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

IN RE: Stephen A. Farley	)	**Docket No.:NU02-0602**
License No.: 026-0023506	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, through State Prosecuting Attorney, Edward G. Adrian, and the Respondent, Stephen A. Farley, who stipulate and agree as follows:

Board Authority

1. The Vermont Board of Nursing (the "Board") has the jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129 and 129a; 26 V.S.A. Chapter 28 and; the rules of the Board and the Vermont Office of Professional Regulation.

Statement of Facts

2. Stephen A. Farley ("Respondent") of Nevada City, California is a registered nurse holding license number 026-0023506 issued by the State of Vermont. Respondent's license was originally issued on July 28, 1997 and is currently set to expire on March 31, 2005.

3. At all times relevant to these charges, the Respondent was practicing as a registered nurse at Fletcher Allen Health Care in Burlington, Vermont.

I. Nurse Doreen Greene Between February 21, 2002 Through February 26, 2002

4. On or about February 21 through February 28, 2002 Doreen Greene RN was the preceptor for the Respondent and observed the following:

   a. On or about February 21, 2002, Respondent did not wear gloves in the Emergency Department at Fletcher Allen Health Care when he was removing an IV catheter from a patient and as a result, Respondent got a patient's blood on his hand.

   b. On or about February 26, 2002, Respondent was assigned an elderly male R.L., with pneumonia in which Respondent was instructed to obtain vital signs. Nurse Greene later reviewed the chart of the patient and observed that no vital signs had been documented in the chart.

II. Nurse Phyllis George Between February 18, 2002 Through March 1, 2002

5. On or about February 18 through March 1, 2002, Phyllis George was preceptor for the Respondent and observed the following:

   a. On or about March 1, 2002, Respondent administered medications to a patient, but failed to document the medication on the patient's chart.

III. Nurse Alice Marsh Between May 23, 2002 Through June 7, 2002

6. On or about May 23, 2002 through June 7, 2002, Nurse Alice Marsh oriented the Respondent to the neuro surgery unit and observed the following:

   a. On or about May 23, 2002 through June 7, 2002, the Respondent left patients' beds in the "high position" unattended when those patients would be in the beds for continual days. Respondent was repeatedly reminded to lower the beds.

   b. On or about May 23, 2002 through June 7, 2002, the Respondent documented administering a patient medication in that patient's chart and failed to administer the medication to the patient. On or about May 23, 2002 through June 7, 2002, the Respondent documented on a patient's chart that he administered a medication and then failed to administer the medication advising Nurse Marsh that the medication was not available. Nurse Marsh found the medication in the tube system and administered the medication to the patient.

IV. Nurse Roy Bixby Between June 7, 2002 Through June 14, 2002

7. On or about June 7, 2002 through June 14, 2002, Nurse Roy Bixby was preceptor for the Respondent and observed the following:

   a. On or about June 7, 2002 through June 14, 2002, the Respondent had difficulty administering Ativan IV push because the Respondent did not dilute the Ativan.

   b. On or about June 7, 2002 through June 14, 2002, the Respondent diluted Morphine for the IV when it was not necessary.

8. By way of information, Respondent's license for practicing nursing in the State of California was revoked on December 23, 1981. The Respondent's California license was reinstated and is currently unencumbered.

9. Respondent disputes that the above incidents have occurred as alleged; however, Respondent does not contest that the State would be able to present evidence to prove those facts at a hearing.

Charges

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

    a. Committed unprofessional conduct by in the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a client, patient or customer has occurred in violation of 3V.S.A. §129a(a)(10);

    b. Committed unprofessional conduct by failing to conform to the essential standards of acceptable and prevailing practice in violation of 3 V.S.A. §129a(b)(2) and Administrative Rules, Chapter 4, Rule IV(II)(B)(2);

    c. Committed unprofessional conduct by the performance of unsafe or unacceptable patient or client care in violation of 3 V.S.A. §129a(b)(1) and Administrative Rules of Nursing Chapter 4, RuleIV(II)(B)(1);

    d. Committed unprofessional conduct by being unable to practice nursing competently by any reason of any cause in violation of 26V.S.A. §1582(a)(3).

Understandings

11. 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.

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

13. Respondent waives any notification period and requests that this be heard at the next available Board meeting. Respondent specifically waives any claims that any disclosures made by him to the full Board during its review of this agreement have prejudiced his rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.

14. Respondent is not under the influence of any drugs or alcohol at the time he signs this Stipulation and Consent Order.

15. Respondent voluntarily enters this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.

16. Respondent voluntarily waives his right to a contested hearing before the Board of Nursing.

17. Respondent agrees that the Board may set forth the Order below.

ORDER

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

A. The Respondent's alleged conduct described in the paragraphs above, taken alone, together or in any combination, constitutes unprofessional conduct in that the Respondent has:

a. Committed unprofessional conduct by in the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a client, patient or customer has occurred in violation of 3V.S.A. §129a(a)(10);

b. Committed unprofessional conduct by failing to conform to the essential standards of acceptable and prevailing practice in violation of 3 V.S.A. §129a(b)(2) and Administrative Rules, Chapter 4, Rule IV(II)(B)(2);

c. Committed unprofessional conduct by the performance of unsafe or unacceptable patient or client care in violation of 3 V.S.A. §129a(b)(1) and Administrative Rules of Nursing Chapter 4, RuleIV(II)(B)(1);

d. Committed unprofessional conduct by being unable to practice nursing competently by any reason of any cause in violation of 26V.S.A. §1582(a)(3).

B. The Board of Nursing hereby **CONDITIONS** Respondent's license for **A MINIMUM OF TWO (2) YEARS** commencing two (2) weeks from the date of entry of this Order. The **CONDITIONS** are as follows:

(1) 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 **two (2) years** 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.

(2) Universal Precautions Course and Medication Administration Course.

Respondent must complete (i.e.: receive a passing grade, if applicable) a course on (1) universal precautions and a course on (2) medication administration with emphasis on IV medications, with prior approval by the Board

or its designee, and then submit written documentation (certificate of completion, etc.) to verify same to the satisfaction of the Board or its designee. These courses must be completed within six months of the date of entry of this Stipulation and Consent Order. The Respondent has engaged in a course of continuing education subsequent to the events alleged above and may petition the Board to credit this course work in order to satisfy the requirements of this condition.

(3) Notification to Employers/Nursing School.

Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting during the conditioned period in which Respondent practices as a nurse and inform them of Respondent's conditional license status.

Within ten (10) days of the date of entry of this Consent Order or of any subsequent nursing employment, Respondent shall cause Respondent's 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.

In the event Respondent is attending a nursing program which has a clinical portion which involves actual patient care, he shall provide a copy of the Stipulation and Consent Order to the Program Director. Respondent shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Stipulation and Consent Order and ability of the program to comply with its conditions during clinical experience.

(4) Reports from Employers/Nursing School.

Within one (1) month of the date of entry of this Consent Order or within one (1) month of the commencement of nursing employment and **monthly** thereafter, Respondent shall cause every nursing employer Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work 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, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of her performance and attendance. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the school's letterhead.

(5) Practice Under Supervision.

Respondent shall practice only in a setting where Respondent has direct supervision for the entire shift by a registered nurse that is licensed and in good standing.

(6) Types of Employment Prohibited.

Respondent shall not work as a supervising nurse, with the exception of supervising LNAs and other unlicensed assistive persons. This condition shall not prohibit the Respondent from answering questions by or correcting the actions of an LPN or LVN. 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 Consent Order.

(7) 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.

(8) 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 his current place of employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in employment, personal address, or telephone number.

(9) Notification to Other States.

In the event that the Respondent is licensed as a nurse in any other state(s), he must inform the nurse licensing board of the state(s) in which the Respondent is licensed of the conditional status of his Vermont nursing license within thirty (30) days of the date of entry of this Order. If the Respondent fails to provide such notification, it will be considered a violation of this Order.

(10) License Renewal.

If the Respondent's license expires while this Order is still in effect, this Order does not automatically extend the license. In that situation, in order to continue to practice nursing, the Respondent must timely apply for renewal, pay the applicable fee and demonstrate that he has otherwise complied with the requirements for license renewal.

(11) Completion of Conditional License Period.

Upon completion of the conditional license period, the Respondent may petition the Board to remove any and all conditions on his license. The Respondent must present proof that he has full complied with the terms of this Order.

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 the Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

Dated: 2/14/05

STATE OF VERMONT
SECRETARY OF STATE

by: _____
Edward G. Adrian
State Prosecuting Attorney

STEPHEN A. FARLEY
RESPONDENT

Dated: 1/20/05

by: _____
Stephen A. Farley

APPROVED AS TO FORM:

Dated: 2/7/05

ATTORNEY FOR RESPONDENT

by: _____
Michael J. Harris, Esq.

APPROVED AND SO ORDERED:

Dated: 2-14-05

VERMONT BOARD OF NURSING

by: _____
Chairperson

Dated entered: 2/22/05

nu.farley2.stip

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

IN RE: Stephen A. Farley) Docket No.:NU02-0602
License No.: 026-0023506)

SPECIFICATION OF CHARGES

Board Authority

1. The Vermont Board of Nursing (the "Board") has the jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129 and 129a; 26 V.S.A. Chapter 28 and; the rules of the Board and the Vermont Office of Professional Regulation.

2. In the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a client, patient or customer has occurred is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. 3 V.S.A. §129a(a)(10).

3. Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records or willfully failing to file the proper reports or records is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. 3 V.S.A. §129a(a)(7).

4. Falsifying or altering clinical records or making inaccurate or misleading entries is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. Administrative Rules of Nursing Chapter 4, Rule IV(II)(D)(3).

5. Failure to conform to the essential standards of acceptable and prevailing practice is unprofessional conduct and is a basis upon which the Board can impose disciplinary action. 3 V.S.A. §129a(b)(2); Administrative Rules of Nursing, Chapter 4, Rule IV(II)(B)(2).

6. Performance of unsafe or unacceptable patient or client care is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. 3 V.S.A. §129a(b)(1); Administrative Rules of Nursing Chapter 4, Rule IV(II)(B)(1).

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Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

7. Being unable to practice nursing competently by reason of any cause is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. 26 V.S.A. §1582(a)(3).

Statement of Facts

8. Stephen A. Farley ("Respondent") of South Burlington, Vermont is a registered nurse holding license number 026-0023506 issued by the State of Vermont. Respondent's license was originally issued on July 28, 1997 and is currently set to expire on March 31, 2005.

9. At all times relevant to these charges, the Respondent was practicing as a registered nurse at Fletcher Allen Health Care in Burlington, Vermont.

I. Nurse Doreen Greene Between February 21, 2002 Through February 26, 2002

10. On or about February 21 through February 28, 2002 Doreen Greene RN was the preceptor for the Respondent and observed the following:

    a. On or about February 21, 2002, Respondent did not wear gloves in the Emergency Department at Fletcher Allen Health Care when he was removing an IV catheter from a patient and as a result, Respondent got a patient's blood on his hand.

    b. On or about February 26, 2002, a patient M.V. was brought to the Emergency Department with respiratory distress and Respondent repeatedly attempted to engage M.V. in conversation with him. Respondent had to be reminded twice to just allow M.V. to breathe and not speak.

    c. Respondent was not sure how to hang a Nitro IV bag even after the Respondent was shown the procedure previously.

    d. On or about February 26, 2002, Respondent received an order by a doctor to "increase the [Nitro] pump to 40 mcq" for patient M.V. Respondent did not know the difference between cc and mcq.

    e. On or about February 26, 2002, Respondent was assigned an elderly male R.L., with pneumonia in which Respondent was instructed to obtain vital signs. Nurse Greene later reviewed the chart of the patient and observed that no vital signs had been documented in the chart.

    f. On or about February 26, 2002, Nurse Greene questioned the Respondent about R.L.'s vital signs and documenting them in his chart and Respondent replied that he did not know where to document the vital signs on the chart.

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Office of
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Montpelier, VT 05602

II. Nurse Phyllis George Between February 18, 2002 Through March 1, 2002

11. On or about February 18 through March 1, 2002, Phyllis George was preceptor for the Respondent and observed the following:

    a. On or about March 1, 2002, Respondent administered medications to a patient, but failed to document the medication on the patient's chart.

    b. On or about February 18, 2002- March 1, 2002, the Respondent performed a pain assessment on the patient in which the patient indicated "a lot of pain from the foley catheter"; Respondent advised the patient that the catheter could be removed.

    c. Nurse George advised the Respondent they should discuss removing the catheter first with the doctor and Respondent replied within hearing distance of the patient that he could have it removed if he wants, he is a "DNR."

III. Nurse Alice Marsh Between May 23, 2002 Through June 7, 2002

12. On or about May 23, 2002 through June 7, 2002, Nurse Alice Marsh oriented the Respondent to the neuro surgery unit and observed the following:

    a. On or about May 23, 2002 through June 7, 2002, the Respondent left patients' beds in the "high position" unattended when those patients would be in the beds for continual days. Respondent was repeatedly reminded to lower the beds.

    b. On or about May 23, 2002 through June 7, 2002, the Respondent documented administering a patient medication in that patient's chart and failed to administer the medication to the patient.

    c. On or about May 23, 2002 through June 7, 2002, the Respondent documented on a patient's chart that he administered a medication and then failed to administer the medication advising Nurse Marsh that the medication was not available.

    d. Nurse Marsh found the medication in the tube system and administered the medication to the patient.

    e. On or about May 23, 2002 through June 7, 2002, Respondent failed to waste a portion of unused morphine and placed the unused portion of the morphine in the locked medication cart for later use.

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Office of
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Montpelier, VT 05602

IV. Nurse Roy Bixby Between June 7, 2002 Through June 14, 2002

13. On or about June 7, 2002 through June 14, 2002, Nurse Roy Bixby was preceptor for the Respondent and observed the following:

    a. On or about June 7, 2002 through June 14, 2002, the Respondent had difficulty administering Ativan IV push because the Respondent did not dilute the Ativan.

    b. On or about June 7, 2002 through June 14, 2002, the Respondent diluted Morphine for the IV when it was not necessary.

    c. On or about June 7, 2002 through June 14, 2002, the Respondent left a flow sheet completely blank for a patient and did not document the admission of the patient.

V. Nurse Educator Joan Jones Between June 14, 2002 through June 17, 2002

14. On or about June 14, 2002 through June 17, 2002, Joan Webber-Jones, a nurse educator, observed the Respondent and reported the following:

    a. On or about June 17, 2002, Jones reported the Respondent failed to perform two finger sticks which was clearly addressed by the cardex for the two patients.

    b. On or about June 14, 2002 through June 17, 2002, Respondent poured a medication metaprolol into an unmarked cup and left the medication in the medication cart with another patient's medication.

15. By way of information, Respondent's license for practicing nursing in the State of California was revoked on December 23, 1981. In addition, the State of California has taken several subsequent actions against the Respondent's license.

Charges

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

    a. Committed unprofessional conduct by in the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a client, patient or customer has occurred in violation of 3V.S.A. §129a(a)(10);

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b. Committed unprofessional conduct by failing to conform to the essential standards of acceptable and prevailing practice in violation of 3 V.S.A. §129a(b)(2) and Administrative Rules, Chapter 4, Rule IV(II)(B)(2);

c. Committed unprofessional conduct by the performance of unsafe or unacceptable patient or client care in violation of 3 V.S.A. §129a(b)(1) and Administrative Rules of Nursing Chapter 4, RuleIV(II)(B)(1);

d. Committed unprofessional conduct by being unable to practice nursing competently by any reason of any cause in violation of 26V.S.A. §1582(a)(3).

Relief Requested

WHEREFORE, the nursing license of Stephen A. Farley should be revoked, suspended or otherwise disciplined.

Dated at Montpelier, Vermont this 30th day of December 2003.

State of Vermont
Secretary of State

By: _____
Edward Adrian
State Prosecuting Attorney

rn.farley.soc

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
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