verify these licensees by selecting 'New Search' and conducting a new search using the 'Search by Personal or Business Name' option. Please note that the 'Related License' section will only appear below if this license is related to another license. Not all licensees have a related license.

If the License Details below include 'Date of Graduation', the month and date of graduation may not be available. In this instance it will be displayed as '01/01/YYYY' where YYYY represents the year of graduation. Please note that not all license types disclose 'Date of Graduation' on the License Details screen.

Press "Previous Record" to display the previous license.

Press "Next Record" to display the next license.

Press "Search Results" to return to the Search Results list.

Press "New Search Criteria" to do another search of this type.

Press "New Search" to start a new search.

License Number: 802190 ***Current Date: 09/25/2017 09:58 PM***

Name:	**SHIN, ALLYSHA RAE ALMADA**
License Type:	**Registered Nurse**
License Status:	**Current**
Secondary Status:	**Accusation Filed**
Expiration Date:	**08/31/2018**
Original Issuance Date:	**07/20/2011**

Disciplinary Actions

There are NO disciplinary actions against the license.

Public Record Actions

Administrative Disciplinary Actions	**Found (1)**
Court Order	**None found**
License Issued with Public Letter of Reprimand	**None found**
Auto Disclosure	**None found**
Public Documents	**Found (1)**

Previous Record **Next Record** **Search Results** **New Search Criteria** **New Search** **Print**

XAVIER BECERRA
Attorney General of California
ARMANDO ZAMBRANO
Supervising Deputy Attorney General
SHERONDA L. EDWARDS
Deputy Attorney General
State Bar No. 225404
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2537
Facsimile: (213) 897-2804
E-mail: Sheronda.Edwards@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **ALLYSHA RAE ALMADA SHIN, AKA ALLYSHA RAE ALMADA** **327 N. Vista Bonita Ave., #3** **Glendora, CA 91741** **Registered Nurse License No. 802190** **Public Health Nurse Certificate No. 81629** Respondent.	Case No. 2017-925 **ACCUSATION**

Complainant alleges:

PARTIES

1. Joseph L. Morris, PhD, MSN, RN (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 20, 2011, the Board of Registered Nursing issued Registered Nurse License Number 802190 to Allysha Rae Almada Shin, aka Allysha Rae Almada (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, 2018, unless renewed.

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3. On or about October 11, 2011, the Board of Registered Nursing issued Public Health Nurse Certificate Number 81629 to Allysha Rae Almada Shin, aka Allysha Rae Almada (Respondent). The Public Health Nurse Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2018, unless renewed.

JURISDICTION

4. 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.

5. 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.

6. 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.

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.

"...

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

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REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the Code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

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, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

STATEMENT OF FACTS

11. From September 20, 2010 through August 20, 2015, Respondent was employed as a registered nurse in the Intensive Care Unit of Huntington Memorial Hospital in Pasadena, CA. On October 12, 2015, the Board of Registered Nursing received a letter of complaint from Huntington Memorial Hospital, alleging that Respondent shared her identification and password with another nurse in order to "make it appear as though [Respondent] had verified that the insulin drip had been properly titrated by RN V.L."

12. On August 23, 2010, Respondent signed a "Confidentiality, Computer Usage and Accountability Agreement" (Confidentiality Agreement). In pertinent part, paragraph 4 of the Agreement provides that "[I] am the only person who has possession of my unique user ID and password, and will not share this information with others or allow anyone to access information systems using my user ID and password." Respondent also agreed to paragraph 6, providing "[I] understand that my user ID and password are the equivalent of my signature and that I am accountable for all data and actions recorded under them."

13. Huntington Memorial Hospital's Clinical Policy & Procedure provides, in pertinent part, that insulin is designated as a "High Risk/High Alert Double Check Medication." It further provides: "Double-checking of specific medications is required to reduce the risk of error. The process of double-checking involves two RNs, RN and a pharmacist, or RN and a physician. Subcutaneous insulin may be checked by an LVN."

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14. The patients in the Coronary Care Unit are on certain IV medications, which must be checked and monitored on a regular basis. Every hour on the hour, the Intensive Care Unit RN must check the patient's blood sugar, and make calculations as to the patient's blood sugar value. Then the RN calls a second RN to verify the calculations so that the correct dose of insulin is administered. An incorrect dose could be fatal to the patient.

15. On July 13, 2015, RN T.G. handed off Patient 1 to RN V.L. for the evening shift. On July 14, 2015, RN T.G. started her day shift with Patient 1 and found a piece of paper called the "Off Bypass Call" sheet on the Computer on Wheels bearing the username and password of Respondent.

16. On July 14, 2015, RN T.G. reported the incident to the Critical Care Unit Manager and the hospital's Compliance Hotline.

17. A review of Patient 1's medical record indicates entries by RN V.L. and reflect that insulin was ordered and completed on July 13, 2015 at 19:10 hours, performed and verified by RN V.L. at 20:00 hours. Then allegedly witnessed by Respondent at 20:00 hours.

18. On August 7, 2015, during a meeting with the Critical Care Unit Manager and Senior Human Resources Business Partner, Respondent was asked whether she witnessed the administration of medication by RN V.L. for Patient 1 on July 13, 2015. Respondent said, "I don't remember working with [RN V.L.] on that night." When asked why she wrote down her username and password on the date of July 13, 2015, on the "Off Bypass Call" sheet and for Patient 1, Respondent said, "I usually write it on a piece of scratch paper. Too many changes to passwords and I sometimes don't remember – must have been busy." Respondent was then suspended from work pending further investigation regarding falsification of documentation, violations of the Confidentiality Agreement, and failure to comply with the double-check process for administering insulin.

19. In Respondent's declaration of August 11, 2015, she stated that she did write down her username and password "on what I thought was 'scratch paper.' At times when I am tired, I will write things down in order to prompt my memory. Instead of locking myself out of Cerner with multiple failed login attempts, I will sometimes write down my information as a

visual/physical prompt. I acknowledge that this was and is a bad habit and can be unsafe." She further stated that, "Although I do not recall giving [RN V.L.] my sign-on information that night, it is a common practice for ICU nurses to share that information as a way to deal with the double-checking requirement for insulin drips. Having a second nurse physically go to the primary nurse's patient's room to witness an insulin drip titration in real time is often impossible given the many other crucial aspects of patient care we are dealing with for ICU patients. Nurses being unavailable to double-check insulin drips is what has led to the practice."

20. On August 9, 2016, the Board of Registered Nursing Inspector interviewed Respondent with her attorney. Respondent acknowledged she had received training of the Computer Usage, Confidentiality and Accountability policy on April 2, 2015, while employed as a RN at Huntington Memorial Hospital. Respondent also stated that she understood she was not to share passwords.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Incompetence)

21. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), as defined in California Code of Regulations, title 16, sections 1443 and 1443.5(2), on the grounds of incompetence in that Respondent breached the Confidentiality Agreement, aided and abetted in the falsification of a medical record, and failed to comply with the double-check process for administering insulin. Complainant refers to and incorporates all the facts and allegations contained in Paragraphs 11 through 20, as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Violation of Nursing Practice Act)

22. Respondent is subject to disciplinary action under section 2761, subdivisions (a) and (d), as defined in California Code of Regulations, title 16, sections 1443 and 1443.5(2), for general unprofessional conduct and/or violating or attempting to violate, any provision or term of the Nursing Practice Act. Complainant refers to and incorporates all the facts and allegations contained in Paragraphs 11 through 20, as though set forth fully.

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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 802190, issued to Allysha Rae Almada Shin, aka Allysha Rae Almada;

2. Revoking or suspending Public Health Nurse Certificate Number 81629, issued to Allysha Rae Almada Shin, aka Allysha Rae Almada;

3. Ordering Allysha Rae Almada Shin 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; and,

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

DATED: May 23, 2017

for JOSEPH L. MORRIS, PHD, MSN, RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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