STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

IN RE:	)	
BARBARA A. ALBRIGHT, R.N.	)	**Docket No. NU 06-0700**
License No. 026-0018578	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

Introduction

The Vermont Board of Nursing (Board) held a disciplinary hearing on the Specification of Charges filed in this case on October 30 and November 6, 2002, at 81 River Street in Montpelier, Vermont. Board Members Susan Farrell, RN; Laurey M. Tyo, RN; Patricia Rock, RN; Alan Weiss, Public Member; Sandra Norton, R.N.; Margaret Luce, Ad Hoc Member; and Louise Lucchina, Ad Hoc Member, attended the hearing and participated in the decision. George C. Haegele, IV, Assistant Attorney General, appeared on behalf of the State of Vermont. Charles N. Hurt, Jr., Esq. appeared on behalf of the Respondent, Barbara A. Albright. Barbara A. Albright (Respondent) was present at the hearing. Phillip J. Cykon, Esq. served as Presiding Officer on behalf of the Board.

Respondent had filed a Motion to Sever and a Motion to Recuse, both dated September 6, 2002. Both motions had been preliminarily denied on September 18, 2002, by Presiding Officer Larry S. Novins. Prior to the disciplinary hearing on October 30, 2002, the Board reviewed and approved the preliminary denials and denied both motions.

Findings of Fact

1. Respondent is a Registered Nurse (RN) holding license number 026-0018578 issued by the State of Vermont.

2. At all times relevant to the allegations regarding this case, Respondent practiced nursing and served as Nurse Manager at the Northeast Regional Correctional Facility in St. Johnsbury, Vermont. Her responsibilities included the work camp. Respondent was responsible for ensuring that nursing services provided proper and competent care to inmates.

3. On or about April 1, 2000, R.P. was an inmate at the Northeast Regional Correctional Facility (NRCF). On or about April 21, 2000, R.P. was transferred from the correctional center to the work camp.

4. In a series of letters dated from February 24 to March 15, 2000, R.P.'s wife communicated information concerning R.P.'s diabetic condition to the Superintendent of the NRCF. The letters referred to R.P.'s medications and his glucometer, and asked several questions concerning these matters. By letter dated March 20, 2000, the Superintendent of the NRCF acknowledged receiving these letters and stated that the facility was more than equipped to deal with diabetes.

5. At all times relevant to the allegations regarding this case, Jonathan Strenio, MD, practiced medicine and provided medical care to inmates in several correctional centers, including the NRCF and the work camp. Dr. Strenio's goal was to provide such medical care in the manner of a community health center.

6. Dr. Strenio provided medical care to R.P. at the correctional center and at the work camp. Based upon his initial visit with R.P., and his review of R.P.'s medical history, Dr. Strenio issued several orders concerning R.P.'s medical care, including medications and regular blood sugar and blood pressure checks.

7. The Glucometer tests (finger-sticks) were not administered to R.P. as ordered by Dr. Strenio. Certain medication, specifically Glucophage, was not administered to R.P. as ordered by Dr. Strenio. There were no notations in the medical records to explain why the Glucometer tests or the Glucophage were not administered as ordered by Dr. Strenio.

8. On April 20, 2000, due to what he diagnosed as a severe aortic stenosis, Dr. Strenio ordered that an echocardiogram be performed on R.P. An echocardiogram was not performed on R.P. until June 14, 2000, on which date, Dr. Strenio diagnosed that R.P. was suffering an acute arterial occlusion. If the echocardiogram had been done more quickly, it probably would have helped Dr. Strenio diagnose R.P.'s problem earlier.

9. On Vermont Department of Corrections Grievance Form #1, R.P. filed a grievance on May 3, 2000, concerning the medical care he was receiving. Specifically, he claimed that he was not receiving his medications as directed by the physician. As part of her duties, Respondent was responsible for addressing this grievance. Although she acknowledged that R.P. had not timely received his medications, she took no investigative action and made no recommendation to the Work Site Manager. Rather, she recommended to R.P. that he arrange to be where he needed to be to receive his medications or make alternative arrangements.

10. On June 9, 2000, during a visit with Nurse Amy Shealy, R.P. complained that he was cramping in his calf muscle and that his right foot felt colder than his other foot. Nurse Shealy noted that a pedal pulse was present and that R.P.'s leg should be monitored. She did not document the color of the leg, the temperature of the leg, or the pedal pulse count.

11. In R.P.'s Progress Notes, a June 10, 2000, entry by Nurse Carl Martin indicates that the facility received a call from an outside physician concerning R.P. and the condition of his leg. Nurse Martin further noted that after an examination of R.P. that evening, R.P.'s right leg was possibly slightly cooler than his left leg, and that a pedal pulse was present. Nurse Martin referred R.P. to the physician.

12. On June 13, 2000, Nurse Shealy issued a Med Pass to R.P. excusing him from work for that day. Nurse Shealy made no notation whatsoever in R.P.'s Progress Notes concerning the Med Pass or the reasons why it was issued.

13. R.P. did not see a physician until June 14, 2000, when he was examined by Dr. Strenio. Dr. Strenio found R.P.'s lower leg to be extremely cold with no pedal pulse. Dr. Strenio diagnosed an acute arterial occlusion and issued an emergency Consultant Request Form.

Conclusions of Law

A. Based on all the evidence, Respondent has shown that she is unable to practice nursing competently, in violation of 26 V.S.A. § 1582(a)(3), in that she performed unacceptable patient care and failed to conform to the essential standards of acceptable and prevailing nursing practice. As Nurse Manager and a practicing nurse at the correctional facility, Respondent was responsible for providing proper and competent nursing services care to inmates, and for ensuring that other staff under her supervision provide such care. As found above, Respondent failed to ensure that the physician's orders regarding administration of the Glucometer tests and certain medications were carried out. Documentation regarding these tests and medications was either nonexistent or seriously deficient. The delay in the echocardiogram was unacceptable. Upon receiving a grievance from R.P. regarding his medications, Respondent shifted the responsibility to the inmate rather than properly investigate and recommend corrective action to ensure timely medication of R.P. Respondent failed to administer and maintain a system that could respond to the emergency situation as presented by R.P. on June 9 through June 14, 2000. R.P. simply should not have had to wait that long to receive proper medical care for his leg. Respondent's actions as both a practicing nurse and a nurse manager fell below acceptable and prevailing nursing practice whether such practice occurs inside or outside of a correctional facility.

B. Based on all the evidence, Respondent engaged in conduct of a character likely to harm the public, in violation of 26 V.S.A. § 1582(a)(7), in that she failed to take appropriate action to safeguard a patient from incompetent health care. As set forth in Paragraph A above, Respondent's failure to carry out competent nursing duties herself and her failure to competently manage the nursing practices of those under her, constitute a violation of this section as well.

Order

Based upon the above Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED by the Board of Nursing that:

1. Respondent's license to practice as a nurse in the State of Vermont is SUSPENDED, for a period of six (6) months, effective as of the date of entry shown below. In addition, her license is CONDITIONED for a period of one (1) year as follows:

    a. Respondent must attend and successfully complete a Board-approved program in nursing education. The program must cover the following components:

        (1) documentation and record-keeping
        (2) pharmacology
        (3) legal ethics
        (4) supervision
        (5) delegation
        (6) assessments

    b. Respondent must obtain approval of the program from the Board or the Executive Director, as designee of the Board, prior to attending the program.

2. Upon Respondent's demonstration, to the Board's satisfaction, that she fully complied with all the terms of this Order, Respondent may petition the Board to remove any and all conditions on her license and after formal review by the Board, Respondent's nursing license may be fully restored by appropriate Board action.

3. Notwithstanding any provision of this Order, Respondent must meet all Nursing Board requirements for license renewal and license reinstatement.

4. Respondent shall bear all costs of complying with this Order.

5. This document is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a).

6. This Order takes effect as of the date of entry shown below.

Appeal Rights

This is a final administrative determination by the Vermont Board of Nursing. You may appeal by sending a notice of appeal in writing to the Director of the Office of Professional Regulation within 30 days of the date of entry below. If you wish to request a stay of the Board's decision, please refer to the attached stay instructions.

BOARD OF NURSING

Susan Farrell Date: January 18, 2003
Susan Farrell, RN
Chair

OFFICE OF PROFESSIONAL REGULATION

Date of Entry: 1/24/03