

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

IN RE:

PAULA G. BURRELL

License No. 026.0023604

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Docket No. 2008-158 (NU85-0408)

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney BetsyAnn Wrask, and the Respondent, Paula G. Burrell, RN, who 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(a); 3 V.S.A. § 129a; 3 V.S.A. § 814(d); 26 V.S.A. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Paula G. Burrell (the "Respondent") of East Lempster, New Hampshire is licensed by the State of Vermont as a Registered Nurse under license number 026.0023604. This license was originally issued on or about September 11, 1997 and lapsed on or about March 31, 2009.
3. At all times relevant, Respondent was employed through Prison Health Services ("PHS"), located in South Burlington, Vermont, and was working as a Registered Nurse at the Southern State Correctional Facility (the "Facility"), located in Springfield, Vermont.
4. On or about April 7, 2008 in a Mandatory Report of Unprofessional Conduct, the District Manager of PHS reported that Respondent was terminated from PHS due to poor documentation. The Mandatory Report stated Respondent had been under corrective action for two (2) months, but failed to show any improvement.
5. Attached to the Mandatory Report was a copy Respondent's termination letter, addressed to Respondent from PHS Nurse Manager M.K., dated March 10, 2008. The termination letter reveals in part the following:

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- a. In or around December 2007, Respondent failed to document any attempts to complete an intake on Inmate C.S. In or around January 2008, Respondent failed to complete documentation on Infirmary Patient S.F. As a result of these two incidents, Respondent was given written counseling and placed on three days' leave without pay.
 - b. On or about January 24, 2008, Respondent failed to document any attempts to complete intake on Inmate W.P., even though W.P. allowed Respondent to take vital signs and provide first aid.
 - c. On or about February 18, 2008, Respondent did a hands-on examination of a juvenile who was not admitted to the Facility, in violation of procedure.
 - d. On or about February 29, 2008, Respondent was counseled regarding her failure to process orders, in violation of procedure. M.K. stated Respondent's failure to follow policy and procedure resulted in a fine of \$6,000 and an inmate missing twelve (12) doses of medication.
 - e. On or about March 4, 2008, Respondent was working as Charge Nurse when two inmates, D.B. and A.L., were admitted to disciplinary segregation. Respondent failed to follow policy and procedure by failing to document their admissions into disciplinary segregation. It was noted that Inmate A.L. had apparent injuries from handcuffs.
 - f. M.K. stated Respondent was terminated because the above-described incidents demonstrate Respondent does not have the skill sets necessary to follow policy and procedures as they relate to safe nursing practice and proper documentation.
6. On or about February 24, 2009 in a telephone interview with State Investigator Gregory Kelly, Respondent stated in part the following:
- a. Respondent denied being responsible for performing the intake of Inmate C.S. in December 2007.
 - b. Respondent stated she failed to complete documentation (a Nurse's Note) for Infirmary Patient S.F. in January 2008 because she wasn't told by the Infirmary's LPN on duty about S.F. being ill. Respondent stated she "figured the LPN would let me know if there was something," and stated she was not aware of S.F.'s condition and therefore didn't perform the appropriate documentation "probably because I didn't ask."
 - c. Respondent stated the Corrections Supervisor did not allow her to perform the intake on Inmate W.P. on January 24, 2008 because W.P. was combative. Respondent denied being responsible to perform any additional documentation.

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- d. Respondent stated she evaluated the juvenile in question on or about February 18, 2008 to ensure he was medically stable to be housed off Facility premises. Respondent stated she asked the juvenile if he was taking any medications, inquired about drug use, checked the juvenile for injuries, and obtained vital signs. Respondent denied being aware of any procedures regarding juveniles who were not being detained.
- e. Respondent denied having been made aware of the need to process orders on or about February 29, 2008. Respondent stated she "didn't see" this inmate's chart because of a flawed system and therefore did not transcribe a new medication order into the inmate's chart.
- f. Respondent admitted that she failed to document the admissions of Inmates D.B. and A.L. into disciplinary segregation on March 4, 2008. Respondent stated that the next day she found that the oncoming nurse had made the appropriate documentation.

Charges

- 7. 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:
 - a. 3 V.S.A. § 129a(b)(1) and (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: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and
 - b. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

Understandings

- 8. 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.
- 9. 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.
- 10. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

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11. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
12. 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.
13. 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.
14. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

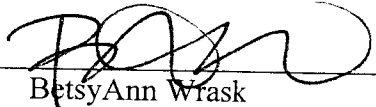
Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

- A. The Board of Nursing hereby **WARNS** Respondent's license to practice registered nursing.
- B. 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).
- C. 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:

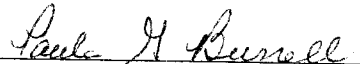
STATE OF VERMONT
SECRETARY OF STATE

Dated: 11-30-09

By: 
Betsy Ann Wrask
State Prosecuting Attorney

PAULA G. BURRELL
RESPONDENT

Dated: 11-23-09

By: 
Paula G. Burrell

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 12-14-09

By: 
Chairperson

Date of Entry: 12/17/09
nu.burrell.stip

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