STATE OF VERMONT
BOARD OF NURSING

IN RE:)
Michael Nagle) Case File No. NU21-0801
License No. 26-18373)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Introduction

The Vermont Board of Nursing ("the Board") held a hearing in this case on Monday, June 14, 2004, at 81 River Street in Montpelier, Vermont. Board members Susan Farrell, Laurey Tyo, De-Ann Welch, Pat Rock, Sandra Norton, Alan Weiss, Elayne Clift, Ellen Leff and Donarae Metcalf participated in the decision. Edward Adrian, Prosecuting Attorney, appeared for the State. Michael Nagle ("the Respondent") was present and was represented by attorney Leslie Pratt. Christopher Winters was the Presiding Officer.

Findings of Fact

1. The Respondent is a registered nurse holding license number 26-1873 issued by the State of Vermont. Respondent's license was originally issued on June 2, 1988 and expired on March 31, 2003, so is currently lapsed.

2. At all times relevant to these charges, the Respondent was practicing as a registered nurse employed by Northwest State Correctional Facility in St. Albans, Vermont.

3. On or about March 8, 2001 Respondent received an Order from the Veteran's Administration Hospital to decrease the dosage of interferon for inmate J.G.

3. On or about March 8, 2001 Respondent decreased the interferon dose for J.G. without prior authorization from one of the facilities providers.

4. According to the facility policy, orders from off-site physicians required the prior approval of the on-site physician or physician on call before administration.

5. A Memorandum from Paulette Simard, Director of Nursing, indicates the Respondent "forgot to call" the Doctor, for which he apologized. Respondent's testimony at hearing was that he called but did not reach the doctor and that he may have left a message.

6. Respondent disagrees with the institution policy and believes the Veteran's

Administration Hospital, from whom the original order was received, was not subject to facility approval or the policy.

7. On or about June 13, 2001 Respondent signed out two syringes of insulin to an inmate when the inmate was due one dose only. Apparently, the second dose was given to another inmate.

9. On or about June 19, 2001 Respondent signed out Phenobarbital for an inmate but did not enter the medication as being administered on the MAR.

10. On or about May 17, 2001 Respondent gave a narcotic medication to a correctional officer to administer to an inmate. The correctional officer did not have any nursing experience or training.

11. On or about June 20, 2001 Respondent was unable to be located for a short time when an inmate had a seizure and the facility attempted to locate Respondent.

12. Respondent had gone on a smoking break in the maintenance area adjacent to the infirmary. There was poor radio reception in that area and noise which made it difficult to hear his radio.

13. Corrections officers called the Respondent 2-3 times on his radio and he did not respond.

12. During this time when he was first unavailable and then responding to the seizure, the Respondent left the door to the infirmary unsecured providing access to the infirmary to the inmates. This was against the policy of the facility.

13. There was one unsupervised inmate in the infirmary at the time the unlocked door was discovered by a corrections officer, who was looking for the Respondent to respond to the seizure.

<u>Conclusions of Law</u>

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

B. By engaging in the conduct set forth above, the Respondent has committed unprofessional conduct in that he:

(1) failed to follow facility policy regarding implementation of new orders which is a violation of the Administrative Rules of Nursing, Chapter 4, Rule IV(II)(B)(2)(Failure to conform to the essential standards of acceptable and prevailing practice) and 26 V.S.A. §

1582(a)(3) (is unable to practice nursing competently by reason of any cause by performing unsafe or unacceptable patient care);

(2) made documentation errors regarding the insulin syringe and phenobarbital administration which is a violation of the Administrative Rules of Nursing, Chapter 4, Rule IV(II)(B)(2)(Failure to conform to the essential standards of acceptable and prevailing practice) and 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause by performing unsafe or unacceptable patient care);

(3) improperly delegated the administration of narcotic medications in violation of 3 V.S.A. §129a(a)(6) (Delegated professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education or licensing credentials to perform them) a and 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause by performing unsafe or unacceptable patient care); and

(4) was temporarily unavailable to attend to an inmate's seizure and left the infirmary door unsecured and an inmate unsupervised with access to the health center in violation of facility policy and the Administrative Rules of Nursing, Chapter 4, Rule IV(II)(B)(2)(Failure to conform to the essential standards of acceptable and prevailing practice) and 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause by performing unsafe or unacceptable patient care).

Opinion

The State's evidence against the Respondent demonstrates a pattern of behavior exhibiting a disregard for policies, procedures and standards of care for the profession. In response, the Respondent offered no more than vague assertions about the complainants' motivations and a multitude of excuses and supposed justifications for his behavior which do not change the very simple facts of this case as they relate to the standard of practice for nursing.

Order

A. In light of the above findings and conclusions, the Board hereby INDEFINITELY SUSPENDS the Respondent's license, effective as of the date of entry, below. This suspension is to remain in effect for a minimum of ONE YEAR before the Board will consider a petition for reinstatement which must demonstrate to the Board that the Respondent is capable of returning to safe nursing practice.

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: Susan Farrell
Susan Farrell
Chair

Date: June 23, 2004

OFFICE OF PROFESSIONAL REGULATION

Date of entry: 6/29/04 .

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

IN RE:	)	
MICHAEL NAGLE, R.N.	)	**Docket No: NU21-0801**
License No.: 026-0018373	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Michael Nagle, RN:

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).

2. Engaging in conduct of a character likely to deceive, defraud or harm the public is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. §1582(a)(3).

3. Being unable 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)(7).

4. Inability to practice nursing competently includes performance of unsafe or unacceptable patient care and failure to conform to the essential standards of acceptable and prevailing nursing practice. Administrative Rules of the Board of Nursing ("ARBN") Chapter 4, Rule IV(B)(2).

5. Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education or licensing credentials to perform them is unprofessional conduct upon which the Board can base disciplinary action. 3 V.S.A. §129a(a)(6).

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Facts

6. The Respondent is a Registered Nurse under License Number 026-0018373.

7. Respondent was originally licensed on June 2, 1988 and Respondent's license has a current expiration date of March 31, 2003.

8. At all times relevant to these Charges, the Respondent was employed by the Northwest State Correctional Facility in St. Albans, Vermont.

Interferon Medication Error

9. Paragraphs 1-8 above are incorporated.

10. On or about March 8, 2001 Respondent decreased the interferon dose of an inmate without prior authorization from one of the facilities providers.

11. Respondent knew or should have known that orders from off-site physicians required the prior approval of the on-site physician before administration.

Improper Wasting

12. Paragraphs 1-7 above are incorporated.

13. On or about June 13, 2001 Respondent signed out two syringes of insulin and the inmate was due one dose only.

14. Respondent failed to properly waste the unused syringe or otherwise account for it.

Phenobarbital Medication Error

15. Paragraphs 1-7 above are incorporated.

16. On or about June 19, 2001 Respondent signed out Phenobarbital for an inmate but did not enter the medication as being administered on the MAR.

Improper Delegation

7. Paragraphs 1-7 above are incorporated.

18. On or about May 17, 2001 Respondent gave a narcotic medication to a correctional officer to administer to an inmate.

19. Respondent knew or should have known that the correctional officer was not qualified by training, experience, education or licensing credentials to perform the task.

Improper Care

20. Paragraphs 1-7 above are incorporated.

21. On or about June 20, 2001 Respondent was unavailable when an inmate had a medical emergency and the facility attempted to locate Respondent.

Conduct Likely to Harm the Public

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22. Paragraphs 1-7 above are incorporated.

23. Respondent left the door to the infirmary unsecured providing access to the infirmary to the inmates.

24. Respondent knew or should have known this was against the policy of the facility.

Charges

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

    a) engaged in conduct of a character likely to deceive, defraud or harm the public, in violation of 26 V.S.A. §1582(a)(7);

    b) delegated professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education or licensing credentials to perform them, in violation of 3 V.S.A. §129a(a)(6); and

    c) shown he is unable to practice nursing competently by reason of any cause, in violation of 26 V.S.A. §1582(a)(3), specifically Respondent:

        i) performed unsafe or unacceptable patient care; and

        ii) failed to conform to the essential standards of acceptable and prevailing nursing practice.

Relief Requested

WHEREFORE, the license of Michael Nagle should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

Dated at Montpelier, Vermont this 20th day of August 2002.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

By: [signature]
George C. Haegele IV
Assistant Attorney General

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