VERMONT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

In re: Susan P. Egan }
License No. 026-0023836 } Docket No. NU 77-0605

FINDINGS OF FACT
CONCLUSIONS OF LAW & ORDER

Introduction:

On Monday 12 June 2006 the Board heard this contested case of alleged unprofessional conduct brought against Respondent Susan P. Egan. Board members Kenneth W. Bush, Susan O. Farrell (Chairperson), Donarae Metcalf, Sandra Norton, Laurey M. Tyo, and Alan Weiss participated in the hearing of this matter. Board member Linda Rice recused herself. The Respondent did not appear. Edward G. Adrian represented the State of Vermont. Board counsel Kevin F. Leahy presided.

The State brought a specification of charges (the "Charges" attached) against Susan Egan (the "Respondent") alleging unprofessional conduct for making a medication error. The Respondent worked at the Southern Vermont Correctional Center (the "Facility") located in Springfield, Vermont at the time of the alleged incident (the "incident").

The pertinent allegation charged is:

> Respondent made a medication error involving [an] inmate []. The inmate had an order for morphine sulfate via CADD of 50 mg per hour. Respondent programmed the CADD to administer over 2000 mg of morphine sulfate over approximately a two and a half to three hour [] period.

Charges at ¶ 4.

Based on these allegations, the State makes three individual charges of unprofessional conduct against the Respondent claiming she violated:

> (i) 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause);
>
> (ii) 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); and
>
> (iii) 3 V.S.A. § 129a(b) (failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute

unprofessional conduct. Failure to practice competently includes . . . failure to conform to the essential standards of acceptable and prevailing practice.)

Charges at ¶ 7 (i) - (iii).

The prosecution did not present any witnesses. The Respondent did not appear at the hearing.

The state prosecuting attorney introduced three exhibits and represented to the Board that the State attempted to contact the Respondent but was unable to reach her.

The Board accepted into evidence:

State's Exhibit 1. Letter from Respondent.

State's Exhibit 2. Letter from Respondent.

State's Exhibit 3. Packet of documents. Incident report, counseling report and letter.

Findings of Fact &
Conclusions of Law:

1. Respondent Susan P. Egan of Springfield, Vermont holds a Vermont issued license to practice as a registered nurse.

2. At the time of the incident, the Respondent was employed as registered nurse at the Southern Vermont Correctional Facility.

3. The Respondent did not appear for the hearing and she was unavailable to answer questions from the Board. Other than her written Answer to the State's *Charges*, she did not submit anything to the Board in her defense.

4. The State prosecuting attorney represented that he spoke with the Respondent and discussed a possible settlement.

5. The Respondent sent to the State (Exhibit 2) a letter indicating intent by the Respondent to settle this matter.

6. In a May 2006 letter to the prosecuting attorney, the Respondent indicated that she was in Florida. (Exhibit 1). The Respondent did not give an address or phone number. *Id.*

7. At the time of the hearing, the Respondent apparently remained in Florida. The Office of Professional Regulation and the prosecuting attorney were unable to contact her although it was the Respondent's duty to inform OPR if she were unable to attend the hearing.

8. Ms. Egan did not notify the Board that she planned not to attend the hearing. She did not request to testify by phone, and Ms. Egan did not seek a continuance.

9. From the evidence available to the Board and from the inferences the Board can draw from that evidence, we find that on the date of the incident, the inmate received a dose of morphine inconsistent (greater than) with the dose prescribed by the treating physician.

10. The inmate suffered no harm as a result of receiving the incorrect dose.

11. It is not clear that the patient received an incorrect dose due to the negligence of the Respondent, due to a CADD pump that did not operate properly or possibly due to another reason.

12. Upon learning of the incident with the CADD pump, the Respondent took immediate remedial action. She checked the patient's vital signs and made sure he was stable. She self reported the error and contacted both her nurse manager and the medical director per the Facility's guidelines.

13. The treating physician was also called immediately. The evidence presented by the state showed that the treating physician's response to the incident was to order more of the same medicine (morphine) for the patient but to continue treating him with oral morphine rather than via IV administration.

14. The prison notes and the Respondent's Answer to the Charges indicate that the patient had throat cancer, was deemed hospice eligible, and it was the goal of the treating physician to maintain the patient's comfort so that he would not need to go to the hospital. The patient suffered no adverse side effects from the maladministration of morphine.

15. The Board is disappointed that it does not have more evidence to review in making its decision, and the Board notes that it is hampered by a total lack of participation by the Respondent in this disciplinary proceeding.

16. What the Board can, with certainty, determine in disposing with this case is:

A. The CADD did not function properly and we will infer that that this was the fault of the Respondent;

B Even if the Respondent did not program the CADD incorrectly, she was ultimately responsible for it;

C. The Respondent took immediate remedial action, the patient was not harmed and his care continued in essentially the same fashion although his pain medicine was switched to oral administration from IV administration;

D. There is no question that, when Respondent discovered the excessive dosing that occurred on her watch, the she did everything expected of her and did it correctly; and

E. The Respondent did not attend the hearing so we are unable to make a substantive evaluation of whether she poses any future risk to patients.

17. Since we cannot determine from the evidence in front of us whether the Respondent poses a safety concern, we will infer that she does. The uncontested

evidence, scant as it is, does raise this issue and the Board is thus compelled to impose a remedy.

18. Absent some showing by the Respondent to refute the inference raised by the prosecution, the Board believes patient safety requires a conditioned license as advocated by the state.

The Charges:

19. In light of the evidence received, the Board finds as follows to the three charges made of unprofessional conduct made by the state:

(i) 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause). The Board concludes that the State did not meet its burden of proof. There is no evidence that Respondent is unable to practice nursing competently.

(ii) (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). The Board concludes that the State did not meet its burden of proof. Outside of the individual charges of unprofessional conduct brought against the Respondent, on which the Board rules individually, there are no factual allegations that Respondent violated any statutes or administrative rules.

(iii) (3 V.S.A. § 129a(b) (performance of unacceptable patient care on one or more occasions). For the reasons set forth in this Order, the Board does find a single incident of unacceptable patient care. While this one instance of unacceptable patient care does not necessarily give rise to a finding of unprofessional conduct, it does suggest the need for one year of supervised practice, and the Board will therefore exercise its remedial authority. 3 V.S.A. § 129(a)(3) (Board of Nursing has authority to "revoke, limit, condition or prevent renewal of licenses, after disciplinary hearings. . .").

20. In light of our conclusion of law relative to 3 V.S.A. §129a(b) and absent some showing by the Respondent to refute the inference raised by the prosecution, the Board believes patient safety requires a one year conditioned license.

21. The Board finds that conditioning Respondent's license for a period of one year is necessary to insure a reasonable level of safe practice. Even though the Board does not brand this one-time event as unprofessional conduct, we will not shirk from our responsibility to put in place reasonable precautions given the inference of potential patient safety issues raised in this disciplinary hearing.

Conclusion:

The Board highlights that this case does *not* stand for the proposition that "if a professional makes a mistake, s/he has engaged in unprofessional conduct." This case also does not stand for the proposition that if a professional makes a mistake, that professional's license will or should be disciplined.

The Board places conditions on the Respondent's license because it only received evidence from the State in support of the prosecution's allegations. In essence, we heard

one side of the story. The Respondent did not appear for the hearing or notify the Board that she would be unable to attend. Based on the skeletal record before the Board, we are conditioning the Respondent's license out of an abundance of caution. Our Order is made in light of the fact that not a single piece of evidence was received by the Board on Respondent's behalf that could shine any mitigating light on the incident.

ORDER

Based on the findings of facts set forth above, the Board of Nursing therefore does not find that the Respondent engaged in unprofessional conduct and the Board CONDITIONS the Respondent's license for failure to conform to the essential standards of acceptable and prevailing practice on a single occasion as charged in paragraph 6(iv) of the Charges.

The Board ORDERS the Respondent's license to be conditioned for a period of one year, which shall include practice under on-site supervision; and

The Board further ORDERS that the CONDITIONS be as follows:

(A) Length of Time Conditions Imposed.

The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall complete one (1) year of supervised nursing practice in which Respondent 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.

(B) Medication course.

Respondent must complete (i.e. receive a passing grade, if applicable) a course on medication with an emphasis in IV administration of medications. The course, preferably, will involve CADD pump instruction if available. The course shall be taken with prior approval by the Board or its designee and the Respondent shall submit documentation showing satisfactory completion (certificate of completion, or attendance etc.). The course must be completed within six months of the date of entry of this Order.

(C) Notification to Employers.

Respondent shall provide a copy of this Order all current and future employers during the course of the conditioned license and within days of entry of this Order for her current employer(s). Respondent shall cause her immediate supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of this Order and the ability to comply with the conditions in this Order.

(D) Reports from Employers.

Within one (1) month of the date of entry of this Order and monthly thereafter, Respondent shall cause every employer Respondent has worked for during the relevant period to submit to the Board an evaluation of Respondent's performance and number of days worked during that period. This report shall be submitted in writing on forms issued by the Board.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of this Order and ability of the program to comply with the conditions in this Order during clinical experience.

(E) Practice Under Supervision.

Respondent shall practice only in a setting where Respondent has on-site supervision for the entire shift by a registered nurse who is licensed and in good standing.

(F) Types of Employment Prohibited.

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

(G) License Renewal.

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

(H) Costs.

Respondent shall bear all costs of complying with this Order.

(I) Completion of Conditional License Period.

Upon completion of the conditional license period, Respondent may petition the Board to remove the license conditions. If the Respondent demonstrates to the Board's satisfaction that she has complied with all conditions, the conditions shall be removed.

- END -

Vermont Board of Nursing:

By: Susan O. Farrell Date: Nov. 13, 2006
Susan O. Farrell, RN
Board Chairperson

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 11/16/06

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

IN RE:	)	
SUSAN P. EGAN	)	**DOCKET No. NU77-0605**
License No. 026-0023836	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Susan P. Egan, R.N.:

Board Authority

1. The Vermont State Board of Nursing ("the Board") has authority to issue warnings or reprimands, suspend, revoke, limit, 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 ("ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Susan P. Egan (the "Respondent") of Springfield, Vermont is a licensed registered nurse holding license number 026-0023836, issued by the State of Vermont. This license was originally issued on or about March 5, 1998 and is currently set to expire on March 31, 2007.

3. At all relevant times, Respondent was employed as a registered nurse at the Southern Vermont Correctional Center located in Springfield, Vermont.

4. On or about May 14, 2005, Respondent made a medication error involving inmate K.P. The inmate had an order for morphine sulfate via CADD of 50mg per hour. Respondent programmed the CADD to administer over 2000mg of morphine sulfate over approximately a two and a half to three hour time period.

5. Respondent self-reported the error to nurse manager L.A. and admitted she had programmed the CADD incorrectly.

6. Respondent's license was conditioned by this Board on or about January 13, 2003 due to inappropriate behavior towards patients.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

Charges

7. The acts, omissions and/or circumstances described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

(i) 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes, but is not limited to, performing unsafe or unacceptable patient care and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Rule IV(II)(B)(1) and (2); and

(ii) 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); and

(iii) 3 V.S.A. § 129a(b) (failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice).

Relief Requested

WHEREFORE, the license of Susan P. Egan should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

DATED at Montpelier, Vermont this 7th day of December, 2005.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

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STATE OF VERMONT

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