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

IN RE:	)	
CHRISTINA LANE LESPERANCE	)	**Docket No. NU 51-0204**
License No: 025-0008404	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, through State Prosecuting Attorney, Edward G. Adrian, and the Respondent, Christina Lane Lesperance, L.P.N., who stipulate and agree as follows:

Board Authority

1. The Vermont Board of Nursing ("the Board") has jurisdiction to investigate complaints of unprofessional conduct and discipline nurses pursuant to 3 V.S.A. §§129 and 129a; 26 V.S.A. §1582; the Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.

Facts

2. The Respondent, Christina Lane Lesperance, is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025-0008404.

3. Respondent's license was originally issued on August 21, 2003 and Respondent's license is currently set to expire on January 31, 2006.

4. At all times relevant, the Respondent was employed as an L.P.N. at Fletcher Allen Health Care ("FAHC") located in Burlington, Vermont.

5. On December 10, 2003, the Respondent failed to chart patient C.B.'s complete assessment at the time it was performed. A chart inspection completed at 1815 hours showed the chart was lacking documentation that should have been completed at 1630 hours. A second look at the chart at 1850 hours revealed that the charting had been completed, and the time listed was that it had been documented at 1620 hours. Although the documentation was not completed at the time of the assessment, no notation was made in the chart that it was a late entry.

6. Additionally, when confronted about this by the Interim Manager, even though patient C.B. had a documented lung O2 saturation of 90%, the Respondent advised that she did not include a lung assessment on C.B. during her assessment.

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7. On December 10, 2003, the Respondent incorrectly programmed information into patient C.B.'s pump under an order to release Hydromorphone PCA 0.2mg/ml to infuse at 0.2 mg per hour continuous with 0.2 lockout every ten minutes. The Respondent programmed into the pump incorrect figures of basal rate, PCA dose, lockout, hour limit, shift total and total ml delivered. The amount released by the Respondent due to the incorrect programming was approximately one-fifth of C.B.'s prescribed order.

8. Additionally, the Respondent failed to document any nursing intervention given to treat C.B.'s pain when C.B. was reporting her pain to be at a 7/10 or 8/10 level. The Respondent also did not document any information regarding the location of C.B.'s pain, quality of pain, or a record of consultation with C.B.'s physician for further pain assessment and treatment.

9. On December 10, 2003, the Respondent failed to place her initials on the scheduled medications page of patient C.B.'s MAR after administering the Hydromorphone at 1600, 1700, 1800 and 1900 hours.

10. Additionally, the Respondent failed to complete the required verification documentation at the beginning of her shift per FAHC's "High Alert Medication" protocol for the Hydromorphone. The protocol requires that a check be made of the medication to verify it is appropriately labeled and that the pump is programmed to deliver the medication as per the prescription order.

11. On December 10, 2003, the Respondent failed to initial and document the dosage and time of administration on the scheduled medications page of patient C.B.'s MAR after administering Promethezine HCL 25 mg PR NOW which was scheduled to be given at 1600 hours. The Respondent commented on the page "given see other sheet", however, she did not indicate the sheet being referred to.

12. tbs

13. On December 10, 2003, the Respondent failed to document as administered patient C.B.'s continuous infusion of IV fluids D5 ½ NS. There was no order to discontinue, thus the infusion was to have been administered and documented by the Respondent.

14. On December 14, 2003, the Respondent failed to chart on the MAR having administered IV fluids to a patient.

15. On December 14, 2003, the Respondent requested to the charge nurse that the

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charge nurse administer medications, which had already been prepared by the Respondent, to one of the Respondent's patients for her.

16. On December 14, 2003, before ending her shift, the Respondent gave a "quick" report about a patient to the oncoming night shift staff nurse. The nurse then went into the patient's room and found the patient on the commode, hypoxic. The patient should not have been left alone in this state.

17. On December 14, 2003, the Respondent failed to turn over her patient assignment to the charge nurse before leaving for the night.

This Stipulation is neither an admission of liability by the Respondent, nor a concession by the State of Vermont that its charges are not well founded. The State alleges that the conduct set forth above occurred and constitutes the basis for findings of unprofessional conduct by the Board. The Respondent does not contest that the Board may have enough evidence to prove the factual allegations. The Parties agree that the Board may discipline the Respondent accordingly.

Charges

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

i. 3 V.S.A. § 129a(b) (failing to practice competently by reason of any cause on a single occasion or on multiple occasions); and

ii. 26 V.S.A. §1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes the performance of unsafe or unacceptable patient care pursuant to ARBN, Chapter 4, Rule IV(II)(B)(1), and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN, Chapter 4, Rule IV(II)(B)(2); and

iii. 26 V.S.A. §1582(a)(7) (engaging in conduct of a character likely to deceive, defraud or harm the public), which includes making inaccurate or misleading entries pursuant to ARBN, Chapter 4, Rule IV(II)(D)(3); and

iv. 3 V.S.A. §129a(a)(3) (failing to comply with the provisions of state statutes or rules governing the practice of the profession).

Understandings

19. The parties understand that the terms of this Stipulation and Consent Order are contingent upon review and acceptance by the Board and that if the Board rejects any portion the entire Stipulation and Consent Order shall be null and void.

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

21. This Stipulation and Consent Order is entered into voluntarily by the Respondent after the opportunity to consult with legal counsel. The Respondent has not been coerced by anyone into signing this Stipulation and Consent Order.

22. The Respondent is voluntarily waiving her right to a contested hearing before the Board.

23. The Respondent agrees that the Order set forth below may be entered by the Board.

WHEREFORE, the parties agree that the following constitutes a reasonable resolution given the above violations:

CONSENT ORDER

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

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

i. 3 V.S.A. § 129a(b) (failing to practice competently by reason of any cause on a single occasion or on multiple occasions); and

ii. 26 V.S.A. §1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes the performance of unsafe or unacceptable patient care pursuant to ARBN, Chapter 4, Rule IV(II)(B)(1), and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN, Chapter 4, Rule IV(II)(B)(2); and

iii. 26 V.S.A. §1582(a)(7) (engaging in conduct of a character likely to deceive, defraud or harm the public), which includes making inaccurate or misleading entries pursuant to ARBN, Chapter 4, Rule IV(II)(D)(3); and

iv. 3 V.S.A. §129a(a)(3) (failing to comply with the provisions of state statutes or rules governing the practice of the profession).

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

(1) License to be labeled "Conditioned".
Any license issued to the Respondent by this Board shall be labeled "Conditioned".

(2) 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 a total of **two (2) years** of supervised nursing practice in which she 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. **If the Respondent obtains an RN license before the expiration of the two year period, the conditioned time remaining on her LPN license will be automatically transferred to her RN license.**

(3) Medication Documentation and Critical Thinking Courses.

Respondent must complete (i.e.: receive a passing grade, if applicable) one course in medication documentation and one course in critical thinking, 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 already completed and satisfied this requirement and has submitted the appropriate documentation to the Board's delegate for review.**

(4) 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, she 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.

(5) Reports from Employers/Nursing School.

Within one (1) month of the date of entry of this Stipulation and Consent Order or within one (1) month of the commencement of nursing employment, and monthly thereafter for the period the conditions are in place, Respondent shall cause every nursing employer Respondent has worked for during the month to submit to the Board an evaluation of Respondent's 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

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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.

(6) 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.

(7) Types of Employment Prohibited.

Respondent shall not work as a supervising nurse, with the exception of LNAs and other unlicensed assistive persons. 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.

(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 her 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 Respondent's 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), she must inform the licensing board of the state(s) in which the Respondent is licensed of the conditional status of her Vermont 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) Costs.

The Respondent shall bear all costs of complying with this Consent Order.

(12) Violation of this Order.

If the Respondent violates the terms of this Order in any respect, the Board, after giving the Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against the Respondent during the

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term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

(13) Completion of Conditional License Period.

After the conditional license period, the Respondent may petition the Board to remove any and all conditions on her license. The Respondent must present proof that she has fully complied with the terms of this Order.

C. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.

D. 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).

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

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: 7/25/05

By: _____
Edward G. Adrian
State Prosecuting Attorney

CHRISTINA LANE LESPERANCE
RESPONDENT

Dated: 6-30-05

By: _____
Christina Lane Lesperance

ATTORNEY FOR RESPONDENT

Dated: 6-7-05

By: _____
Tina L. Shoup

STATE OF VERMONT

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Office of
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Montpelier, VT 05602

APPROVED AND SO ORDERED: VERMONT BOARD OF NURSING

Dated: Aug. 8, 2005 By: Susan Farnell
Chairperson

Date of Entry: 8/12/05

nu.lesperance3.stip

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IN RE:	)	
CHRISTINA LANE LESPERANCE	)	**Docket No. NU 51-0204**
License No: 025-0008404	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Christina Lane Lesperance, L.P.N.:

Board Authority

1. The Vermont Board of Nursing ("the Board") has jurisdiction to investigate complaints of unprofessional conduct and discipline nurses pursuant to 3 V.S.A. §§129 and 129a; 26 V.S.A. §1582; the Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.

2. Failing to practice competently by reason of any cause on a single occasion or on multiple occasions is unprofessional conduct upon which the Board can base disciplinary action. 3 V.S.A. § 129a(b).

3. The inability to practice nursing competently by reason of any cause is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. §1582(a)(3).

4. The inability to practice nursing competently includes the performance of unsafe or unacceptable patient care pursuant to ARBN, Chapter 4, Rule IV(II)(B)(1), and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN, Chapter 4, Rule IV(II)(B)(2).

5. Engaging in conduct of a character likely to deceive, defraud or harm the public is unprofessional conduct upon which the Board can impose disciplinary action. 26 V.S.A. §1582(a)(7).

6. Conduct of a character likely to deceive, defraud, or harm the public includes making inaccurate or misleading entries. ARBN, Chapter 4, Rule IV(II)(D)(3).

7. Failing to comply with the provisions of state statutes or rules governing the practice of the profession is unprofessional conduct upon which the Board can base disciplinary action. 3 V.S.A. §129a(a)(3).

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Facts

8. The Respondent, Christina Lane Lesperance, is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025-0008404.

9. Respondent's license was originally issued on August 21, 2003 and Respondent's license is currently set to expire on January 31, 2006.

10. At all times relevant, the Respondent was employed as an L.P.N. at Fletcher Allen Health Care ("FAHC") located in Burlington, Vermont.

11. On December 10, 2003, the Respondent failed to chart patient C.B.'s complete assessment at the time it was performed. A chart inspection completed at 1815 hours showed the chart was lacking documentation that should have been completed at 1630 hours. A second look at the chart at 1850 hours revealed that the charting had been completed, and the time listed was that it had been documented at 1620 hours. Although the documentation was not completed at the time of the assessment, no notation was made in the chart that it was a late entry.

12. Additionally, when confronted about this by the Interim Manager, even though patient C.B. had a documented lung O2 saturation of 90%, the Respondent advised that she did not include a lung assessment on C.B. during her assessment.

13. On December 10, 2003, the Respondent incorrectly programmed information into patient C.B.'s pump under an order to release Hydromorphone PCA 0.2mg/ml to infuse at 0.2 mg per hour continuous with 0.2 lockout every ten minutes. The Respondent programmed into the pump incorrect figures of basal rate, PCA dose, lockout, hour limit, shift total and total ml delivered. The amount released by the Respondent due to the incorrect programming was approximately one-fifth of C.B.'s prescribed order.

14. Additionally, the Respondent failed to document any nursing intervention given to treat C.B.'s pain when C.B. was reporting her pain to be at a 7/10 or 8/10 level. The Respondent also did not document any information regarding the location of C.B.'s pain, quality of pain, or a record of consultation with C.B.'s physician for further pain assessment and treatment.

15. On December 10, 2003, the Respondent failed to place her initials on the scheduled medications page of patient C.B.'s MAR after administering the Hydromorphone at 1600, 1700, 1800 and 1900 hours.

16. Additionally, the Respondent failed to complete the required verification documentation at the beginning of her shift per FAHC's "High Alert Medication" protocol for the Hydromorphone. The protocol requires that a check be made of the medication to verify it is appropriately labeled and that the pump is programmed to deliver the medication as per the prescription order.

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17. On December 10, 2003, the Respondent failed to initial and document the dosage and time of administration on the scheduled medications page of patient C.B.'s MAR after administering Promethezine HCL 25 mg PR NOW which was scheduled to be given at 1600 hours. The Respondent commented on the page "given see other sheet", however, she did not indicate the sheet being referred to.

18. On December 10, 2003, the Respondent failed to initial and document the dosage and time of administration on the scheduled medications page of patient C.B.'s MAR after administering Zofran 4 mg IV NOW which was scheduled to be given at 1400 hours. The Respondent noted on the page "given see other sheet", however, she did not indicate the sheet being referred to.

19. On December 10, 2003, the Respondent failed to document as administered patient C.B.'s continuous infusion of IV fluids D5 ½ NS. There was no order to discontinue, thus the infusion was to have been administered and documented by the Respondent.

20. On December 14, 2003, the Respondent failed to chart on the MAR having administered IV fluids to a patient.

21. On December 14, 2003, the Respondent requested to the charge nurse that the charge nurse administer medications, which had already been prepared by the Respondent, to one of the Respondent's patients for her.

22. On December 14, 2003, before ending her shift, the Respondent gave a "quick" report about a patient to the oncoming night shift staff nurse. The nurse then went into the patient's room and found the patient on the commode, hypoxic. The patient should not have been left alone in this state.

23. On December 14, 2003, the Respondent failed to turn over her patient assignment to the charge nurse before leaving for the night.

Charges

24. The acts, omissions and/or circumstances described above constitute grounds for discipline because Respondent violated:

i. 3 V.S.A. § 129a(b) (failing to practice competently by reason of any cause on a single occasion or on multiple occasions); and

ii. 26 V.S.A. §1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes the performance of unsafe or unacceptable patient care pursuant to ARBN, Chapter 4, Rule IV(II)(B)(1), and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN, Chapter 4, Rule IV(II)(B)(2); and

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iii. 26 V.S.A. §1582(a)(7) (engaging in conduct of a character likely to deceive, defraud or harm the public), which includes making inaccurate or misleading entries pursuant to ARBN, Chapter 4, Rule IV(II)(D)(3); and

iv. 3 V.S.A. §129a(a)(3) (failing to comply with the provisions of state statutes or rules governing the practice of the profession).

Relief Requested

WHEREFORE, the license of Christina Lane Lesperance should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

Dated at Montpelier, Vermont this 5th day of November 2004.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

nu.lesperance.soc

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