

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

IN RE:)
ERICA J. CONAWAY)
License No. 026.0034305)

Docket No. 2013-1

STIPULATION AND CONSENT ORDER

NOW COME the State of Vermont, by State Prosecuting Attorney Gabriel M. Gilman, and the respondent, Erica J. Conaway, who stipulate and agree follows:

Board Authority

1. The Vermont State Board of Nursing ("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. Erica J. Conaway ("Respondent") of Groton, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026.0034305. This license was originally issued on or about September 20 2006 and expires on or about March 31, 2015.
3. At all times relevant, Respondent was employed as a Registered Nurse at Central Vermont Medical Center (the "Facility") in Barre, Vermont.
4. On or about December 18, 2012, Respondent was working in the Emergency Department at the Facility. During the course of her shift, the following errors occurred:
 - a. Respondent was caring for a patient with diabetic ketoacidosis. Initially, the patient's potassium level was low so a potassium IV was started. Respondent failed to review the patient's hourly blood tests in a timely manner. The patient's potassium level became dangerously high, and the patient had to be admitted to the intensive care unit.
 - b. Respondent started an insulin drip for the patient described in the above paragraph. Facility protocol required that two nurses do independent calculations before drawing up and administering an insulin injection into an IV bag. Both nurses

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must witness the administration and both must sign off. Respondent did not have another nurse double check the calculations or witness the administration. Respondent also did not label the IV bag.

- c. While caring for a different patient, Respondent asked N.L., an Emergency Department Technician, to prepare a medication vial by reconstituting a powdered antibiotic in a vial. This was outside N.L.'s scope of practice.
5. On or about April 19, 2013, in an interview with Investigator Dennis Menard of the Office of Professional Regulation, Respondent acknowledged that she made a medication error with regard to the potassium IV. Respondent also acknowledged that she did not label the insulin bag or have another nurse witness the injection of insulin into the bag. Respondent indicated that she took full responsibility for the medication error, which she attributed to unfamiliarity with DKA protocol and simultaneous responsibility for multiple, complex patients. Respondent felt scheduling pressures and an unusual number of high-need patients contributed to the events of December 18.
6. The events described above were isolated to a single shift early in Respondent's return to work at the Facility after moving away for a number of years. Investigator Menard found no indication of prior patient-care or performance issues.
7. While this matter was pending, and in order to obviate a period of conditional licensure, Respondent successfully completed, through the NCSBN Learning Extension, recommended coursework pertaining to error prevention and critical thinking.

Charges

8. 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(a)(6) (Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education, or licensing credentials to perform them);
 - b. 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

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UNDERSTANDINGS

9. Respondent acknowledges that the facts above are true and accurate.
10. 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.
11. 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.
12. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
13. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
14. 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.
15. 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.
16. 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** the Respondent's license.
- B. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- C. 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).
- D. 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.

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AGREED TO:

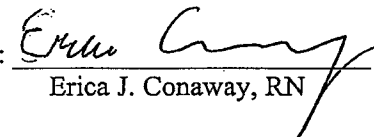
Dated: 10/11/13

STATE OF VERMONT
SECRETARY OF STATE

By: 
Gabriel Gilman
State Prosecuting Attorney

ERICA J. CONAWAY
RESPONDENT

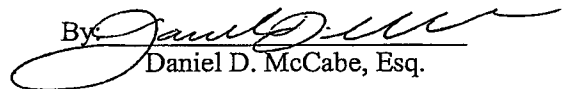
Dated: 10/10/13

By: 
Erica J. Conaway, RN

APPROVED AS TO FORM

DANIEL D. McCABE, ESQ.
ATTORNEY FOR RESPONDENT

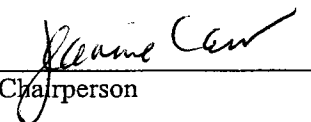
Dated: 10/11/13

By: 
Daniel D. McCabe, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 10/14/13
Date of Entry: 10/15/13

By: 
Chairperson

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