STATE OF VERMONT
WASHINGTON COUNTY, SS.

FILED
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WASHINGTON SUPERIOR COURT

Rheanne M. Fisk	)	
	)	Washington Superior Court
v.	)	Docket No. 351-98 Wncv
	)	
Board of Nursing	)	

MEMORANDUM OF DECISION

This matter is before the court on the plaintiff's appeal of a decision of an appellate officer for the Secretary of State's Office of Professional Regulation. Plaintiff is represented by Christopher A. Micciche, Esq.; the defendant is represented by William H. Ahlers, Special Assistant Attorney General.

Background

Plaintiff was reprimanded by the Board of Nursing, and her license was made conditional on a number of terms and restrictions. One of these terms was completion of "one year of supervised nursing practice in which she works at least forty hours every two weeks in nursing." In re Fiske, No. NU08-0795, slip op. at 6 (Vt. Bd. of Nursing, June 27, 1997).

Plaintiff appealed the Board's decision to an appellate officer of the Office of Professional Regulation in order to seek credit for 500 hours of supervised clinical practice she had allegedly already completed. Plaintiff claimed that the Board had failed to address or make specific findings on her oral offer of proposed findings regarding the 500 hours. The appellate officer determined, without deciding whether the rules of the Board of Nursing allow parties to submit proposed findings of fact, that "it is clear on this record that the appellant waived her right to do so during the hearing." In re Fiske, No. AO-NU01-0797, slip op. at 4 (Vt. Sec'y of State,

Dec. 8, 1997). The appellate officer affirmed the Board's decision. See id.

Analysis/Conclusions of Law

Appeals of decisions of the appellate officer are subject to review on the record. See 3 V.S.A. § 130a. The standard of review on appeal affords deference to the appellate officer's decision. "Where the findings of an administrative agency 'fairly and reasonably' support the agency's conclusions of law" the court must uphold the agency's decision. In re New England Tel. and Tel. Co., 159 Vt. 459 (1993) (quoting Caledonian Record Publ'g Co. v. Department of Employment & Training, 151 Vt. 256, 260 (1989)). It is presumed "that decisions made within an administrative agency's area of expertise are correct, valid, and reasonable, absent a clear showing to the contrary." Close v. Superior Excavating Co., 166 Vt. 318, 321 (1997).

The plaintiff bases her appeal on the statute describing the procedure to be followed in board hearings. The statute states that: "If, in accordance with agency rules, a party submitted proposed findings of fact, the decision shall include a ruling upon each proposed finding." 3 V.S.A. § 812. The defense makes two arguments in response: 1) that agency rules do not provide for submission of proposed findings of fact; and 2) that regardless of agency rules, plaintiff was offered an opportunity to [redacted] submit proposed findings of fact and waived it at the hearing.

Careful review of the written procedures for disciplinary proceedings reveals no mention whatsoever of the submission of proposed findings of fact by the parties. See Secretary of State, Office of Professional Regulation Bulletin 2.0, *Procedures for Disciplinary Hearings* (last updated Nov. 25, 1997) <http://vtprofessionals.org/opr/oprbulls/bull2.htm>. The only mention of findings of fact states that: "Decisions . . . must be in writing and must include findings of fact and conclusions of law in sufficient detail to show how the decision was reached." See id. §

IV(K). Thus, given that there is no "agency rule" providing for submission of proposed findings of fact, the conditional nature of the statute in question was not triggered.

Furthermore, the appellate officer, based upon a review of the tape record, noted that when offered an opportunity at the hearing to provide proposed findings of fact the plaintiff declined to do so. Thus, regardless of agency rules concerning party submission of proposed findings of fact, or the lack thereof, the plaintiff was provided an opportunity to submit such proposed findings and did not. Plaintiff argues that the board failed to specifically address her proposed findings of fact, yet the appellate officer found that no such proposed findings were ever submitted. Plaintiff's argument is without merit.

This court further notes that had the board been willing to credit plaintiff with time toward the specified supervision hours it would have done so. The board's decision is silent on this point, and thus it is clear that they did not.

ORDER

Based on the foregoing reasons, the decision of the appellate officer is AFFIRMED.

Dated at Montpelier, Vermont this 24th day of November 1998.

Hon. David A. Jenkins
Presiding Judge

STATE OF VERMONT
BOARD OF NURSING

In re:	)	
Rheanne Myranda Fiske	)	Docket No. NU08-0795
License No. 25-6832	)	

PRESENT: Ingrid Brodin, RN, Hearing Panel Chair
Catherine McGee, Public Member
Marjorie Allard, RN
Kim Keaton, RN
Michelle Walker, RN, Ad Hoc
Raymond Phillips, Public Member

APPEARANCES: Diane Zamos, Assistant Attorney General
for Petitioner

Christopher A. Micciche, Esq.
for Respondent

Rheanne Myranda Fiske, Respondent

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

INTRODUCTION

This cause came before the Board of Nursing on a Specification of Charges filed by Attorney General's Office and dated November 14, 1996. The Board held hearings on the merits on March 10 and May 12, 1997. Based on the evidence that was presented at those hearings, the Board has determined the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. Respondent, Rheanne Myranda Fiske, is a licensed practical nurse holding license number 25-6832 issued by the State of Vermont.

2. Respondent was employed by McKerley Health Care Centers, Inc., (McKerley) in Morrisville, Vermont, for approximately two and one-half years. Her employment ended in July, 1995.

3. In June, 1995, K.D., N.B., E.B., R.W., R.C., I.B., H.H., E.M. and B.T. were residents at McKerley.

Counts I and II

4. In June, 1995, Respondent administered PRN medications numerous times to these eight residents. Respondent noted on the residents' Medical Administration Records (MAR) that she administered the medication. Respondent failed to always enter a corresponding notation on the MARs to record the time, reason and effect (TRE) of the administration.

5. During June, 1995, Respondent administered acetaminophen PRN to resident K.D. 15 times. She documented the corresponding TRE only 2 times.

6. During June, 1995, Respondent administered acetaminophen PRN to resident N.B. 18 times. She documented the corresponding TRE only 3 times.

7. During June, 1995, Respondent administered acetaminophen PRN to resident E.B. 18 times. She documented the corresponding TRE only 3 times.

8. During June, 1995, Respondent administered acetaminophen PRN to resident R.W. 15 times. She documented the corresponding TRE only 4 times.

9. During June, 1995, Respondent administered acetaminophen PRN to resident R.C. 12 times. She documented the corresponding TRE only 3 times.

10. During June, 1995, Respondent administered acetaminophen PRN to resident I.B. 13 times. She documented the corresponding TRE only 2 times.

11. During June, 1995, Respondent administered acetaminophen PRN to resident H.H. 15 times. She documented the corresponding TRE only 3 times.

12. During June, 1995, Respondent administered acetaminophen PRN to resident E.M. 9 times. She documented the corresponding TRE only 2 times.

13. The standard of acceptable and prevailing nursing practice at all times relevant to the specification of charges is that a nurse must record TRE on the Medication Administration Record of the patient each time a PRN medication is administered to that patient. This procedure is essential to provide continuity of care by the succeeding nurses. Competent nursing practice requires conformance to this standard.

14. As set forth in Paragraphs 5 through 12, Respondent repeatedly violated this standard of acceptable and prevailing nursing practice. Furthermore, failure to make required entries or failure to make accurate entries in clinical records is conduct that could have resulted in harm to patients and the public.

15. Respondent knew at the time that the recording of TRE along with the administration of PRN medication was acceptable and prevailing nursing practice, and her subsequent nursing education re-affirmed this knowledge.

Counts III and IV

16. On June 27, 1995, Resident E.B. complained of chest pains to Deanna Finn, a nursing aide, during the 3:00 - 11:00 PM shift. During the same shift, Ms. Finn reported E.B.'s complaints to Respondent, who was the nurse for that shift. Ms. Finn did not see Respondent attend to E.B.

17. Luke Mestas, L.P.N., was the nurse for the 11:00 PM - 7:00 AM shift, the shift following Respondent's shift. During his shift on June 27, 1997, he was informed by the nursing aides that E.B. had complained of chest pain and that an aide had reported this to Respondent. Mr. Mestas reviewed E.B.'s Progress Notes and found no record of any observations or action taken concerning E.B.'s complaints. He checked E.B., who indicated that she still had the pain. He administered nitroglycerin to E.B., checked her condition until she no longer complained of pain, continued to monitor the situation and documented his assessments and actions in E.B.'s Progress Notes.

18. It was Respondent's duty to check on E.B.'s complaints. Furthermore, it was Respondent's duty to assess E.B.'s condition and take appropriate action to treat E.B. Any action taken should have been documented in E.B.'s Progress Notes. If Respondent determined that no treatment was warranted, then that assessment should have been documented in E.B.'s Progress Notes. This procedure is essential to provide continuity of care by the succeeding nurses. Competent nursing practice requires conformance to this standard.

19. Respondent failed to appropriately assess, treat and monitor E.B. subsequent to E.B.'s complaints of chest pain. Furthermore, Respondent failed to record anything in E.B.'s Progress Notes concerning E.B.'s complaints or Respondent's observations or actions as a result of those complaints. This was unacceptable patient care and was a failure to take action to safeguard a patient.

Counts V and VI

20. On June 27, 1995, Resident B.N. complained of abdominal pains to Debra Charland, a nursing aide, during the 3:00 - 11:00 PM shift. During the same shift, Ms. Charland reported B.N.'s complaints to Respondent, who was the nurse for that shift. Ms. Finn did not see Respondent attend to B.N.

21. Luke Mestas, L.P.N., was the nurse for the 11:00 PM - 7:00 AM shift, the shift following Respondent's shift. During his shift on June 27, 1997, he was informed by the nursing aides that B.N. had complained of chest pain and that an aide had reported this to Respondent. Mr. Mestas reviewed B.N.'s Progress Notes and found no record of any observations or action taken concerning B.N.'s complaints. He checked B.N. who was still complaining of abdominal pains. He treated B.N. until the pain was relieved, continued to monitor the situation and documented his assessment and actions in B.N.'s Progress Notes.

22. It was Respondent's duty to check on B.N.'s complaints. Furthermore, it was Respondent's duty to assess B.N.'s condition and take appropriate action to treat B.N. Any action taken should have been documented in B.N.'s Progress Notes. If Respondent determined that no treatment was warranted, then that assessment should have been documented in B.N.'s Progress Notes. This procedure is essential to provide continuity of care by the succeeding nurses. Competent nursing practice requires conformance to this standard.

23. Respondent failed to appropriately assess, treat and monitor B.N. subsequent to B.N.'s complaints of abdominal pain. Furthermore, Respondent failed to record anything in B.N.'s Progress Notes concerning B.N.'s complaints or Respondent's observations or actions as a result of those complaints. This was unacceptable patient care and was a failure to take action to safeguard a patient.

Count VII

24. On June 18, 1995, at approximately 10:40 PM, Luke Mestas, L.P.N., was beginning his shift as nurse at McKerley. Respondent, as the 3:00 - 11:00 PM shift nurse, was ending her shift. Together, they performed a change of shift narcotic count. They discovered that one Wygesic tablet was missing from the packet of Resident K.D.

25. Unable to account for the missing Wygesic tablet, Respondent took one Wygesic tablet from the packet of Resident B.T. and placed it in the packet of K.D. On B.T.'s Controlled Drug Record, Respondent entered the notation that one Wygesic tablet from B.T.'s packet was "wasted." Both Respondent and Mr. Mestas initialed this notation.

26. On June 28, 1995, Mr. Mestas reported this incident to his supervisor, Anne Johnson. Subsequently, Ms. Johnson discussed the incident with Respondent, and Respondent admitted to Ms. Johnson that she, Respondent, had written the entry and that she had made a mistake.

27. The notation that Respondent had written on B.T.'s Controlled Drug Record was false. The Wygesic tablet had not been wasted, if anything, it had been borrowed. Respondent admitted this. True and accurate records are essential for continuity of care and the proper operation of a health care facility. Creating false records undermines these goals and the public's confidence in health care.

CONCLUSIONS OF LAW

A. Respondent, by failing to record on several residents' Medical Administration Records the time, reason and effect of her administration of medication to those residents, has demonstrated an inability to practice nursing competently by failing to conform to the essential standards of acceptable and prevailing nursing practice, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(3) and Nursing Board Rule IV.B.2.

B. Respondent, by failing to record on several residents' Medical Administration Records the time, reason and effect of her administration of medication to those residents, has engaged in conduct of a character likely to harm the public, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(7) and Nursing Board Rule IV.B.4.

C. Respondent, by failing to appropriately assess, treat and monitor resident E.B. after being informed of E.B.'s complaints of chest pains, and by failing to record in E.B.'s Progress Notes Respondent's actions or reasons for no action as a result of those complaints, has demonstrated an inability to practice nursing competently by failing to conform to the essential standards of acceptable and prevailing nursing practice and by performing unacceptable patient care, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(3) and Nursing Board Rules IV.B.2.b and IV.B.2.a.

D. Respondent, by failing to appropriately assess, treat and monitor resident E.B. after being informed of E.B.'s complaints of chest pains, and by failing to record in E.B.'s Progress Notes Respondent's actions or reasons for no action as a result of those complaints, has engaged in conduct of a character likely to harm the public by failing to take appropriate action to safeguard a patient, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(7) and Nursing Board Rules IV.B.4.c.

E. Respondent, by failing to appropriately assess, treat and monitor resident B.N. after being informed of B.N.'s complaints of abdominal pains, and by failing to record in B.N.'s Progress Notes Respondent's actions or reasons for no action as a result of those complaints, has demonstrated an inability to practice nursing competently by failing to conform to the essential standards of acceptable and prevailing nursing practice and by performing unacceptable patient care, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(3) and Nursing Board Rules IV.B.2.b and IV.B.2.a.

F. Respondent, by failing to appropriately assess, treat and monitor resident B.N. after being informed of B.N.'s complaints of abdominal pains, and by failing to record in B.N.'s Progress Notes Respondent's actions or reasons for no action as a result of those complaints, has engaged in conduct of a character likely to harm the public by failing to take appropriate action to safeguard a patient, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(7) and Nursing Board Rules IV.B.4.c.

G. Respondent, by entering the notation "wasted" on the Controlled Drug Record of B.T. to document what happened to a Wygesic tablet that Respondent took from the drug packet of B.T., has engaged in conduct of a character likely to harm the public by knowingly falsifying a clinical record, which constitutes unprofessional conduct under 26 V.S.A. § 1582(a)(3) and Nursing Board Rule IV.B.4.

H. Count VIII alleges that Respondent's actions and omissions set forth in Counts I through VII individually or collectively constitute unprofessional conduct. Since those actions and omissions have been separately found to constitute unprofessional conduct, the Hearing Panel chooses not to decide whether together they constitute another act of unprofessional conduct.

ORDER

IT IS HEREBY ORDERED by the Board of Nursing that:

1. Count VIII of the Specification of Charges is DISMISSED.

2. On the basis of each of the Conclusions of Law A, B, C, D, E, F or G, and not a combination of any or all of them, Respondent is REPRIMANDED and her nursing license is CONDITIONED for a minimum period of one (1) year commencing with the date of entry of this Order and subject to the following terms and restrictions:

A. The conditions shall remain in place until Respondent has completed one (1) year of supervised nursing practice in which she works at least forty (40) hours every two (2) weeks in nursing. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis.

B. 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 Order.

C. Within five (5) days of the date of entry of this Order, Respondent shall notify the Board, in writing, of her current place of nursing employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in nursing employment, personal address, or telephone number.

D. Respondent shall provide a copy of this Order to all employers in any current or future setting in which she practices as a nurse and inform them of her conditional license status. Within ten (10) days of the date of entry of this Order or of any subsequent employment, Respondent shall cause her immediate supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of the Order and the ability to comply with the conditions in the Order. In the event Respondent is attending a nursing education program, she shall provide a copy of the Order to the Program Director. Petitioner shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Order and ability of the program to comply with the conditions in the Order during clinical experience.

E. Within one (1) month of the date of entry of this Order and every month thereafter, Respondent shall cause every employer she has worked for during the month to submit to the Board an evaluation of Respondent's attendance and performance, including whether she is complying with the employer's policies and procedures related to documentation, medication

administration and narcotic count during that month. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the employer's letterhead. In the event the Respondent attends a nursing education program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of Respondent's attendance and performance, including whether she is complying with the program's policies and procedures related to documentation, medication administration and narcotic count during that month. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the school's letterhead. In the event Respondent is not employed in nursing or attending school during any month or portion thereof, Respondent shall submit to the Board, in writing, a self-report describing other employment or activities. Respondent shall authorize her employer and her school administrator to provide all information requested by the Board, or its designee, either orally or in writing, at any time during the period the Order is in effect.

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

G. If Respondent violates the terms of this Order in any respect, the Board, after giving Respondent notice and an opportunity to be heard, may revoke the terms of the conditional license and take further disciplinary action. If a complaint or charges are filed against Respondent during the term of this Order, the conditional license period shall be extended until the matter is final.

H. Upon completion of the conditional license period, Respondent may petition the Board to remove any and all conditions on her license and after formal review by the Board, Respondent's nursing license may be fully restored by appropriate Board action. Respondent shall demonstrate, to the Board's satisfaction, that she fully complied with all the terms of this Order.

I. Notwithstanding any provision above, Respondent must meet all Nursing Board requirements for license renewal and license reinstatement.

J. Within five (5) days of the date of entry of this Order, Respondent shall submit her LPN and RN licenses to the Board for re-issued licenses labelled "conditioned."

I. Pursuant to 3 V.S.A. § 1331(c)(2)(C), this document is a public record, and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a)(7).

J. This Order takes effect as of the date of entry shown below.

APPEAL RIGHTS

This is a final administrative determination. A party may appeal by filing a written notice of appeal with the Director of the Office of Professional Regulation, Office of the Secretary of State, within 30 days of the effective date of this Order.

BOARD OF NURSING

Ingrid Brodin RN
Ingrid Brodin, RN, Hearing Panel Chair

Dated: 6/27/97

Date of Entry: 6-30-97