**STATE OF VERMONT**
**BOARD OF NURSING**

| | | |
|---|---|---|
| In re: Chidi E. Boston<br>License No. 026-30303 | }<br>}<br>} | Docket No. NU66-0407 |

**Decision on**
**UNPROFESSIONAL CONDUCT CHARGE**

Participating Board Members:
Ellen W. Leff, RN, Chair
Alan Weiss
Sandra Norton, LNA
Donarae Metcalf, LPN
Deborah Robinson, RN
Susan Dumas, APRN

Appearances:
for Petitioner, State of Vermont: Edward G. Adrian
for Respondent: Susan J. Flynn

Presiding Officer: Larry S. Novins

**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER**

The Vermont Board of Nursing held a hearing in the above matter on April 13, 2009 at the National Life Building in Montpelier, Vermont.

The prosecution has the burden of proof in this matter. To prevail on any unprofessional conduct charge, it must prove the charge by a preponderance of the evidence.

**Background**

The prosecution alleges in its Specification of Charges that Mr. Boston failed to properly take patient vital signs, and falsified records of those vital signs in violation of several Vermont statutes.

**Findings of Fact**

Based on the evidence presented, the Board finds as follows:

1. Mr. Boston is licensed as a registered nurse by and subject to the disciplinary authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. §§ 1582(a), the Administrative Rules of

the Board of Nursing, and the Rules of the Office of Professional Regulation.

2. Mr. Boston, at all times relevant to this Decision was employed as a registered nurse in the critical care nurse internship program at Fletcher Allen Health Care (FAHC), located in Burlington, Vermont.

3. Mr. Boston was trained as a nurse in Nigeria. He graduated from Nursing School in 1988. He has worked in a mission hospital. He came to the United States and passed his qualifying nursing examinations the first time. He practiced as a nurse in an Ohio rehabilitation facility. He desired to increase his knowledge of nursing and applied for an ICU nurse training program at Fletcher Allen Health Care. Mr. Boston as part of this program took courses at the University of Vermont.

4. On April 13, 2007, Mr. Boston was working as a nurse intern in the medical intensive care unit at FAHC. For the previous six weeks he had been closely monitored as part of his training program. His preceptors had been training him in ICU care, including the use of the many electronic monitors used there. It seems that there was some tension or discomfort between the preceptors and Mr. Boston. It is unclear if this may have stemmed from cultural or personal differences. Mr. Boston testified that he was supposed to have daily assessments of his performance, but that they did not occur. It is unfortunate that this Board did not have preceptor logs to review. They could have shown what the preceptors observed and noted and shed light on Mr. Boston's preceptorship and training.

5. On April 13 Mr. Boston was assigned to care for two (2) patients. This was the first day that Mr. Boston was not closely "guided like a baby." He was essentially practicing independently.

6. Patient #1 had orders for vital signs to be taken every four (4) hours, and Patient #2 had orders for vital signs to be taken every hour.

7. Mr. Boston did not feel he was competent to use all the monitoring equipment in the ICU. Rather than asking for assistance from his preceptor or others at the facility, Mr. Boston testified that he used his own equipment to take vital sign readings.

8. On April 13, 2007 Mr. Boston's nurse preceptor, L.J., repeatedly (at least five times) asked Mr. Boston to document the patients' vital signs in "real time" on the patients' flow sheets. She did not make entries herself, but waited to see if Mr. Boston would.

9. At approximately 6:00 p.m., L.J. noted that the patients' flow sheets still lacked documentation of vital signs from approximately 2:00p.m., onward.

10. L.J. left Mr. Boston for a short period of time. When she returned she saw that Mr. Boston had filled in all the vital signs on the flow sheets. Mr. Boston advised that he had earlier recorded the patients' vital signs on a piece of paper that he carried with him throughout the day, and that after L.J. confronted him about the missing documentation, he transferred the vital signs from the piece of paper to the flow sheets. Transferring readings from sheets of paper to flow sheets is not uncommon.

11. There was conflicting evidence on whether or not Mr. Boston could have used his own manual equipment to take the vital signs. We do not definitively determine how Mr. Boston obtained the readings he entered.

12. FAHC had electronic evidence of Mr. Boston's patients' vital signs. The entries made by Mr. Boston did not exactly correspond to the electronic evidence, but did not vary substantially from them. What he entered was consistent with the way he arrived at his

vital sign readings and computations.

13. Mr. Boston is currently employed at a nursing home.

## Discussion

Mr. Boston's primary error in this matter was his failure to ask for help in using the electronic monitors he was being trained to use as part of his ICU training, the monitors he was supposed to use for the care of his patients. Mr. Boston pointed out his error saying that in hindsight he would do it differently. He would have to take responsibility. Even though he was in a training program where responsibility is shared between preceptors and those in training, Mr. Boston was already an experienced licensed professional. If he lacked the specific training to do what was required of him, his responsibility as a nurse was to speak up. The resulting delay in entering vital signs on his patients' flow charts could have been avoided.

## Conclusions of Law

Based on the evidence presented and Facts found above we conclude as follows:

1. **Re: Alleged Violation of 26 V.S.A. § 1582(a)(3):** The State has not proved by a preponderance of the evidence that Mr. Boston is unable to practice nursing competently by reason of any cause. This charge is dismissed.

2. **Re: Alleged Violation of 26 V.S.A. § 1582(a)(7):** The State has not proved by a preponderance of the evidence that Mr. Boston has engaged in conduct of a character likely to deceive, defraud or harm the public. This charge is dismissed.

3. **Re: Alleged violation of 3 V.S.A. § 129a(a)(7)**: The State has not proved by a preponderance of the evidence that Mr. Boston willfully made or filed false reports or records in the practice of the profession; or willfully impeded or obstructed the proper making or filing of reports or records or willfully failed to file the proper reports or records. This charge is dismissed.

4. **Re: Alleged violation of 3 V.S.A. § 129a(b)(1) and (2)**: The State has proved by a preponderance of the evidence that Mr. Boston failed to practice competently. We conclude that Mr. Boston's conduct as found above constituted a failure to conform to the essential standards of acceptable and prevailing practice. 3 V.S.A. § 129a(b)(2). This is unprofessional conduct.

5. **Re: Alleged Violation of 26 V.S.A. § 129a(a)(3)**: 3 V.S.A. § 129a(a)(3) defines unprofessional conduct to include failing to comply with provisions of federal or state statutes or rules governing the practice of the profession. Any allegation of failure to comply with statutes or rules has been addressed above. This statute does not provide an independent grounds for discipline. There is no violation of this statute. This charge is dismissed.

For the violation above, to protect the public, health, safety and welfare, the following sanction is necessary.

**Order**

Mr. Boston's license is conditioned as follows:

1) For six months and until these conditions are removed Mr. Boston shall practice only in a setting where he has direct supervision for the entire shift by a licensed registered nurse in good standing.

2) Mr. Boston shall take a course in documentation, pre-approved by the Board or its designee, within 120 days.

3) Within one (1) month of the date of entry of this Order or within one (1) month of the commencement of nursing employment and monthly thereafter, Mr. Boston shall cause every nursing employer for whom he worked during that month to submit an evaluation of his work performance and number of days worked. The employer report shall be submitted on a form provided by the Board.

4) In the event Mr. Boston is attending a nursing program, Mr. Boston shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of his performance and days attended. The report shall be submitted on a form provided by the Board and accompanied by a cover letter on the school's letterhead.

5) Mr. Boston shall provide a copy of this Order to all employers in any current or future setting in which he practices nursing and inform them of his conditional license status.

a. Within ten (10) days of the date of entry of this Order, or with ten (10) days of obtaining any subsequent nursing employment, Mr. Boston shall cause his supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of the Order and acknowledging the ability to comply with its conditions.

b. In the event Mr. Boston attends a nursing program, he shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Order and ability of the program to comply with the conditions in the Order during clinical experience.

6) Mr. Boston shall bear all costs of complying with this Order.

7) After six months Mr. Boston may petition the Board to remove these conditions. When the Board has determined that the documentation course has been successfully completed, and that six months of satisfactory employer reports have been received, the conditions shall be removed.

**APPEAL RIGHTS**

This is a final administrative determination by the Vermont Board of Nursing. A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, Office of Professional Regulation, National Life Bldg., North, FL2, Montpelier, Vermont 05620-3402 within 30 days of the entry of this Order.

If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: _____
Ellen Leff, RN, Chair

April 15, 2009
Date

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 4/22/09