STATE OF VERMONT
BOARD OF NURSING

IN RE:	)	
Christopher Paul Miranne	)	Case File No. NU75-0404
License No. 26-29061	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

The Vermont Board of Nursing ("the Board") held a hearing in this case on Monday, February 14, 2005, at the Central Vermont Hospital, 130 Fisher Road in Berlin, Vermont. Board members Elayne Clift, Susan Farrell, Ellen Leff, Linda Rice, Sandra Norton and De-Ann Welch participated in the decision. Edward Adrian, Prosecuting Attorney, appeared for the State. Christopher Miranne ("the Respondent") was not present.

The Respondent did receive the Charges against him and did file an answer in response. The Board was given copies of that answer as part of the hearing. The Respondent was also made aware of a prehearing conference at which a hearing date was to be chosen. The presiding officer left the Respondent a voice mail message at the time of the prehearing conference. The Respondent did phone the presiding officer after the time of the scheduled prehearing conference and was informed of the hearing date.

Subsequent mailings to the Respondent were returned with a new address in California. The last attempt to contact the Respondent in California was a returned letter marked "unable to forward, address not known."

Findings of Fact

1. The Respondent, Christopher Paul Miranne, is licensed in the State of Vermont as a Registered Nurse under License Number 026-0029061.

2. The Respondent was originally licensed on December 23, 2003 and the Respondent's license is currently set to expire on March 31, 2005.

3. At all times relevant, the Respondent was employed under a traveling nurse contract assignment at Fletcher Allen Health Care located in Burlington, Vermont.

4. On March 3, 2004, the Respondent, without notifying the physician, discontinued patient R.R.'s 14 gauge Foley catheter and placed a larger 18 gauge catheter when the Respondent observed it to be leaking. This placement caused trauma to R.R.'s urethra, which resulted in clots and blood in R.R.'s urine. A 16 gauge catheter was available to the Respondent.

5. Subsequently, the Respondent notified the physician and requested that a hematocrit be drawn, which the physician ordered as well as a flush of the bladder to attempt to remove blood clots. The flush did not return, indicating that there was a clot blocking the catheter. The Respondent then, without notifying the physician or receiving further instructions, removed the catheter and placed a Texas catheter on the patient.

6. On April 7, 2004, the Respondent failed to chart in the medication administration record the dosage amount of Ambien that the Respondent gave to patient T.M. at 10:30 p.m.

7. The Respondent did initial the chart, which indicated only one dosage amount. His initials indicate that he gave the medication as ordered because there was no multiple choice as to dosage amount.

8. On April 9, 2004, the Pyxis report indicated that the Respondent withdrew one tablet of Ambien for patient T.M. However, the Respondent did not document in the medication administration record that he gave this tablet to T.M.

9. The Respondent believes his electronic signature on the Pyxis machine should suffice and that his failure to document on the medication administration record should thus be excused.

10. On April 8, 2004, the Pyxis report indicated that the Respondent withdrew 3 tablets of Percocet for patient B.G. However, the medication administration record for B.G. indicates that only one tablet was given. The Respondent advised State Investigator Jackie Cholewa that he had a heavy patient load, 4 to 5 patients and he "probably gave them to another patient."

11. The Respondent asserts that the other two tablets were returned to the Pyxis. If true, this was not documented or explained in any way.

12. On April 8, 2004, the medication administration record for patient N.L. indicated that the Respondent gave patient N.L. two tablets of Percocet at 10:30 p.m. However, the Pyxis report does not show any Percocet tablets withdrawn for N.L. by the Respondent at or anytime around 10:30 p.m.

13. In his answer, the Respondent admits this was a mistaken entry on N.L.'s record..

14. On April 11, 2004, the Pyxis report indicated that the Respondent withdrew two tablets of Acetaminophen for patient A.P. However, the Respondent did not document in the medication administration record that he gave these tablets to A.P.

15. Again for this charge, the Respondent asserts that his electronic signature via

Pyxis should suffice and that a written medication administration record is unnecessary.

16. On April 11, 2004, the Pyxis report indicated that the Respondent withdrew one tablet of Ambien for patient T.M. The Respondent documented the medication administration record as having given T.M. the Ambien, however, the Respondent then crossed it off stating "error."

17. The Respondent states that the patient refused this medication and that he charted the wasting of the medication. The charting codes indicate that he should have used the code "E" for refuses medication. The Respondent failed to document wasting of the medication by simply writing "error."

Conclusions of Law

1. 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 or 3 V.S.A. §129a, which includes any violation of the Board of Nursing Administrative Rules (3 V.S.A. §129a(a)(3). Failing to comply with the provisions of state statutes or rules governing the practice of the profession).

2. The Respondent, by his actions as described above, committed unprofessional conduct constituting grounds for discipline because Respondent violated:

A. 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

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

3. More specifically, the Respondent made several charting errors in the course of a few days, those detailed in the State's Specification of Charges at Paragraphs 13-17. The Charge at Paragraph 12 was proved but does not constitute unprofessional conduct.

4. Additionally, the Respondent committed unprofessional conduct by discontinuing a physician's order, attempting to insert another catheter without a physician's order and eventually using a different catheter, all without further instructions from a physician. This was outside the Respondent's scope of practice.

Opinion

The Respondent's errors were pervasive and his attitude distressing. The Board does not agree with his contention that a Pyxis electronic signature is enough charting of medication administration without further entry on the medication administration record. His practice was careless and he does not appear to comprehend the seriousness of his errors in judgement. The Board is also very much concerned that he would go outside his scope of practice without consulting a physician and that the Respondent's charting errors will continue. Therefore, conditions on the Respondent's license are deemed appropriate, as detailed below.

Order

A. The Board of Nursing hereby CONDITIONS Respondent's license for A MINIMUM OF TWO (2) YEARS from the date of entry of this Order. Because the Respondent was not present for the hearing and did not contact the Office regarding his absence, the Board understands that imposition of conditions may be inappropriate if the Respondent cannot be found. Therefore, the Respondent must contact the Board within THIRTY (30) DAYS of the date of entry of this Order to acknowledge receipt of this Order and his acceptance of these conditions.

B. Should he fail to contact the Board within 30 days, his license will be INDEFINITELY SUSPENDED until such time as he contacts the Board and requests reinstatement under conditions similar to those set forth below. 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) Medication Administration Course

Respondent must complete (i.e.: receive a passing grade, if applicable) a course on medication administration and documentation, with prior approval by the Board or its designee. The courses must be completed within six months of the date of entry of this Order.

(3) Notification to Employers.

Respondent shall provide a copy of this Order to all employers in any current or future setting 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 Order or of any subsequent employment, Respondent shall cause Respondent's immediate supervisor to write

to the Board, on the employer's letterhead, acknowledging receipt of the Order and the ability to comply with its conditions.

Reports from Employers.

Within one (1) month of the date of entry of this Order and monthly thereafter, Respondent shall cause every employer Respondent has worked for during the relevant time period to submit to the Board an evaluation of Respondent's performance and attendance during that time period. 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 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.

Respondent shall sign a consent, upon request of the Board, to authorize Respondent's employer to provide all information requested by the Nursing Board, or its designee, either orally or in writing, at any time during the period the Order is in effect.

(5) Practice Under Supervision.

Respondent shall practice only in a setting where Respondent has on-site 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 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.

(7) License Renewal.

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

Costs.

Respondent shall bear all costs of complying with this Order.

Violation of the 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 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.

(10) Completion of Conditional License Period.

Upon completion of the conditional license period, Respondent may petition the Board to remove any and all conditions on his license and after formal review by the Board, Respondent's nursing license may be formally restored by appropriate Board action. Respondent shall demonstrate, to the Board's satisfaction that Respondent fully complied with all the terms of this Order. If the Respondent demonstrates to the Board's satisfaction that he has complied with all of his conditions, then any and all conditions shall be removed.

C. 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).

D. This Order will remain part of the 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.

Susan Farrell

Susan Farrell, R.N.
Chair

Date: Feb. 25, 2005

OFFICE OF PROFESSIONAL REGULATION

Date of entry: 3/7/05

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

IN RE:	)	
CHRISTOPHER PAUL MIRANNE	)	**Docket No. NU 75-0404**
License No: 026-0029061	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Christopher Paul Miranne, R.N.:

Board Authority

1) The Vermont State Board of Nursing ("the Board") has authority to approve consent orders, issue warnings or reprimands, suspend, revoke, limit, condition or prevent the renewal of current or lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. §129(a)(5); 3 V.S.A. §814(d); 26 V.S.A. §1582(a): Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.

2) 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).

3) 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)

4) 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).

5) Engaging in conduct of a character likely to deceive, defraud or harm the public includes falsifying or altering clinical records or making inaccurate or misleading entries pursuant to ARBN, Chapter 4, Rule IV(II)(D)(4).

6) Failure 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).

Facts

7) The Respondent, Christopher Paul Miranne, is licensed in the State of Vermont as a Registered Nurse under License Number 026-0029061.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

8) The Respondent was originally licensed on December 23, 2003 and the Respondent's license is currently set to expire on March 31, 2005.

9) At all times relevant, the Respondent was employed under a traveling nurse contract assignment at Fletcher Allen Health Care located in Burlington, Vermont.

10) On March 3, 2004, the Respondent, without notifying the physician, discontinued patient R.R.'s 14 gauge Foley catheter and placed a larger 18 gauge catheter when the Respondent observed it to be leaking. This placement caused trauma to R.R.'s urethra, which resulted in clots and blood in R.R.'s urine. A 16 gauge catheter was available to the Respondent.

11) Subsequently, the Respondent notified the physician and requested that a hematocrit be drawn, which the physician ordered as well as a flush of the bladder to attempt to remove blood clots. The flush did not return, indicating that there was a clot blocking the catheter. The Respondent then, without notifying the physician or receiving further instructions, removed the catheter and placed a Texas (condom) catheter on the patient.

12) On April 7, 2004, the Respondent failed to chart in the medication administration record the dosage amount of Ambien that the Respondent gave to patient T.M. at 10:30 p.m.

13) On April 9, 2004, the Pyxsis report indicated that the Respondent withdrew one tablet of Ambien for patient T.M. However, the Respondent did not document in the medication administration record that he gave this tablet to T.M.

14) On April 8, 2004, the Pyxsis report indicated that the Respondent withdrew 3 tablets of Percocet for patient B.G. However, the medication administration record for B.G. indicates that only one tablet was given. The Respondent advised State Investigator Jackie Cholewa that he had a heavy patient load, 4 to 5 patients and he "probably gave them to another patient."

15) On April 8, 2004, the medication administration record for patient N.L. indicated that the Respondent gave patient N.L. two tablets of Percocet at 10:30 p.m. However, the Pyxsis report does not show any Percocet tablets withdrawn for N.L. by the Respondent at or anytime around 10:30 p.m.

16) On April 11, 2004, the Pyxsis report indicated that the Respondent withdrew two tablets of Acetaminophen for patient A.P. However, the Respondent did not document in the medication administration record that he gave these tablets to A.P.

17) On April 11, 2004, the Pyxsis report indicated that the Respondent withdrew one tablet of Ambien for patient T.M. The Respondent documented the medication administration record as having given T.M. the Ambien, however, the Respondent then crossed it off stating "error".

Charges

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

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

i. 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

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

iii. 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 Christopher Paul Miranne should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

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

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

nu.miranne.soc

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602