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

IN RE: **CLIFFORD D. PEEBLES** **License No. 026-0030619**	)))	**Docket No. NU84-0308**

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, by and through State Prosecuting Attorney Edward G. Adrian, and the Respondent, Clifford D. Peebles, RN, who stipulate and agree as follows:

Board Authority

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

Statement of Facts

2. Clifford D. Peebles (the "Respondent") of St. Albans, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026-0030619. This license was originally issued on or about February 10, 2005 and is currently set to expire March 31, 2009.

3. At all times relevant, Respondent was employed as a registered nurse in the Surgical ICU of Fletcher Allen Healthcare (the "Facility"), located in Burlington, Vermont.

4. On or about March 17, 2008, Patient G.S., who had received a pancreas and kidney transplant earlier on this date, was admitted to the Surgical ICU by Charge Nurse K.C. and Respondent at or around 11:30 p.m. Upon presentation, G.S. was in stable condition and was assigned to be cared for by Respondent. Respondent was given a copy of G.S.'s post-operation orders, which included the order that the House Officer (the resident physician on call for transplant services) be called if G.S.'s urine output was less than one hundred (100) ml for one (1) hour, or if G.S.'s systolic blood pressure was above one hundred sixty (160) or below one hundred ten (110).

5. According to G.S.'s flow sheets during the early morning hours of March 18, 2008, G.S.'s urine output was forty (40) at midnight; ten (10) at 1:00 a.m.; ten (10) at 2:00 a.m.; and fifteen (15) at 3:00 a.m. During this time, G.S.'s systolic blood pressure was ninety-one (91) at midnight; eighty-seven (87) at 1:00 a.m.; seventy-three (73) at 2:00 a.m.; and not documented at 3:00 a.m.

6. Respondent never called the House Officer, Dr. E.T., to tell him that G.S's urine output and systolic blood pressure were below acceptable limits as he was directed to by G.S.'s post-operation orders.

7. Moreover, on or about March 18, 2008 at approximately 1:40 a.m., and again at approximately 3:30 a.m., Dr. E.T. came to G.S.'s room to check on G.S. Even when Dr. E.T. was physically present at these times, Respondent did not alert Dr. E.T. that G.S.'s urine output and systolic blood pressure were below acceptable limits.

8. On or about March 18, 2008 in Manager's Notes written by M.R., a Facility Nurse Manager, M.R. stated that she received a call from Charge Nurse K.C. at approximately 6:00 a.m. on this date, alerting M.R. that a serious complication had arisen with G.S.'s transplant. K.C. told M.R. that Respondent had not reported significant changes in G.S.'s blood pressure and urine output, and G.S. was now back in the operating room.

9. In these same notes, M.R. reported that K.C. informed M.R. that Respondent was on the internet at times, which was corroborated by another registered nurse, M.A. Moreover, K.C. also reported to M.R. that Respondent's notes on G.S. were minimal, and there were multiple areas on the flowsheet that were blank. Furthermore, K.C. reported that K.C. also looked at the flow sheets of Respondent's other patient he was assigned to care for on this date, and noted that Respondent had minimal documentation on this patient as well.

10. Finally, M.R. reported that K.C. subsequently advised M.R. that G.S.'s transplanted pancreas was "gone" and there was a huge clot going up into the Inferior Vena Cava which was then scraped out. K.C. also advised that Dr. A.D. stated that the patient could possibly throw a clot (pulmonary embolus) and die, and that Dr. A.D. had also stated to Respondent that he didn't know how to explain this situation to G.S.'s family. K.C. reported to M.R. that Respondent kept saying he "was sorry, but didn't know why he didn't report the signs of shock."

11. On or about March 18, 2008 in M.R.'s Manager's Notes from a meeting with Dr. A.D., M.R. reported that Dr. A.D. stated that G.S. was clearly in a state of shock for four (4) hours and that it was not recognized by Respondent or Dr. E.T.

12. On or about March 18, 2008 in an interview of Respondent in which M.R.; T.M., an Administrative Nurse Coordinator; and K.Q., a union steward were present, Respondent stated that he mistakenly thought that Dr. E.T. had seen the low urine output when Dr. E.T. came to write G.S. an order for medication at 1:40 a.m. on that

date. Respondent also stated that he should have reported G.S.'s low urine output and blood pressure to Dr. E.T. During this interview, M.R. discussed that Respondent did not utilize the help offered to him by his coworkers, and that Respondent was using the internet during his shift. According to the meeting notes, Respondent did not address why he declined help, but admitted to using the internet for about thirty (30) minutes over the entire 12.5 hour shift.

13. On or about March 18, 2008 in an email to M.R. and K.C., Respondent admitted that he erred in not calling the House Officer regarding G.S.'s low urine output.

14. One reason that Respondent was not alarmed by the low urine output was that he believes he was told the organs had come from a cadaver donor.

15. On or about March 21, 2008, Respondent was given a written warning for practice and documentation deficiencies; removed from the schedule for two (2) weeks without regular pay; and was given strict return-to-work conditions.

16. On or about March 28, 2008 in a Mandatory Report of Unprofessional Conduct, M.R. stated that on or about March 18, 2008 at or about 4:00 a.m., the physician caring for G.S. noted that Respondent had failed to report significant changes in the patient's condition, including minimal urine output, hypotension, hypovolemia, and hyperglycemia.

17. On or about June 18, 2008 in an interview with State Investigator Mark Jacobs, Respondent stated that during the early morning hours in question, Respondent did not think the patient was that sick and he underestimated the importance of the urine output. Respondent explained that he thought the issue for him that night was that he had a hard time focusing on his duties and he did not follow the written orders critically enough.

18. On or about July 17, 2008 in an interview with Investigator Jacobs, Charge Nurse K.C. stated that after G.S. came to the ICU, K.C. and other nursing staff asked Respondent several times whether Respondent needed any assistance, but that Respondent denied the assistance. Furthermore, K.C. advised that on or about March 18, 2008 at approximately 4:00 a.m., she heard a lot of commotion and discovered that G.S. was being prepared for surgery and that at this time, Respondent informed K.C. that G.S.'s urine output was low. Moreover, K.C. stated that after G.S. had gone back to the operating room, K.C. asked Respondent why he did not call the House Officer when Respondent realized the urine output was low. K.C. advised that Respondent stated that he thought the House Officer, Dr. E.T., was aware of the low urine output. However, K.C. advised that when K.C. asked Respondent how Dr. E.T. was to know that G.S.'s urine output was low without Respondent alerting him, K.C. advised that Respondent did not have good answers as to why Respondent did not notify Dr. E.T. Finally, K.C. advised that she reviewed Respondent's charts for G.S. and found that Respondent had not documented much on them.

19. On or about July 31, 2008 in an interview with Investigator Jacobs, Dr. A.D. advised that G.S. went through very unnecessary surgery and the outcome could have been worse.

Charges

20. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

    a. 3 V.S.A. § 129a(b)(1) and (2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and

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

Understandings

21. Respondent admits the facts above are true.

22. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.

23. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced his rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.

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

25. Respondent is not under the influence of any drugs or alcohol at the time he signs this Stipulation and Consent Order.

26. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.

27. Respondent voluntarily waives his right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.

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

ORDER

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

A. The Board of Nursing hereby **CONDITIONS** Respondent's license to practice registered nursing for a **MINIMUM PERIOD OF ONE (1) YEAR from the date of entry below.** The conditions are as follows:

(1) Re-issue of License.

Upon the imposition of these conditions, Respondent shall be issued a license 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 **one (1) year** of supervised nursing practice in which he 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. The Respondent shall be prohibited from working more than forty (40) hours per week during the conditioned period.

(3) Comprehensive Assessment Course(s).

Respondent must successfully complete (i.e., receive a passing grade, if applicable) an assessment course or courses focusing on collecting, interpreting, and documenting data, and notification of that data, with prior approval by the Board or its designee, and then submit written documentation of completion (certificate of completion, etc.) to verify the same to the satisfaction of the Board or its designee. This course must be completed within ninety (90) days of the date of entry of this Stipulation and Consent Order.

(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 that involves actual patient care, Respondent 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 the ability of the program to comply with its conditions during clinical experience.

(5) Reports from Employers/Program Director.

Within one (1) month of the date of entry of this Order and **monthly** thereafter, 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 time period. This report shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance and attendance.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of his 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. All nursing program reports shall indicate satisfactory performance and attendance.

(6) Practice Under Supervision.

Respondent shall practice nursing only in a setting where Respondent has direct supervision for the entire shift by a registered nurse that is licensed and in good standing with the Board.

(7) Types of Employment Prohibited.

Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency, or as a private duty nurse or personal care provider during the effective period of this Consent Order.

(8) Out-of-State Practice.

Before any out-of-state practice can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board prior to Respondent practicing nursing outside the State of Vermont. If Respondent fails to receive such approval before practicing nursing outside the State of Vermont, none of the time spent practicing nursing out-of-state will be credited toward the fulfillment of the terms and conditions of this Consent Order. The Board will approve out-of-state nursing practice so long as the Respondent can still comply with the provisions of this Consent Order

(9) Notification of Place of Employment/ Personal Address/Telephone Number.

Within five (5) days of the date of entry of this Order, Respondent shall notify the Board, in writing, of his 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 employment, personal address, or telephone number.

(10) Notification to Other States.

In the event that the Respondent is licensed in nursing in any other state(s), he must inform the nursing licensing board of the state(s) in which the Respondent is licensed of the conditional status of his Vermont nursing 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.

(11) 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.

(12) Costs.
The Respondent shall bear all costs of complying with this Consent Order.

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

(14) Completion of Conditional License Period.
After the conditional license period, the Respondent may petition the Board to remove any and all conditions on his license. The Respondent must present proof that he has fully complied with the terms of this Order.

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

C. 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).

D. 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:

Dated: 4/6/09

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

CLIFFORD D. PEEBLES
RESPONDENT

Dated: 4/6/2009

By: _____
Clifford D. Peebles

APPROVED AS TO FORM:

Dated: 4/6/09

ATTORNEY FOR RESPONDENT

By: _____
John L. Pacht, Esq.

APPROVED AND SO ORDERED:

Dated: 4.29.09

VERMONT BOARD OF NURSING

By: _____
Chairperson

Date of Entry: 5/1/09

nu.peebles.stip

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

IN RE:	)	
CLIFFORD D. PEEBLES	)	**Docket No. NU84-0308**
License No. 026-0030619	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Clifford D. Peebles, RN:

Board Authority

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

Statement of Facts

2. Clifford D. Peebles (the "Respondent") of St. Albans, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026-0030619. This license was originally issued on or about February 10, 2005 and is currently set to expire March 31, 2009.

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5. According to G.S.'s flow sheets during the early morning hours of March 18, 2008, G.S.'s urine output was forty (40) at midnight; ten (10) at 1:00 a.m.; ten (10) at 2:00 a.m.; and fifteen (15) at 3:00 a.m. During this time, G.S.'s systolic blood pressure

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was ninety-one (91) at midnight; eighty-seven (87) at 1:00 a.m.; seventy-three (73) at 2:00 a.m.; and not documented at 3:00 a.m.

6. Respondent never called the House Officer, Dr. E.T., to tell him that G.S's urine output and systolic blood pressure were below acceptable limits as he was directed to by G.S.'s post-operation orders.

7. Moreover, on or about March 18, 2008 at approximately 1:40 a.m., and again at approximately 3:30 a.m., Dr. E.T. came to G.S.'s room to check on G.S. Even when Dr. E.T. was physically present at these times, Respondent did not alert Dr. E.T. that G.S.'s urine output and systolic blood pressure were below acceptable limits.

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9. In these same notes, M.R. reported that K.C. informed M.R. that Respondent was on the internet at times, which was corroborated by another registered nurse, M.A. Moreover, K.C. also reported to M.R. that Respondent's notes on G.S. were minimal, and there were multiple areas on the flowsheet that were blank. Furthermore, K.C. reported that K.C. also looked at the flow sheets of Respondent's other patient he was assigned to care for on this date, and noted that Respondent had minimal documentation on this patient as well, including no documentation of this patient's respiratory rate.

10. Finally, M.R. reported that K.C. subsequently advised M.R. that G.S.'s transplanted pancreas was "gone" and there was a huge clot going up into the Inferior Vena Cava which was then scraped out. K.C. also advised that Dr. A.D. stated that the patient could possibly throw a clot (pulmonary embolus) and die, and that Dr. A.D. had also stated to Respondent that he didn't know how to explain this situation to G.S.'s family. K.C. reported to M.R. that Respondent kept saying he "was sorry, but didn't know why he didn't report the signs of shock."

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12. On or about March 18, 2008 in an interview of Respondent in which M.R.; T.M., an Administrative Nurse Coordinator; and K.Q., a union steward were present, Respondent stated that he mistakenly thought that Dr. E.T. had seen the low urine output when Dr. E.T. came to write G.S. an order for medication at 1:40 a.m. on that date. Respondent also stated that he should have reported G.S.'s low urine output and blood pressure to Dr. E.T. During this interview, M.R. discussed that Respondent did

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not utilize the help offered to him by his coworkers, and that Respondent was using the internet during his shift. According to the meeting notes, Respondent did not address why he declined help, but admitted to using the internet for about thirty (30) minutes.

13. On or about March 18, 2008 in an email to M.R. and K.C., Respondent admitted that he erred in not calling the House Officer regarding G.S.'s low urine output.

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16. On or about June 18, 2008 in an interview with State Investigator Mark Jacobs, Respondent stated that during the early morning hours in question, Respondent did not think the patient was that sick and he underestimated the importance of the urine output. Respondent explained that he thought the issue for him that night was that he had a hard time focusing on his duties and he did not follow the written orders critically enough.

17. On or about July 17, 2008 in an interview with Investigator Jacobs, Charge Nurse K.C. stated that after G.S. came to the ICU, K.C. and other nursing staff asked Respondent several times whether Respondent needed any assistance, but that Respondent denied the assistance. Furthermore, K.C. advised that on or about March 18, 2008 at approximately 4:00 a.m., she heard a lot of commotion and discovered that G.S. was being prepared for surgery and that at this time, Respondent informed K.C. that G.S.'s urine output was low. Moreover, K.C. stated that after G.S. had gone back to the operating room, K.C. asked Respondent why he did not call the House Officer when Respondent realized the urine output was low. K.C. advised that Respondent stated that he thought the House Officer, Dr. E.T., was aware of the low urine output. However, K.C. advised that when K.C. asked Respondent how Dr. E.T. was to know that G.S.'s urine output was low without Respondent alerting him, K.C. advised that Respondent did not have good answers as to why Respondent did not notify Dr. E.T. Finally, K.C. advised that she reviewed Respondent's charts for G.S. and found that Respondent had not documented much on them.

18. On or about July 31, 2008 in an interview with Investigator Jacobs, Dr. A.D. advised that G.S. went through very unnecessary surgery and the outcome could have been worse.

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Charges

19. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

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

b. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud, or harm the public) which includes performing duties and assuming responsibilities within the scope of the definitions of nursing practice, 26 V.S.A. § 1572(2) and (3), when competence has not been achieved or maintained;

c. 3 V.S.A. § 129a(b)(1) and (2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and

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

Relief Requested

WHEREFORE, the license of Clifford D. Peebles should be revoked, suspended, reprimanded, conditioned, or otherwise disciplined.

DATED at Montpelier, Vermont this 3rd day of December, 2008.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

nu.peebles.soc

STATE OF VERMONT

Prosecuting Attorney
Office of
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