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

IN RE:	)	
Jane M. Bouton	)	Docket No. 2018-126
License No. 025.0008795	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through Prosecuting Attorney Jennifer B. Colin, and the Respondent, Jane M. Bouton, by and through her counsel, Devin McLaughlin, Esq., who hereby Stipulate and Agree as follows:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. §129; 3 V.S.A. §129a; 3 V.S.A. §814(d); 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation ("OPR").

Stipulated Facts

2. Jane Bouton ("Respondent") of Shoreham, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0008795. This license was originally issued on August 22, 2005 and expires on January 31, 2020.

3. During the relevant time period, Respondent was employed as an LPN at The Residence at Otter Creek ("the Facility") in Middlebury, Vermont.

4. While at the Facility, Respondent provided end-of-life care to a hospice patient (the "Patient") in February 2018.

5. The Patient had a provider order for sub-lingual morphine sulfate, 5mg/0.25mL every 4 hours, starting on February 9, 2018. Patient also had a provider order for morphine sulfate, 0.25 mL by mouth every 15 minutes as needed for pain/shortness of breath starting on April 18, 2017.

6. The Facility maintained a supply of pharmacy bottles of concentrated liquid morphine. New bottles contained 30 mL of morphine at a concentration of 20 mg/mL. The bottles of concentrated liquid morphine were stored in a separate locked area within the medication cart.

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7. Each bottle of concentrated liquid morphine was assigned to an individual patient and was accounted for on a separate paper Controlled Drug Record for that patient.

8. Nurses prepared individual doses of concentrated liquid morphine for administration to patients by pre-filling numerous syringes for each patient from the patient's designated bottle.

9. The syringes containing individual doses of concentrated liquid morphine were stored in plastic bags that were labeled for each patient and stored in a locked narcotic box on the medication cart. The syringes were accounted for on a separate paper Controlled Drug Record for each patient.

10. On February 8, 2018, Patient's Controlled Drug Record for a bottle of morphine sulfate 20 gm/mL documented that 14 mL of the drug was left in the bottle after P.P., an RN and Director of Nursing for the Facility, drew up 35 syringes of 0.25 mL in each syringe at 09:00. This was the last entry in the log for Patient's bottle of concentrated morphine.

11. On February 11, 2018 at 17:50, Respondent documented on the Controlled Drug Record for the pre-filled morphine syringes that she drew up twelve morphine syringes of 0.25 mL in each for Patient.

12. Respondent did not document on the Controlled Drug Record for the Patient's bottle of liquid morphine that she removed any amount of liquid morphine from the bottle on February 11, 2018 when she drew up the twelve syringes.

13. The record Respondent did create for drawing up twelve syringes for the Patient was also not consistent with normal protocol because the current active Controlled Drug Record sheet for the Patient on which Respondent should have documented the new syringes had six additional blank entry spaces left on February 11, 2018 at 17:50 and showed that Respondent had fifteen syringes remaining in the plastic bag.

14. Rather than record the syringes she drew up on February 11, 2018 on the current active Controlled Drug Record sheet for the Patient in one of the six blank lines, Respondent started a new page in the record and documented adding the twelve syringes she filled as if the syringe count prior to those new syringes was zero (0), rather than fifteen.

15. The Patient died on February 12, 2018.

16. With the twelve syringes Respondent documented that she added the Patient's plastic bag, the final count of pre-filled morphine syringes for the Patient on February 12, 2018 should have been 20 syringes. However, only 11 syringes remained in the bag and were documented as wasted on February 12, 2018.

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17. On February 14, 2018, RN P.P. determined that Patient's bottle of concentrated liquid morphine was missing and unaccounted for. The last entry on the corresponding Controlled Drug Record for the Patient's liquid morphine bottle, which was entered by RN P.P., indicated that 14 mL remained in the bottle on February 8, 2018 at 09:00.

18. When RN P.P. questioned Respondent about the unaccounted-for morphine, Respondent informed RN P.P. that Respondent had prepared approximately thirty-four prefilled syringes from the amount remaining in the bottle on February 11, 2018, and not the twelve syringes she documented.

19. Respondent also advised RN P.P. that, on February 11, 2018, Respondent wasted the few drops of liquid morphine remaining in the bottle, stating that there was not enough remaining morphine to draw up one more additional 0.25 mL syringe.

20. Respondent told RN P.P. that she wasted the remaining liquid morphine by flushing with bottle with water in front of LNA W.C., as a witness to the waste.

21. There is no existing record where Respondent documented drawing up thirty-four syringes of liquid morphine with 0.25 mL in each on February 11, 2018 for Patient. Respondent documented only twelve.

22. There is no existing record where Respondent documented removing concentrated liquid morphine from the Patient's bottle, in any amount, on February 11, 2018.

23. There is no existing record where Respondent documented wasting any amount of the Patient's liquid morphine in front of LNA W.C. on February 11, 2018.

24. In an interview with OPR Investigator John Lewis in March 2018, Respondent stated that she inadvertently discarded into a recycling bin the Controlled Drug Record sheet on which she correctly documented drawing up the thirty-four syringes she prefilled with liquid morphine on February 11, 2018, instead of discarding the sheet that incorrectly documented that she filled twelve syringes.

25. Respondent further stated that after drawing up the morphine syringes for the Patient on February 11, 2018, Respondent could not find the narcotic log for the bottle of liquid morphine in order to document the withdrawal, that she was tired, and that she decided to wait to document the withdrawal and the waste until the next day.

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Violation One: 3 V.S.A. §129a(b)(2) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable and prevailing practice.

26. Paragraphs 3 through 25 above are incorporated herein.

27. The essential standards of acceptable and prevailing practice require that an LPN accurately document the withdrawal, administration, and waste of controlled medications.

28. Paragraphs 3 through 25 above demonstrate that Respondent failed to conform to the essential standards of acceptable and prevailing practice when she failed to document withdrawing liquid morphine from the Patient's designated bottle, failed to accurately document the number of liquid morphine syringes she drew up, and failed to document wasting liquid morphine from the Patient's bottle.

29. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of 3 V.S.A. §129a(b)(2).

Understandings

30. Respondent admits that the facts above are true and that the conditions below are necessary to protect the public.

31. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.

32. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced her rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.

33. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

34. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.

35. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.

36. Respondent voluntarily waives her right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.

37. Respondent agrees that the Order set forth below may be entered by the Board.

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ORDER

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

A. The Board of Nursing hereby **WARNS** Respondent's license.

B. Respondent's license is **CONDITIONED** as follows:

Respondent shall, within sixty days of this Order, at her own expense, complete the following courses:
Narcotic Drugs: Handling and Documentation (RN.org) and
Documentation: A Critical Aspect of Client Care (learningext.com)
Or two equivalent courses that are pre-approved by the Nursing Case Manager.

Respondent shall submit the completed assignment book(s), if applicable, and certificates of completion to the Office of Professional Regulation.

Failure to complete both courses within the prescribed timeframe shall constitute a violation of this Order.

C. Upon completion of the required conditions, Respondents may petition to remove the conditions on her license and restore the license to unencumbered status. Respondent shall bear the burden of proof to establish that she has fully complied with the terms of this Order and that the conditions are no longer necessary to protect the public.

D. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.

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

F. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

Dated: 3/15/19

By: _____
Jennifer B. Colin
Prosecuting Attorney

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RESPONDENT

Dated: 3/19/19

By: Jane M. Bouton
Jane M. Bouton

APPROVED AS TO FORM:

COUNSEL FOR RESPONDENT

By: Devin McLaughlin, Esq.
Langrock Sperry & Wool
Attorney for Jane M. Bouton

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 4-8-2019

By: Chairperson

Date of Entry: 4.9.19

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