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

In re: SUSAN L. MORALE	}	Docket No. 2015-311 (RN)
License No. 026.0026499	}	

Decision on
UNPROFESSIONAL CONDUCT CHARGE

Participating Board Members:
Jeanine Carr, RN, Chair
Ellen Watson, APRN, Vice Chair
Deborah Swartz, RN
William G. White, Jr., Public Member
Douglas Sutton, RN
Jennifer Laurent, APRN
Kelly Sinclair, LNA
Luana Tredwell, LPN

Appearances:
Prosecuting the case: Elizabeth Jarvis, Esq.
Respondent: did not appear

Presiding Officer: George K. Belcher

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Vermont Board of Nursing held a hearing in the above matter on June 13, 2016 in Montpelier, Vermont. The Specification of Charges alleges that Respondent committed unprofessional conduct in violation of Vermont Statute.

Findings of Fact

Based on the evidence presented and the Answer which the Respondent filed to the Specification of Charges, the Board finds as follows:

1. Susan L. Morale, (the "Respondent") is a Registered Nurse and is therefore subject to the regulatory authority of this Board, pursuant to 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1595, the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation. Her Vermont license is active and is currently set to expire on or about March 31, 2017.

2. In 2015 the Respondent was employed as a Registered Nurse at the Vermont Psychiatric Care Hospital in Berlin, Vermont. She began work on or about June 29, 2015 and was terminated on July 24, 2015.
3. During the Respondent's time at the hospital several members of the nursing staff expressed concerns about her ability to practice safely. Even patients inquired of staff as to whether the Respondent was impaired during her work.
4. One of the nurses who was conducting orientation of the Respondent noted that she could not remember basic components of instruction and would ask the same basic questions each day for several days.
5. On or about July 10 or 11, 2015 the Respondent identified the wrong patient on the Medication Administration Record, despite there being photos of the patients in the medication dispensing area and in the Medication Administration Record file. This error was discovered by another nurse who prevented the wrong medication being given by the Respondent to the patient.
6. On or about July 14, 2015 during a psychiatric patient emergency, a patient had to be placed in restraints. The patient was one of the patients assigned to the Respondent. The Respondent, not only was non-responsive and unhelpful during the restraining process, but she continually asked interfering questions which demonstrated a lack of understanding of the facility emergency procedures. While the patient was being wheeled to another section of the hospital, and while the patient was clearly in restraints, the Respondent asked whether the patient was going to be placed in restraints.
7. The Respondent asked a co-worker why the 5:45 AM patient checks had not yet been done at 5:40 AM. It was necessary to explain to Respondent that the 5:45 AM patient checks were not yet due to be done.
8. On or about July 17, 2015 the Respondent indicated that she did not have the set of facility keys assigned to her because they had been taken back from her by another staff person. She then indicated that she might have lost the keys. The Respondent later found that she had the keys in her purse. (See Respondent's answer to Charge #11)
9. On July 21, 2015 the Respondent prepared an IV injection of Haldol for a patient whose prescribed medication was oral Haldol. When the patient became agitated and disruptive because the wrong medication form was being prepared, another staff person pointed out the error to the Respondent. It thereafter took 18 minutes for the Respondent to assemble the correct medications. The patient, by this time, was so upset that she did not cooperate in receiving the correct medication. (See Charges 12-14 and Respondent's answers thereto as well as the testimonial evidence.)
10. Three co-working Registered nurses and one Mental Health Specialist (who is now a Registered Nurse) testified at the hearing. Their testimony was essentially consistent in describing the Respondent's behavior as unsafe in the nursing setting. They described the Respondent as unable to remember basic information from moment to moment or from day to day. They also described her as requiring constant supervision and prompting. The four co-workers all had serious concerns about the inability of the Respondent to make judgments, her inability to safely work on her own, her inability to communicate her understanding of procedures and protocols, and her inability to follow simple directions. One co-worker stated that the Respondent was barely able to do one task with prompting, much less be able to multi-task. Another stated that the Respondent could not correctly prioritize her work, despite being prompted repeatedly as to what should be done first

before other tasks. All four witnesses expressed a concern about the Respondent's inability to practice nursing safely. One experienced nurse stated that the Respondent was "Not safe to practice". Another stated that she was, "Very concerned about her [the Respondent], safe-wise". All four witnesses found the behavior of the Respondent to be far outside the norm of their experience in working with other nurses.

11. Several of the co-working Registered Nurses described the Respondent as appearing to have a mental or cognitive impairment which was interfering with her ability to understand information or perform her work.
12. The testimony of the witnesses was accepted and the facts contained therein are found to be true and correct.
13. It was the position of the State that the Respondent's license should be indefinitely suspended. Should the Respondent apply for reinstatement, reinstatement should only be considered if the Respondent is evaluated by an independent evaluator.

Conclusions of Law

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

1. 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. 3 VSA Sec. 129a(c).
2. Re: Alleged Violation of 3 VSA Sec. 129a(b)(1) and (2): The Prosecution has proven by a preponderance of the evidence that Respondent failed to practice competently by performance of unacceptable patient care and failed to conform to the essential standards of acceptable and prevailing practice. This is unprofessional conduct.
3. Re: Alleged Violation of 3 VSA Sec. 129a(a)(5): The Prosecution has proven by a preponderance of the evidence that Respondent practiced her profession when medically or psychologically unfit to do so. This is unprofessional conduct.
4. Re: Alleged Violation of 3 VSA Sec. 129a(a)(15): The Prosecution has proven by a preponderance of the evidence that Respondent failed to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession. This is unprofessional conduct.
5. Re: Alleged Violation of 26 VSA Sec. 1582(a)(14): The Prosecution has proven by a preponderance of the evidence that Respondent failed to take appropriate action to safeguard a patient from incompetent health care (her own). This is unprofessional conduct.
6. The Board declines to find a violation of 3 VSA Sec. 129a(a)(3) (Failure to comply with State or Federal statutes or rules regarding the profession).

Order

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

Respondent's license is hereby **INDEFINITELY SUSPENDED**. Her license shall remain suspended until such time as she applies for reinstatement and the Board decides, in its discretion, that she qualifies for reinstatement. Any application for reinstatement shall be accompanied by a report, prepared by an independent and suitable evaluator, pre-approved by the Vermont Board of Nursing. The report shall address at a minimum: (1) the behavior of the Respondent as described herein; (2) the violations set forth above; (3) the mental and cognitive capacity of the Respondent put in issue by the facts identified in the Findings and Conclusions of this order; and (4) her capability to practice nursing safely. The evaluation must be completed within 45 days of the application for reinstatement and shall be performed at the sole expense of the Respondent.

Vermont Board of Nursing

By: Jeanine Carr Date: June 13, 2016
Jeanine Carr, RN, Chair

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY

6/17/16

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, 89 Main Street, Fl. 3, 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.