STATE OF VERMONT
BOARD OF NURSING

IN RE:	)	
Nancy Langdon	)	Case File No. NU89-0502
License No. 25-3726	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Introduction

The Vermont Board of Nursing ("the Board") held a hearing in this case on Monday, November 22, 2004 and Monday, April 25, 2005, at 81 River Street in Montpelier, Vermont. Board members Ellen Leff, Alan Weiss, Elayne Clift, Laurey Tyo, Sandra Norton, *ad hoc* member Margaret Luce and Donarae Maetcalf participated in the decision. Edward Adrian, Prosecuting Attorney, appeared for the State for the first day of the hearing and Angela Stanski appeared for the State on the second day. Nancy Langdon ("the Respondent") was present and was represented by attorney Judy Barone. Christopher Winters presided for the Board.

At the close of the State's case, the Respondent moved for a summary judgement on the allegations other than the medication errors. After a deliberative session, the Board determined that the State had not met its burden on the issues of the so-called gunshot wound (See State's Specification of Charges, Paragraphs 9-11); wires in jaw (Paragraphs 12-15); and chest pains (Paragraph 18) and decided no further testimony was necessary on those issues, which were dismissed. The board proceeded to take testimony on the mental health intake issue (Paragraphs 16 and 17) and the medication errors (Paragraphs 19-23).

Findings of Fact

1. The Respondent is a licensed practical nurse who holds license number 25-3726 issued by the State of Vermont.

2. Respondent, at all times relevant, was employed as a licensed practical nurse by Correctional Medical Services at the Marble Valley Regional Correctional Facility ("the Facility") located in Rutland, Vermont.

3. On or about March 23, 2002, Respondent filled out an intake form for inmate C.C.. The Respondent was screening inmate C.C., or performing an initial assessment of his general mental and physical health as he came into the Facility. Inmate C.C. had a gunshot

wound. The inmate had been seen at the Brattleboro Hospital Emergency Room for this wound. The inmate reported that it occurred "months" ago. The Respondent observed it to be a "lesion" on the right wrist which was not red, raised, warm, open or bleeding. The inmate advised that he had been put on antibiotics for the wound and that he had recently finished them.

4. The Respondent did not note on the intake form the prescriptions inmate C.C.had been taking (the antibiotics) and had finished the day before the screening. The Respondent did not make a referral to a physician for inmate C.C. for the gunshot wound.

5. Each inmate who comes through the screening process at the Facility is eventually seen by a physician. Typically, within a few days but no longer than two weeks. Inmates with "emergent" medical problems, either mental or physical, are referred to a physician for immediate attention and follow-up.

6. The Respondent was working the second shift and did not believe that an immediate referral to a physician was necessary.

7. Another nurse in the Facility later added to the intake form, noting that inmate C.C. was "grazed" on his right wrist and was seen in the emergency room in Brattleboro, Vermont for the gunshot wound.

8. On or about March 25, 2002, Respondent filled out an intake form for another inmate C.C., noting that he had "wires in jaw." The Respondent left a "sticky note" for nurses on the next shift stating that inmate C.C. had wires in his jaws which may need to be removed. Respondent asked inmate C.C. if the wires in his jaw were braces and he replied "Yeah, braces."

9. The Respondent did not look in inmate C.C.'s mouth to confirm if the wires were braces. The Respondent did not note on the screening form that inmate C.C. had not seen a dentist since May 2001, and did not give inmate C.C. a dentist referral and did not supply inmate C.C. with wire cutters and remove him from the general population.

10. Inmate C.C. had apparently had the wires in his mouth for quite some time (since 2001). These wires did not prevent him from eating or talking.

11. Providing and inmate with wire cutters would have been a security risk.

12. On or about March 25, 2002, Respondent completed an intake form for inmate R.G. which indicated that he was possibly suicidal. The form included notations on several risk factors, including a suicide attempt when the inmate was a child.

13. Respondent did not make a referral of R.G. to the Facility's mental health providers. The Respondent did check "no mental health problems" on the form and did not fill out any of the comments sections on the form.

14. Inmate R.G. came to the Respondent from the general population. It had always been the Respondent's experience that inmates were not allowed into the general population until they had already been seen by mental health providers at the Facility.

15. Respondent believed inmate R.G. was already cleared by mental health. Respondent did not note this information (that R.G. had already been cleared) on the form. The medical files for inmates generally include the mental health provider form in the file.

16. On or about May 3, 2002, inmate D.L. complained of nausea, vomiting and pains in his chest and/or abdominal area. The Respondent gave him antacid and zantac. She then kept the inmate under her observation at the infirmary for approximately 90 minutes and then sent him back.

17. Respondent did not notify the physician of D.L.'s complaints at this time. Later, when D.L. vomited again and complained to a guard of "chest pains," he was referred to a physician.

18. Inmate D.L. had been to see a physician earlier that day and was a frequent visitor to the infirmary. D.L. had previously been diagnosed with an acid reflux disease.

19. On or about May 4, 2002, Respondent was responsible for a double check on the medication administration record for inmate R.L. The medication administration record contained an incorrect meter dosage for the inhaler for inmate R.L. The Respondent did not notice this error on the double check.

20. On or about May 4, 2002, Respondent transcribed two orders for medications for inmate B.B. on the medication administration record. The Respondent did not order the medications for inmate B.B.

21. The Respondent would typically have 1 or 2 records to double-check on her evening shift because they were usually done during the day when there were 2-3 nurses on duty. On this particular evening, there had been an in-service during the day which did not allow the double-checks to be done by the day shift nursing staff. The Respondent had approximately 3 hours worth of transcribing and double-checking to do that evening, which she was not able to complete. The Respondent was the only nurse on duty that night.

22. The Respondent left a note for the next shift indicating she had not completed the double-checks or transcriptions.

23. The Respondent had never received training in transcription and the wrong medications were never given to any inmate as a result.

24. On or about May 4, 2002, the Respondent extended the medication orders for inmates F.B., W.C., and J.C.. The Respondent extended the orders from the end date when the original medication orders expired rather than from the date the physician saw the inmate

and ordered the extension.

25. It is possible the physician did not intend to extend the medication that far into the future and meant the extension to be effective from the date the extension was ordered. However, the Facility's policy on extending expired medications was unclear.

26. Nurse C.S. came into the facility on her day off and went through the records to find the five double-checking and transcription "errors" listed above. Nurse C.S. and the Respondent had a history of personal conflict and animosity toward each other at the Facility.

Conclusions of Law

A. The Board of Nursing may revoke, suspend, discipline or otherwise condition the license of a nurse who engages in unprofessional conduct as defined by 26 V.S.A. §1582.

B. Respondent, by engaging in the conduct described above, has not committed unprofessional conduct as alleged in the State's Specification of Charges. The Respondent has not:

1) committed unprofessional conduct by failing to comply with provisions of federal or state statutes or rules governing the practice of the profession in violation of 3 V.S.A. §129a(a)(3);

2) 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);

3) committed unprofessional conduct by performing unsafe or unacceptable patient or client care in violation of 3 V.S.A. §129a(b)(1);

4) 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);

5) committed unprofessional conduct by filing to conform to the essential standards of acceptable and prevailing nursing practice in violation of Administrative Rules, Chapter 4, Rule IV(II)(B)(2).

C. More specifically, based on the evidence and the facts as found by the Board:

1) The "gunshot wound" was not of an emergent nature that would require an immediate referral to a physician. Although perhaps advisable, it was not unprofessional for the Respondent to not have made notations about the inmates completed antibiotic medications.

2) Regarding the inmate with wires in his jaw, again, it would have been better practice to make all indications on the chart rather than on a sticky note, but doing so was not unprofessional conduct as she did try to draw attention to the inmate's dental situation. It was understandable that the Respondent did not try to look into the inmates mouth, nor would it have been advisable to give the inmate wire cutters.

3) It was again understandable that the Respondent believed the inmate with suicide indications had already been seen by the Facility's mental health professionals because he had come from the general population. Again, it would have been better practice if the Respondent would have been more thorough under her comments sections on the screening form in indicating that belief.

4) The Respondent acted appropriately with regard to the inmate who complained of "chest pains." She was diligent in observing him for some time and referred him to a physician when appropriate, under the circumstances.

5) Regarding the "medication errors," these were errors in adequately performing a double check and are thus not the same as making the errors in the first instance. The double-checks and transcriptions were left in a pile as incomplete for the next shift to do. Further, the exceptional circumstances of that evening mitigate those errors to some extent. As for the improper extension of medications without a physician's order, it was found that there was a physician's order and it was simply unclear as to how the Facility handled extensions of this type.

Opinion

While the Respondent would like the Board to excuse all actions based on the nursing environment in which she was working, the Board does not agree with such an argument. Despite the difficulties of any environment, a nurse has a greater obligation to his or her profession and patients to uphold nursing standards. On occasion, the difficulties of the work environment may make it difficult or even impossible to comply with those standards. If that is the case, the nurse has the responsibility to draw that to the attention of his or her supervisors and management. Standards remain the same, regardless of environment.

In this case, the State's evidence did not support the allegations in its Charges. In particular, the Board found the testimony of nurse Cristine Smith not to be credible. The

Board also found that the Facility's policies were unclear and difficult for any nurse to comply with. While the Respondent's practices could be improved upon, there was nothing that rose to the level of a finding of unprofessional conduct.

Order

A. In light of the above findings and conclusions, the Board hereby DISMISSES the Specification of Charges, effective as of the date of entry of this Order, below.

B. This Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. §129(a).

C. This Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

Appeal Rights

This is a final administrative determination by the Vermont Board of Nursing. You may appeal by sending a notice of appeal in writing to the Director of the Office of Professional Regulation within 30 days of the date of entry of this order. If you wish to request a stay of the Board's decision, please refer to the attached stay instructions.

By: Laurey M. Tyb
Laurey Tybo, R.N.
Acting Board Chair

Date: 5/21/05

OFFICE OF PROFESSIONAL REGULATION

Date of entry: 6/3/05

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

IN RE: Nancy Noth Langdon	)	Docket No.:NU89-0502
License No.: 025-0003726	)	

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, 129a and 814; 26 V.S.A. Chapter 28 and; the rules of the Board and the Vermont Office of Professional Regulation.

2. Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. 3 V.S.A. §129a(a)(3).

3. 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 no 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).

4. 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).

5. Failure to conform to the essential standards of acceptable and prevailing practice is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. 3 V.S.A. §129a(b)(2).

6. Inability to practice nursing competently by failure to conform to the essential standards of acceptable and prevailing nursing practice is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. Administrative Rules of Nursing, Chapter 4, Rule IV(II)(B)(2).

Statement of Facts

7. Nancy Noth Langdon ("Respondent") of Rutland, Vermont is a licensed practical nurse holding license number 025-0003726 issued by the State of Vermont. Respondent's license was issued on or about February 1, 2002 and is set to expire on January 31, 2004.

8. At all times relevant to these charges, the Respondent was practicing as a licensed practical nurse employed by Correctional Medical Services at Marble Valley Regional Correctional Facility (the "Facility") located in Rutland, Vermont.

9. On or about March 23, 2002, Respondent filled out an intake form for inmate C.C. with a gunshot wound. Respondent failed to make a referral for a physician for inmate C.C. for the gunshot wound.

10. Another nurse in the Facility completed the report adding that inmate C.C. was "grazed" on his right wrist and was seen in the emergency room in Brattleboro, Vermont for the gunshot wound.

11. Respondent also failed to note prescriptions inmate C.C.was taking.

12. On or about March 25, 2002, Respondent filled out an intake form for another inmate C.C., noting that he had "wires in jaw."

13. Respondent left a "sticky note" stating inmate C.C. had wires in his jaws and they needed to be removed.

14. Respondent asked inmate C.C. if the wires in his jaw were braces and he replied "yeah." Respondent failed to look in inmate C.C.'s mouth to confirm if the wires were braces.

15. Respondent stated inmate C.C. had not seen a dentist since May 2001, but failed to note this information and failed to give inmate C.C. a dentist referral and failed to supply inmate C.C. with wire cutters and remove him from the general population.

16. On or about March 25, 2002, Respondent completed an intake form for inmate R.G. which indicated that he was possibly suicidal. Respondent failed to make a referral to mental health.

17. Respondent stated inmate R.G. was cleared by mental health. Respondent failed to note this information on the form for inmate R.G.

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Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

18. On or about May 3, 2002, inmate D.L. complained of nausea, vomiting and chest pains. Respondent failed to notify the physician of D.L.'s complaints and gave him antacid and zantac.

19. On or about May 4, 2002, Respondent was responsible for a double check on the medication administration record for inmate R.L. The medication administration record contained an incorrect meter dosage for the inhaler for inmate R.L. Respondent failed to adequately perform the double check.

20. On or about May 4, 2002, Respondent transcribed two orders for medications for inmate B.B. on the medication administration record, but failed to order the medications for inmate B.B.

21. On or about May 4, 2002, Respondent incorrectly extended the medication that had expired for inmate F.B. without a physician's order.

22. On or about May 4, 2002, Respondent incorrectly extended the medication that had expired for inmate W.C. without a physician's order.

23. On or about May 4, 2002 Respondent incorrectly extended the medications that had expired for inmate J.C. without a physician's order.

Charges

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

    a. Committed unprofessional conduct by failing to comply with provisions of federal or state statutes or rules governing the practice of the profession in violation of 3 V.S.A. §129a(a)(3);

    b. 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);

    c. Committed unprofessional conduct by performing unsafe or unacceptable patient or client care in violation of 3 V.S.A. §129a(b)(1);

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Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

d. 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);

e. Committed unprofessional conduct by filing to conform to the essential standards of acceptable and prevailing nursing practice in violation of Administrative Rules, Chapter 4, Rule IV(II)(B)(2).

Relief Requested

WHEREFORE, the nursing license of Nancy Noth Langdon 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.langdon.soc

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602