

**STATE OF VERMONT
BOARD OF NURSING**

In re: Jeanne Marie Duckett
License No. 025-4264

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Docket No. 2008-403
NU45-1008

**Decision on
UNPROFESSIONAL CONDUCT CHARGE**

Participating Board Members:

Ellen W. Leff, RN, Chair
Jeanine Carr, RN, Vice Chair
Alan Weiss
Sandra Norton, LNA
Donarae Metcalf, LPN
Deann Welch, LPN
William G. White Jr.
Deborah Robinson, RN
John Todd, ARPN

Decision on Unprofessional Conduct Charges

Appearances:

for Petitioner, State of Vermont: Betsy Ann Wrask
for Respondent: Drew Palcsik

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 January 11, 2010 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 Ms. Duckett in violation of Vermont Statutes 1) held a patient's medicine, 2) put applesauce down a patient's feeding tube, 3) failed to sign out a narcotic, 4) delayed calling 911 in an emergency situation, 5) made several transcription errors, and 5) failed to keep a medication cart and medicine room door locked.

Findings of Fact

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

1. Ms. Duckett is licensed as a practical nurse and is therefore subject to the regulatory 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. At all times relevant Ms. Duckett was employed as an LPN at Birchwood Terrace in Burlington, Vermont.
3. In August 2007 a co-worker advised Ms. Duckett that a resident's nicotine patch was missing. Another nurse on duty, wrote in the patient's record a note indicating that they could not locate the patch. When Ms. Duckett came on duty, she found the patch on the patient's shoulder.
4. Instead of making a new entry in the patient's record, Ms. Duckett crossed out the "lost patch" entry and changed the note entry so that it would reflect the facts at the time the patch was located. Unfortunately, the actual record was not introduced into evidence. The only evidence of this record change was Ms. Duckett's own testimony. It was impossible for this Board to see exactly in what manner Ms. Duckett altered the patient's record. The essential standards for nursing do not allow entries in patient records to be crossed out and replaced. Ms. Duckett forthrightly admitted that it was wrong to make the change to the patient's record. She admitted that she erred, and that she should have written an addendum to the note instead of writing over it. Ms. Duckett received additional education through her employer in response to this error.
5. In August 2008 Ms. Duckett held one dose of a patient's anti gout medication. Ms. Duckett wrote in the chart that the medication was "held." Ms. Duckett testified that the patient told her that she did not want the medication until the physician was consulted. Ms. Duckett testified that the patient had previously had side-effects from the medication, and that patient's pain had decreased. Ms. Duckett admitted that she should have documented what occurred differently. This was a failure to meet the essential standards of practice.
6. At that time Ms. Duckett was aware of the patient's previous medical history. And, she took that history into consideration. She did not discuss that history or other information with patient's doctor before holding the medication. Based on her record entries and the circumstances and considerations as she described them, Ms. Duckett should have consulted with the patient's physician.
7. As Ms. Duckett described it, withholding the gout medicine involved making a medical judgment. This is outside the LPN scope of practice. This matter was addressed by her employer which included a plan of correction, education, and continued monitoring.
8. At one time when Ms. Duckett was orienting a new nurse to Birchwood, Ms. Duckett discussed the practice of crushing medication and mixing it with apple sauce and diluting with water to be placed in a patient's feeding tube. That practice was not used at Birchwood she said, but was one she had learned at another facility. There was no evidence to support that allegation that Ms. Duckett actually put crushed medication in applesauce and put it in the feeding tube of any patient at Birchwood at any time.
9. On May 24, 2006 Ms. Duckett failed to sign out a narcotic drug, although she did note

that the medication was given as ordered. This was a failure to comply with documentation requirements which Ms. Duckett acknowledged. We decline, in this case, to label that one omission unprofessional conduct.

10. Ms. Duckett failed to administer insulin to a patient on four occasions. We note that other nurses made the same error with the same patient. That does not, however, excuse the error. Ms. Duckett was counseled on that failure in April of 2007.
11. No evidence was presented at the hearing about any 911 call or an unattended patient as charged in paragraph 13(c) of the charges. We make no such findings.
12. There was insufficient evidence for us to find what role, if any, Ms. Duckett may have had in five transcription errors that were noted in February of 2008.
13. On one occasion Ms. Duckett failed to ensure that the medication cart and medicine room were locked.
14. In November 2008 Ms. Duckett was reprimanded by her employer and given a corrective plan. The plan was based on all the conduct found above and other conduct for which we make no findings.
15. Ms. Duckett was required by her employer to take a course called "Write it Right, The legal implications of documentation." She completed that course. Ms. Duckett also took a course on "Medicare documentation." She was given a 90 day action plan at Birchwood. She completed the course on November 25, 2008. Following the matters discussed above, her performance at work has been monitored with no irregularities noted. Her progress at work satisfies her employers and supervisors. There have been no complaints about her professional conduct since the complaint in this matter was filed.

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 Ms. Duckett 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 Ms. Duckett 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 Ms. Duckett 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(a)(13):** The State has proved by a preponderance of the evidence that Ms. Duckett performed treatments or provided services which were beyond the scope of her scope of practice. This is unprofessional conduct.

5. **Re: Alleged Violation of 3 V.S.A. § 129a(b)(1) and (2):** The State has proved by a preponderance of the evidence that Ms. Duckett failed to practice competently. As found above she failed to conform to the essential standards of acceptable and prevailing practice. This is unprofessional conduct.
6. **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.

Discussion

Much of Ms. Duckett's conduct has been addressed by Ms. Duckett and her employer. We are unable to conclude however that the corrective action sufficiently addressed the issues of scope of practice or medicine administration. We see no need to remove Ms. Duckett from practice to protect the public. But, her errors must be officially recognized and addressed. For the violations above, to protect the public, health, safety and welfare, the following sanction is necessary.

Order

Ms. Duckett's license is issued a **reprimand**. Ms. Duckett's license shall be conditioned as follows:

Within 120 days Ms. Duckett shall successfully complete two courses, pre-approved by the Board or its designee, one course covering scope of practice and one course in medicine administration. She may submit documentation of courses previously taken to see if they satisfy this requirement.

When the Board or its designee is satisfied that Ms. Duckett has complied with the conditions, they 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

Date January 12, 2010

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 1/19/2010