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

IN RE:	)	
Maureen Brockway, R.N.	)	Docket No: NU22-0900
License No. 026-0023907	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Maureen Brockway, RN:

Board Authority

1. The Vermont State Board of Nursing ["the Board"] has authority to approve consent orders, issue warnings or reprimands, suspend, revoke, limit, condition or prevent the renewal of current or lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. §129(a)(5); 3 V.S.A. §814(d); 26 V.S.A. §1582(a).

2. Being unable to practice nursing competently by reason of any cause is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. §1582(a)(3).

3. Inability to practice nursing competently includes performance of unsafe or unacceptable patient care and failure to conform to the essential standards of acceptable and prevailing nursing practice. Administrative Rules of the Board of Nursing ("ARBN") Chapter 4, Rule IV(B)(2).

Facts

4. The Respondent (whose address is listed in the database of the Office of Professional Regulation as 17 Waterman Hill, Quechee, VT 05059) is a Registered Nurse under License Number 026-0023907.

5. Respondent's license has a current expiration date of March 31, 2001.

6. At all times relevant to these Charges, the Respondent was employed by the Mt. Ascutney Hospital in Windsor, Vermont.

7. During the month of September 2000, the Respondent delegated, without appropriate supervision, responsibility to monitor patient(s) glucose level(s) derived from the glucose monitoring machine(s).

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8. Respondent was responsible for recording these results in the patient(s) medication administration records (MAR).

9. During the month of September 2000, Respondent recorded glucose finger stick test results on the MARs that did not match those from the glucose monitoring machine(s).

10. Based on the conduct alleged above in paragraph seven (7) through nine (9), Respondent gave improper medical treatment to two patients.

Charges

11. By committing the above act(s), circumstance(s) and/or omission(s), the Respondent has:

a) shown she is unable to practice nursing competently by reason of any cause, in violation of 26 V.S.A. §1582(a)(3), specifically Respondent:

i) performed unsafe or unacceptable patient care; and

ii) failed to conform to the essential standards of acceptable and prevailing nursing practice.

Relief Requested

WHEREFORE, the license of Maureen Brockway, RN, should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

Dated at Montpelier, Vermont this 28th day of December 2000.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

By: _____
George C. Haegele IV
Assistant Attorney General

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IN RE:	)	
Maureen Brockway, R.N.	)	Docket No: NU22-0900
License No. 026-0023907	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, through Attorney General William H. Sorrell, and Respondent Maureen Brockway, R.N. who stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Nursing ["the Board"] has authority to approve consent orders, issue warnings or reprimands, suspend, revoke, limit, condition or prevent the renewal of current or lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. §129(a)(5); 3 V.S.A. §814(d); 26 V.S.A. §1582(a).

2. Being unable to practice nursing competently by reason of any cause is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. §1582(a)(3).

3. Inability to practice nursing competently includes performance of unsafe or unacceptable patient care and failure to conform to the essential standards of acceptable and prevailing nursing practice. Administrative Rules of the Board of Nursing ("ARBN") Chapter 4, Rule IV(B)(2).

Facts

4. The Respondent (whose address is listed in the database of the Office of Professional Regulation as 17 Waterman Hill, Quechee, VT 05059) is a Registered Nurse under License Number 026-0023907.

5. Respondent's license has a current expiration date of March 31, 2001.

6. At all times relevant to these Charges, the Respondent was employed by the Mt. Ascutney Hospital in Windsor, Vermont.

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7. During the month of September 2000, the Respondent delegated, without appropriate supervision, responsibility to monitor patient(s) glucose level(s) derived from the glucose monitoring machine(s).

8. Respondent was responsible for recording these results in the patient(s) medication administration records (MAR).

9. During the month of September 2000, Respondent recorded glucose finger stick test results on the MARs that did not match those from the glucose monitoring machine(s).

10. Based on the conduct alleged above in paragraph seven (7) through nine (9), Respondent gave improper medical treatment to two patients.

Charges

11. By committing the above act(s), circumstance(s) and/or omission(s), the Respondent has:

    a) shown she is unable to practice nursing competently by reason of any cause, in violation of 26 V.S.A. §1582(a)(3), specifically Respondent:

        i) performed unsafe or unacceptable patient care; and

        ii) failed to conform to the essential standards of acceptable and prevailing nursing practice.

Understandings

A. The Respondent understands that the Board of Nursing must review and accept the terms of the Order set forth below and that if the Board rejects all or any portion of the Order, then this entire document shall be null and void.

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

C. The Respondent is not under the influence of any drugs or alcohol at the time this document is being signed.

D. The Respondent agrees that she has had sufficient opportunity to consult with legal counsel before signing this document.

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E. The Respondent is voluntarily waiving her right to a contested hearing before the Board of Nursing.

F. The Respondent agrees that the Order set forth immediately below may be entered by the Board of Nursing.

G. Based on the above stipulations, it is **ADJUDGED** as follows:

(1) The "Facts" listed above are true; and

(2) The Respondent has engaged in unprofessional conduct in that the Respondent has:

(a) shown she is unable to practice nursing competently by reason of any cause, in violation of 26 V.S.A. §1582(a)(3), specifically Respondent:

i) performed unsafe or unacceptable patient care; and

ii) failed to conform to the essential standards of acceptable and prevailing nursing practice.

H. Based on the above stipulation and on the above findings and conclusions of this Board, it is **ORDERED** follows:

(1) The Board hereby **CONDITIONS** Respondent's license to practice nursing **for a minimum period of one (1) year.** The **CONDITIONS** on Respondent's license would be as follows:

(a) Respondent shall complete the following education in addition to those conditions imposed below:

i) A diabetic management course;

ii) The educational course listed above must be approved by the Board or it's designee prior to Respondent receiving credit for the course; and

iii) The educational course shall be completed no later than three (3) months following the entry of this Order.

(2) Length of Time Conditions Imposed.

The conditions shall remain in place until respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes one (1) year of supervised nursing practice in which she works at least forty (40) hours every two (2) weeks as a nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty-eight (48) hours per week. Respondent's license is additionally conditioned as follows.

(3) Interview with the Board or its designee.

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Respondent shall appear in person for interviews with the Board or its designee upon request.

(4) Re-issue of License.

Upon the imposition of these conditions, Respondent shall be issued a license labeled "conditioned".

(5) Out of State Practice/Residence.

Before any out-of-state practice or residence can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board prior to Respondent leaving the State of Vermont. If Respondent fails to receive such approval before leaving the State, none of the time spent out-of-state will be credited toward the fulfillment of the terms and conditions of this Consent Order. The Board will approve out-of-state practice so long as the Respondent can still comply with the provisions of this Consent Order.

(6) Notification of Place of Employment/ Personal Address/Telephone Number.

Within five (5) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of her current place of nursing employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in nursing employment, personal address, or telephone number. Respondent shall provide a copy of this Consent Order to all employers, current and future, and shall inform them of the conditional status of her license.

(7) Notification to Employers.

Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which she practices as a nurse and inform them of her conditional license status. Within ten (10) days of the date of entry of this Consent Order or of any subsequent employment, Respondent shall cause her immediate supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

(8) Reports from Employers.

Within one (1) month of the date of entry of this Consent Order and every month thereafter, Respondent shall cause every employer she has worked for during the month to submit to the Board an evaluation of Respondent's performance and attendance during that month. This report shall be submitted in writing on forms issued by the Board. In the event the Respondent is attending a nursing program, she shall provide a copy of the Consent Order to the Program Director. Respondent shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Consent Order and ability of the program to comply with the conditions in the Consent Order during clinical experience.

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Respondent shall sign a consent, upon request of the Board, to authorize her employer to provide all information requested by the Nursing Board, or its designee, either orally or in writing, at any time during the period the Consent Order is in effect.

(9) Practice Under Supervision.

Respondent shall practice only in a setting where she has on-site supervision for the entire shift by a registered nurse in good standing with the Vermont Board of Nursing.

(10) Types of Employment Prohibited.

Respondent shall not work for a nurse registry, travelling nurse agency, float-pool, home health care agency, temporary nursing employment agency, or as a personal care provider during the effective period of this Consent Order.

(11) Prohibited Duties.

Respondent shall be prohibited from being a Charge Nurse during the effective period of the Consent Order.

(12) License Renewal.

In the event Respondent's license is scheduled to expire during the period this Consent Order is in effect, Respondent shall apply for renewal of the license, pay the applicable fee, and otherwise maintain qualifications to practice nursing in the State of Vermont.

(13) Costs.

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

(14) Violation of the Consent Order.

If Respondent violates the terms of this Consent Order in any respect, the Board, after giving Respondent notice and an opportunity to be heard, may revoke the terms of the conditional license and take further disciplinary action. If a complaint or charges are filed against Respondent during the term of this Consent Order, the conditional license period shall be extended until the matter is final.

(15) Completion of Conditional License Period.

Upon completion of the conditional license period, 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. Respondent, however, must present proof of successful rehabilitation and demonstrate, to the satisfaction of the Nursing Board, that she poses no danger to the practice of nursing and that she can safely and competently perform the duties of a nurse. Such proof shall include appropriate support from her employer and/or nursing school administrator. Furthermore, Respondent shall

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demonstrate, to the Board's satisfaction, that she fully complied with all the terms of this Consent Order.

J. Notwithstanding any provision above, Respondent must meet all Nursing Board requirements for license renewal and license reinstatement.

K. At any time after the entry of this Order, the Respondent may petition the Board to reinstate her license and/or modify the conditions.

L. 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).

M. This Stipulation and Consent Order will remain part of the Respondent's licensing file and may be used in determining sanctions in future disciplinary matters.

AGREED TO:

BY: MAUREEN BROCKWAY
RESPONDENT

Date: 4-6-01

Maureen Brockway

AND BY: STATE OF VERMONT
WILLIAM H. SORRELL
ATTORNEY GENERAL

Date: 4/9/01

George C. Haegele IV
Assistant Attorney General

Office of the
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ACCEPTED AND SO ORDERED:

BOARD OF NURSING

Date: May 14, 2001

Susan Farrell
Chairperson

Dated entered: 5-17-01

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STATE OF VERMONT
BOARD OF NURSING

In re:	)	
Rheanne Myranda Fiske	)	Docket No. NU08-0795
License No. 25-6832	)	

PRESENT: Ingrid Brodin, RN, Hearing Panel Chair
Catherine McGee, Public Member
Marjorie Allard, RN
Kim Keaton, RN
Michelle Walker, RN, Ad Hoc
Raymond Phillips, Public Member

APPEARANCES: Diane Zamos, Assistant Attorney General
for Petitioner

Christopher A. Micciche, Esq.
for Respondent

Rheanne Myranda Fiske, Respondent

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

INTRODUCTION

This cause came before the Board of Nursing on a Specification of Charges filed by Attorney General's Office and dated November 14, 1996. The Board held hearings on the merits on March 10 and May 12, 1997. Based on the evidence that was presented at those hearings, the Board has determined the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. Respondent, Rheanne Myranda Fiske, is a licensed practical nurse holding license number 25-6832 issued by the State of Vermont.

2. Respondent was employed by McKerley Health Care Centers, Inc., (McKerley) in Morrisville, Vermont, for approximately two and one-half years. Her employment ended in July, 1995.

3. In June, 1995, K.D., N.B., E.B., R.W., R.C., I.B., H.H., E.M. and B.T. were residents at McKerley.

Counts I and II

4. In June, 1995, Respondent administered PRN medications numerous times to these eight residents. Respondent noted on the residents' Medical Administration Records (MAR) that she administered the medication. Respondent failed to always enter a corresponding notation on the MARs to record the time, reason and effect (TRE) of the administration.

5. During June, 1995, Respondent administered acetaminophen PRN to resident K.D. 15 times. She documented the corresponding TRE only 2 times.

6. During June, 1995, Respondent administered acetaminophen PRN to resident N.B. 18 times. She documented the corresponding TRE only 3 times.

7. During June, 1995, Respondent administered acetaminophen PRN to resident E.B. 18 times. She documented the corresponding TRE only 3 times.

8. During June, 1995, Respondent administered acetaminophen PRN to resident R.W. 15 times. She documented the corresponding TRE only 4 times.

9. During June, 1995, Respondent administered acetaminophen PRN to resident R.C. 12 times. She documented the corresponding TRE only 3 times.

10. During June, 1995, Respondent administered acetaminophen PRN to resident I.B. 13 times. She documented the corresponding TRE only 2 times.

11. During June, 1995, Respondent administered acetaminophen PRN to resident H.H. 15 times. She documented the corresponding TRE only 3 times.

12. During June, 1995, Respondent administered acetaminophen PRN to resident E.M. 9 times. She documented the corresponding TRE only 2 times.

13. The standard of acceptable and prevailing nursing practice at all times relevant to the specification of charges is that a nurse must record TRE on the Medication Administration Record of the patient each time a PRN medication is administered to that patient. This procedure is essential to provide continuity of care by the succeeding nurses. Competent nursing practice requires conformance to this standard.

14. As set forth in Paragraphs 5 through 12, Respondent repeatedly violated this standard of acceptable and prevailing nursing practice. Furthermore, failure to make required entries or failure to make accurate entries in clinical records is conduct that could have resulted in harm to patients and the public.

15. Respondent knew at the time that the recording of TRE along with the administration of PRN medication was acceptable and prevailing nursing practice, and her subsequent nursing education re-affirmed this knowledge.

Counts III and IV

16. On June 27, 1995, Resident E.B. complained of chest pains to Deanna Finn, a nursing aide, during the 3:00 - 11:00 PM shift. During the same shift, Ms. Finn reported E.B.'s complaints to Respondent, who was the nurse for that shift. Ms. Finn did not see Respondent attend to E.B.

17. Luke Mestas, L.P.N., was the nurse for the 11:00 PM - 7:00 AM shift, the shift following Respondent's shift. During his shift on June 27, 1997, he was informed by the nursing aides that E.B. had complained of chest pain and that an aide had reported this to Respondent. Mr. Mestas reviewed E.B.'s Progress Notes and found no record of any observations or action taken concerning E.B.'s complaints. He checked E.B., who indicated that she still had the pain. He administered nitroglycerin to E.B., checked her condition until she no longer complained of pain, continued to monitor the situation and documented his assessments and actions in E.B.'s Progress Notes.

18. It was Respondent's duty to check on E.B.'s complaints. Furthermore, it was Respondent's duty to assess E.B.'s condition and take appropriate action to treat E.B. Any action taken should have been documented in E.B.'s Progress Notes. If Respondent determined that no treatment was warranted, then that assessment should have been documented in E.B.'s Progress Notes. This procedure is essential to provide continuity of care by the succeeding nurses. Competent nursing practice requires conformance to this standard.

19. Respondent failed to appropriately assess, treat and monitor E.B. subsequent to E.B.'s complaints of chest pain. Furthermore, Respondent failed to record anything in E.B.'s Progress Notes concerning E.B.'s complaints or Respondent's observations or actions as a result of those complaints. This was unacceptable patient care and was a failure to take action to safeguard a patient.

Counts V and VI

20. On June 27, 1995, Resident B.N. complained of abdominal pains to Debra Charland, a nursing aide, during the 3:00 - 11:00 PM shift. During the same shift, Ms. Charland reported B.N.'s complaints to Respondent, who was the nurse for that shift. Ms. Finn did not see Respondent attend to B.N.

21. Luke Mestas, L.P.N., was the nurse for the 11:00 PM - 7:00 AM shift, the shift following Respondent's shift. During his shift on June 27, 1997, he was informed by the nursing aides that B.N. had complained of chest pain and that an aide had reported this to Respondent. Mr. Mestas reviewed B.N.'s Progress Notes and found no record of any observations or action taken concerning B.N.'s complaints. He checked B.N. who was still complaining of abdominal pains. He treated B.N. until the pain was relieved, continued to monitor the situation and documented his assessment and actions in B.N.'s Progress Notes.

22. It was Respondent's duty to check on B.N.'s complaints. Furthermore, it was Respondent's duty to assess B.N.'s condition and take appropriate action to treat B.N. Any action taken should have been documented in B.N.'s Progress Notes. If Respondent determined that no treatment was warranted, then that assessment should have been documented in B.N.'s Progress Notes. This procedure is essential to provide continuity of care by the succeeding nurses. Competent nursing practice requires conformance to this standard.

23. Respondent failed to appropriately assess, treat and monitor B.N. subsequent to B.N.'s complaints of abdominal pain. Furthermore, Respondent failed to record anything in B.N.'s Progress Notes concerning B.N.'s complaints or Respondent's observations or actions as a result of those complaints. This was unacceptable patient care and was a failure to take action to safeguard a patient.

Count VII

24. On June 18, 1995, at approximately 10:40 PM, Luke Mestas, L.P.N., was beginning his shift as nurse at McKerley. Respondent, as the 3:00 - 11:00 PM shift nurse, was ending her shift. Together, they performed a change of shift narcotic count. They discovered that one Wygesic tablet was missing from the packet of Resident K.D.

25. Unable to account for the missing Wygesic tablet, Respondent took one Wygesic tablet from the packet of Resident B.T. and placed it in the packet of K.D. On B.T.'s Controlled Drug Record, Respondent entered the notation that one Wygesic tablet from B.T.'s packet was "wasted." Both Respondent and Mr. Mestas initialed this notation.

26. On June 28, 1995, Mr. Mestas reported this incident to his supervisor, Anne Johnson. Subsequently, Ms. Johnson discussed the incident with Respondent, and Respondent admitted to Ms. Johnson that she, Respondent, had written the entry and that she had made a mistake.

27. The notation that Respondent had written on B.T.'s Controlled Drug Record was false. The Wygesic tablet had not been wasted, if anything, it had been borrowed. Respondent admitted this. True and accurate records are essential for continuity of care and the proper operation of a health care facility. Creating false records undermines these goals and the public's confidence in health care.

CONCLUSIONS OF LAW

A. Respondent, by failing to record on several residents' Medical Administration Records the time, reason and effect of her administration of medication to those residents, has demonstrated an inability to practice nursing competently by failing to conform to the essential standards of acceptable and prevailing nursing practice, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(3) and Nursing Board Rule IV.B.2.

B. Respondent, by failing to record on several residents' Medical Administration Records the time, reason and effect of her administration of medication to those residents, has engaged in conduct of a character likely to harm the public, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(7) and Nursing Board Rule IV.B.4.

C. Respondent, by failing to appropriately assess, treat and monitor resident E.B. after being informed of E.B.'s complaints of chest pains, and by failing to record in E.B.'s Progress Notes Respondent's actions or reasons for no action as a result of those complaints, has demonstrated an inability to practice nursing competently by failing to conform to the essential standards of acceptable and prevailing nursing practice and by performing unacceptable patient care, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(3) and Nursing Board Rules IV.B.2.b and IV.B.2.a.

D. Respondent, by failing to appropriately assess, treat and monitor resident E.B. after being informed of E.B.'s complaints of chest pains, and by failing to record in E.B.'s Progress Notes Respondent's actions or reasons for no action as a result of those complaints, has engaged in conduct of a character likely to harm the public by failing to take appropriate action to safeguard a patient, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(7) and Nursing Board Rules IV.B.4.c.

E. Respondent, by failing to appropriately assess, treat and monitor resident B.N. after being informed of B.N.'s complaints of abdominal pains, and by failing to record in B.N.'s Progress Notes Respondent's actions or reasons for no action as a result of those complaints, has demonstrated an inability to practice nursing competently by failing to conform to the essential standards of acceptable and prevailing nursing practice and by performing unacceptable patient care, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(3) and Nursing Board Rules IV.B.2.b and IV.B.2.a.

F. Respondent, by failing to appropriately assess, treat and monitor resident B.N. after being informed of B.N.'s complaints of abdominal pains, and by failing to record in B.N.'s Progress Notes Respondent's actions or reasons for no action as a result of those complaints, has engaged in conduct of a character likely to harm the public by failing to take appropriate action to safeguard a patient, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(7) and Nursing Board Rules IV.B.4.c.

G. Respondent, by entering the notation "wasted" on the Controlled Drug Record of B.T. to document what happened to a Wygesic tablet that Respondent took from the drug packet of B.T., has engaged in conduct of a character likely to harm the public by knowingly falsifying a clinical record, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(3) and Nursing Board Rule IV.B.4.

H. Count VIII alleges that Respondent's actions and omissions set forth in Counts I through VII individually or collectively constitute unprofessional conduct. Since those actions and omissions have been separately found to constitute unprofessional conduct, the Hearing Panel chooses not to decide whether together they constitute another act of unprofessional conduct.

ORDER

IT IS HEREBY ORDERED by the Board of Nursing that:

1. Count VIII of the Specification of Charges is DISMISSED.

2. On the basis of each of the Conclusions of Law A, B, C, D, E, F or G, and not a combination of any or all of them, Respondent is REPRIMANDED and her nursing license is CONDITIONED for a minimum period of one (1) year commencing with the date of entry of this Order and subject to the following terms and restrictions:

A. The conditions shall remain in place until Respondent has completed one (1) year of supervised nursing practice in which she works at least forty (40) hours every two (2) weeks in nursing. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis.

B. Before any out-of-state practice or residence can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board prior to Respondent leaving the State of Vermont. If Respondent fails to receive such approval before leaving the State, none of the time spent out-of state will be credited toward the fulfillment of the terms and conditions of this Order.

C. Within five (5) days of the date of entry of this Order, Respondent shall notify the Board, in writing, of her current place of nursing employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in nursing employment, personal address, or telephone number.

D. Respondent shall provide a copy of this Order to all employers in any current or future setting in which she practices as a nurse and inform them of her conditional license status. Within ten (10) days of the date of entry of this Order or of any subsequent employment, Respondent shall cause her immediate supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of the Order and the ability to comply with the conditions in the Order. In the event Respondent is attending a nursing education program, she shall provide a copy of the Order to the Program Director. Petitioner 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.

E. Within one (1) month of the date of entry of this Order and every month thereafter, Respondent shall cause every employer she has worked for during the month to submit to the Board an evaluation of Respondent's attendance and performance, including whether she is complying with the employer's policies and procedures related to documentation, medication

administration and narcotic count during that month. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the employer's letterhead. In the event the Respondent attends a nursing education program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of Respondent's attendance and performance, including whether she is complying with the program's policies and procedures related to documentation, medication administration and narcotic count during that month. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the school's letterhead. In the event Respondent is not employed in nursing or attending school during any month or portion thereof, Respondent shall submit to the Board, in writing, a self-report describing other employment or activities. Respondent shall authorize her employer and her school administrator to provide all information requested by the Board, or its designee, either orally or in writing, at any time during the period the Order is in effect.

F. In the event Respondent's license is scheduled to expire during the period this Order is in effect, Respondent shall apply for renewal of license, pay the applicable fee, and otherwise maintain qualifications to practice nursing in the State of Vermont.

G. If Respondent violates the terms of this Order in any respect, the Board, after giving Respondent notice and an opportunity to be heard, may revoke the terms of the conditional license and take further disciplinary action. If a complaint or charges are filed against Respondent during the term of this Order, the conditional license period shall be extended until the matter is final.

H. Upon completion of the conditional license period, 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. Respondent shall demonstrate, to the Board's satisfaction, that she fully complied with all the terms of this Order.

I. Notwithstanding any provision above, Respondent must meet all Nursing Board requirements for license renewal and license reinstatement.

J. Within five (5) days of the date of entry of this Order, Respondent shall submit her LPN and RN licenses to the Board for re-issued licenses labelled "conditioned."

I. Pursuant to 3 V.S.A. § 1331(c)(2)(C), this document is a public record, and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a)(7).

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

APPEAL RIGHTS

This is a final administrative determination. A party may appeal by filing a written notice of appeal with the Director of the Office of Professional Regulation, Office of the Secretary of State, within 30 days of the effective date of this Order.

BOARD OF NURSING

Ingrid Brodin RN
Ingrid Brodin, RN, Hearing Panel Chair

Dated: 6/27/97

Date of Entry: 6-30-97