STATE OF VERMONT
BOARD OF NURSING

In re: Heath E. Miller License No. 026-3001	}	Docket No. 2009-201 (RN)

Decision on
UNPROFESSIONAL CONDUCT CHARGE

Participating Board Members:
Ellen W. Leff, RN, Chair
Jeanine Carr, RN, Vice Chair
Alan Weiss
Sandra Norton, LNA
Donarae Metcalf, LPN
De-Ann Welch, LPN
Kenneth W. Bush, RN
William G. White Jr.
John Todd, APRN

Appearances:
for Petitioner, State of Vermont: Betsy Ann Wrask
for Respondent: Did not appear for the hearing.

Presiding Officer: Larry S. Novins

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Vermont Board of Nursing held a hearing in the above matter on September 13, 2010 at the National Life Building in Montpelier, Vermont.

The prosecution has the burden of proof in this matter. To prevail on any unprofessional conduct charge, it must prove the charge by a preponderance of the evidence.

Background

The prosecution alleges in its Specification of Charges that Mr. Miller, in violation of Vermont Statutes, made a series of drug administration and medical errors between 2006 and 2009.

Findings of Fact

Based on the evidence presented, the Board finds as follows:

1. Mr. Miller is licensed as a registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. Mr. Miller did not appear for the hearing despite receiving notice. We note that the hearing was originally scheduled to be held on August 11, 2010. On that date Mr. Miller called saying he had had car problems and would not be able to make it in time for his scheduled hearing. The matter was continued to September 13, 2010.
3. The State submitted into evidence Mr. Miller's Answer which admitted most of the State's charges. Regarding paragraphs D and S, Mr. Miller's answer did not deny them. We take them as admitted and therefore proved.
4. At all times Mr. Miller was employed as a registered nurse at the Springfield Hospital in Springfield, Vermont.
5. Mr. Miller administered Morphine to Patient #1 via PCA pump on December 11, 2006, when this was not the medication that was ordered by Patient #1's physician. Mr. Miller failed to verify the written order, and he removed the medication from the Pyxis machine using the override function.
6. Mr. Miller documented in Patient #2's progress notes that he completed a partial physical assessment of Patient #2 on March 17, 2007 at 07:43. However, it was logistically impossible for Mr. Miller to have completed the assessment at this time because Mr. Miller was receiving a morning shift report in the staff lounge at this time.
7. Mr. Miller documented in Patient #3's progress notes that he reassessed Patient #3 on March 29, 2007 at 12:33. However, Patient #3 had been transported to another hospital for a procedure on March 29, 2007 at 10:28, and did not return until 14:12. Therefore, it was logistically impossible for Mr. Miller to have performed this assessment of Patient #3.
8. On April 23, 2007, Mr. Miller failed to provide hospital and nursing standards of care for Patient #4, who had arrived from PACU (post-anesthesia care unit) on the operative day. Mr. Miller failed to take vital signs every four (4) hours as required; failed to document the administration of any medications between 11:00 and 19:25; made no documentation regarding Patient #4's pain after 11:00; and made no documentation regarding Patient #4's nutrition or mobility.
9. On an unidentified date, Mr. Miller made an incomplete lab transfusion slip for Patient #7
10. On an unidentified date, Mr. Miller did not change IV fluid for Patient #8, as was ordered.
11. On an unidentified date, Mr. Miller hung for Patient #6 an incorrect epidural PCA mixture.
12. On an unidentified date, Mr. Miller made an incomplete lab transfusion slip for Patient #9.
13. On May 18, 2008 Mr. Miller did not administer until 18:00 a blood pressure medication that was ordered at 10:00 for Patient #6, who was hypertensive.
14. On May 22, 2008 Mr. Miller signed off on an admission checklist for Patient #5 when he did not perform the Medication Reconciliation, Care Plan, or Mobility and Fall Assessment. Patient #5 had arrived post-operative at 14:30 on that date, but Mr. Miller did not document this patient's assessment until 17:10. The patient had been admitted for excessive bleeding during surgery.

15. Members of the night staff were frustrated with the amount of time they were spending entering into the system SRMs (errors) involving Mr. Miller and the amount of extra work they were finding they had to do when they followed him.
16. On November 29, 2008 Mr. Miller failed to properly identify Patient #11 and instead hung for this patient an antibiotic labeled for another patient who was ordered the same medication.
17. On December 29, 2008 Mr. Miller omitted an antibiotic due at 19:00 for Patient #12, for whom he had assumed care at 17:00. Thereafter, Mr. Miller failed to hand off this information to the oncoming nurse.
18. On January 15, 2009 Mr. Miller omitted an antibiotic due at 18:00 for Patient #13. Thereafter, Mr. Miller failed to hand off this information to the oncoming nurse.
19. On January 15, 2009 Mr. Miller documented inaccurate information regarding Patient #14's bathing, skin concerns, and swallowing status. Mr. Miller failed to administer medications for this patient.
20. On January 20, 2009 at 11:50, Mr. Miller admitted Patient #10, but failed to document any further assessment of this patient for the remainder of his shift which ended at 19:30. Mr. Miller communicated to the oncoming nurse that all admission paperwork and chart checks were complete, which was inaccurate.
21. On February 13, 2009 Mr. Miller failed to document the Plan of Care for Patient #16, as required by Facility policy.
22. On February 13, 2009 Mr. Miller failed to document all pertinent patient information for Patient #17, as required by Facility policy.
23. On February 13, 2009 Mr. Miller failed to document a complete physical assessment of Patient #18 within the medical record, as required by Facility policy.
24. On February 13, 2009 Mr. Miller failed to document aspects of Patient #19's care, including assessment of the IV, as well as the plan of care, as required by Facility policy.
25. On February 17, 2009 Mr. Miller failed to document the plan of care for Patient #20, as required by Facility policy.
26. On February 17, 2009 Mr. Miller failed to validate all documentation of the LPNs working with him as a team in caring for Patient #21, as required by Facility policy.
27. On February 17, 2009 Mr. Miller failed to validate all documentation of the LPNs working with him as a team in caring for Patient #22, and failed to document the plan of care, as required by Facility policy.
28. On February 17, 2009 Mr. Miller failed to document pertinent patient information regarding Patient #23, as required by Facility policy.
29. On February 17, 2009 Mr. Miller documented inaccurate information and thereafter failed to amend this information prior to discharge; failed to document pertinent information; and failed to document a plan of care for Patient #24, as required by Facility policy.
30. On February 18, 2009 Mr. Miller failed to validate all documentation of the LPNs working with him as a team in caring for Patients #20 and #21, as required by Facility policy.
31. On February 18, 2009 Mr. Miller validated the documentation of an LPN at 06:47 regarding Patient #22, but there was no assessment to validate at that time, and Mr. Miller had not yet been handed off this patient by the night registered nurse.
32. On February 18, 2009 Mr. Miller failed to validate the documentation of the LPN

working with him as a team in caring for Patient #24, and failed to document the plan of care, as required by Facility policy.

33. On February 18, 2009 Mr. Miller failed to document pertinent information regarding Patients #25 and #16, and failed to document the plans of care for these patients, as required by Facility policy.

34. On February 18, 2009 Mr. Miller documented inaccurate information and failed to amend this information prior to discharge; and failed to document pertinent information regarding Patient #26, as required by Facility policy.

35. On February 21, 2009 Mr. Miller failed to document pertinent information and failed to document the plans of care for Patients #27 and #28, as required by Facility policy.

36. On February 21, 2009 Mr. Miller failed to document aspects of Patient #21's care, including assessment of bowel movement; ambulation or repositioning, as well as the plan of care, as required by Facility policy.

37. On February 22, 2009 Mr. Miller failed to document aspects of Patient #29's care, including assessment of the GU, GI, skin, wound, or IV, as well as the plan of care, as required by Facility policy.

38. On February 22, 2009 Mr. Miller failed to document aspects of Patient #16's care, including assessment of activity and toileting or incontinence needs, as well as the plan of care, as required by Facility policy.

39. On February 22, 2009 Mr. Miller documented inaccurate information and failed to amend this information prior to discharge; failed to document pertinent information in Patient #27's record; and failed to document the plan of care for this patient, as required by Facility policy.

40. On February 22, 2009 Mr. Miller failed to document aspects of Patient #28's care, including assessment of activity and toileting or incontinence needs, as well as the plan of care, as required by Facility policy.

41. On February 26, 2009 Mr. Miller's supervisor, S.D., referred Mr. Miller to the Facility's Employee Assistance & Work/Life Program for the job performance concerns of ineffective patient handoff/communication; improper documentation within patient medical records; and the recent lack of ability to organize/prioritize his workload. Mr. Miller signed this referral on March 12, 2009.

42. On March 18, 2009 Mr. Miller received counseling regarding his incomplete charting of a patient on March 17, 2009. Mr. Miller skipped GU and the patient's IV charting throughout the entire shift. Mr. Miller was counseled regarding charting of a patient's IV that had been removed by the previous shift. Mr. Miller charted a skin assessment without assessing the patient's impaired skin. Mr. Miller wrote a telephone order and transcribed the wrong medication (Diltiazem rather than the stated Digoxin), which was caught by the Charge nurse in verifying the order. Mr. Miller's inability to focus was discussed as a concern regarding the "extremely dangerous" error in writing a telephone order for cardiac medication. During this counseling, Mr. Miller advised he had not yet sought the assistance or medical attention he had agreed to.

43. On April 4, 2009 Mr. Miller inaccurately documented in the medical record that Patient #33's hand grips were equal, when this patient was admitted with the amputation of two fingers on one hand.

44. On April 5, 2009 Mr. Miller failed to document an assessment within the medical record

for Patient #34 regarding complaints of pain and any medications or treatments offered, and no plan of care was noted for this patient.

45. On April 15, 2009 Mr. Miller incorrectly wrote a telephone order with read back regarding Patient #31, in that Mr. Miller omitted the potassium in the IV fluids that the physician had ordered for this patient.

46. On April 19, 2009 Mr. Miller entered inaccurate information in the medical record of Patient #35. Mr. Miller documented that this patient had no sensory impairment and walked frequently. Patient #35 was admitted with a tibial plateau fracture. This patient was emaciated and gaunt-appearing. Mr. Miller documented that this patient had an excellent nutritional status.

47. On April 23, 2009 Mr. Miller failed to follow up with a physician on Patient #30's low oxygen saturation, which had been reported to Mr. Miller by a nursing student. Mr. Miller failed to document any knowledge of this information or any interventions.

48. On April 23, 2009 Mr. Miller prepared a Morphine PCA for surgical Patient #32 without a written or telephone order to confirm the appropriate pain medication. Subsequently, when the medical record arrived, this patient's written order was for a Fentanyl PCA.

Conclusions of Law

Based on the evidence presented and Facts found above we conclude as follows:

1. **Re: Alleged Violation of 26 V.S.A. § 1582(a)(3):** The State has proved by a preponderance of the evidence that Mr. Miller is unable to practice nursing competently by reason of any cause. This is unprofessional conduct. 3 V.S.A. § 129a(a)(3).

2. **Re: Alleged Violation of 26 V.S.A. § 1582(a)(7):** The State has proved by a preponderance of the evidence that Mr. Miller has engaged in conduct of a character likely to deceive, defraud, or harm the public. This is unprofessional conduct. 3 V.S.A. § 129a(a)(3).

3. **Re: Alleged Violation of 3 V.S.A. § 129a(a)(7)**: The State has proved by a preponderance of the evidence that Mr. Miller willfully made or filed false reports or records in the practice of the profession; and willfully failed to file the proper reports or records. This is unprofessional conduct.

4. **Re: Alleged Violation of 3 V.S.A. § 129a(b)(1) and (2)**: The State has proved by a preponderance of the evidence that Mr. Miller failed to practice competently. We find that Mr. Miller's conduct as found above constitutes (1) performance of unsafe or unacceptable patient or client care, 3 V.S.A. § 129a(b)(1) and (2) a failure to conform to the essential standards of acceptable and prevailing practice. This is unprofessional conduct.

5. **Re: Alleged Violation of 26 V.S.A. § 129a(a)(3)**: 3 V.S.A. § 129a(a)(3) defines unprofessional conduct to include failing to comply with provisions of federal or state statutes or rules governing the practice of the profession. Any allegation of failure to comply with statutes or rules has been addressed above. This statute does not provide an

independent grounds for discipline. There is no violation of this statute. This charge is dismissed.

Order

For the violations above, to protect the public, health, safety and welfare, the following sanction is necessary.

Mr. Miller's license is **indefinitely suspended,** effective the date of this decision. It shall remain suspended until Mr. Miller satisfies the Conditions set forth in the **Appendix** hereto. At that time his license will be reissued as "**Conditioned**" as set forth in the **Appendix.**

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing. A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, Office of Professional Regulation, National Life Bldg., North, FL2, Montpelier, Vermont 05620-3402 within 30 days of the entry of this Order.

If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.

To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: Ellen Leff
Ellen Leff, RN, Chair

Date September 14, 2010

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: September 16, 2010

Vermont Board of Nursing
Disciplinary Decision
Appendix

In re: Heath Miller
Docket No. 2009-201 (RN)
License No. 026-3001

Mr. Miller's license is **Indefinitely Suspended**.

Mr. Miller may petition to have his licensed reinstated, once he has:

a. Successfully completed a medication administration course which has been pre-approved by the Board or its designee;

b) Successfully completed a documentation course which has been pre-approved by the Board or its designee; and

c) Successfully completed the "theory" component of the Re-Entry Program.

Thereafter, his license shall be re-issued labeled "**conditioned**." The conditions shall remain in place until Mr. Miller completes all requirements ordered and meets each condition.

1. Mr. Miller may only practice as permitted in the clinical component of the Re-Entry Program.

2. Mr. Miller must practice under direct supervision of a registered nurse with monthly reports from the Re-entry Program's Director, until that clinical component is successfully completed.

3. **Duration:** Following completion of the Re-entry program, Mr. Miller shall be subject to these conditions until Mr. Miller completes **one year** of supervised practice in which Mr. Miller works at least forty (40) hours every two (2) weeks as a registered nurse.

4. **Part time work:** Part-time work of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Mr. Miller's license shall remain conditioned for a minimum of one (1) year of regular nursing practice.

5. **Out-of-State Practice:** Out-of-state practice can be credited toward fulfillment of this Order only if Respondent shall first obtain prior approval from this Board for out-of-state practice. If Respondent fails to obtain prior approval before practicing out-of-state, none of the out of state practice time will be credited toward fulfillment of this terms of this

Order. The Board will approve out-of-state practice so long as Respondent can still comply with the provisions of this Order.

6. **Notification of Place of Employment, Personal Address, Telephone Number** Within ten (10) days of the entry of this 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, withing forty-eight (48) hours of any change of employment, personal address, or telephone number.

7. **Notification to Employers**: Mr. Miller shall provide a copy of this Order to all employers in any setting in which Mr. Miller practices and inform them of the conditional license status. Within ten (10) days of any subsequent employment, Mr. Miller shall cause his immediate supervisor to write on the employer's letterhead to the Vermont Board of Nursing, Attn: Executive Director, acknowledging receipt of this Order and acknowledging the employer's ability to comply with the conditions required by this Order.

8. **Reports from Employers**: Within one (1) month of the date beginning employment and monthly thereafter, Mr. Miller shall cause every employer for whom he works during the relevant period as to submit to the Board an evaluation of Mr. Miller's performance during that period. This report shall be on forms issued by the Board.

9. **Nursing Programs:** In the event Mr. Miller is attending a nursing program, Mr. Miller 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 the Order during clinical experience.

10. **Practice Under Supervision:** Mr. Miller shall practice only in a setting where he has "direct supervision" for the entire shift by a licensed registered nurse in good standing.

11. **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.

12. **Costs**: Respondent shall bear all costs of complying with this Order.

13. **License Renewal:** The Board's Order, and these conditions, do not affect Mr. Miller's license renewal responsibilities. Mr. Miller must timely apply for and otherwise comply with the requirements for license renewal.

14. **Violation of this Order:** If Respondent violates the terms of this Order in any respect, the Board, after giving Respondent notice and an opportunity to be heard, may rescind or

modify this Order and impose additional appropriate disciplinary sanctions. If a complaint of unprofessional conduct is made against Respondent during the term of this Order, the Order shall be automatically extended until the unprofessional conduct matter is concluded.

15. **Completion of Conditional License Period:** After the conditional license period, Mr. Miller may petition the Board to remove any and all license conditions. Mr. Miller must present proof that all terms of this Order have been met. Once Mr. Miller has shown that all conditions of this Order have been met, the Board will remove the conditions on Mr. Miller's license and restore Mr. Miller's licensure privileges.

Vermont Board of Nursing, by

Ellen W. Leff

Ellen W. Leff, RN, Chair

Entered: 9-16-2010

September 14, 2010