VERMONT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

In re	Diane Pierce	}
License No.	025-0008131	}
Docket No.	NU86-0606	}

FINDINGS OF FACT
CONCLUSIONS OF LAW & ORDER

Introduction:

On Monday 5 November 2007, the Board of Nursing heard this contested case of alleged unprofessional conduct brought by the State of Vermont against Respondent Diane Pierce. Board members Kenneth W. Bush, Susan O. Farrell (Chairperson)[1], Ellen W. Leff, Donarae Metcalf, Sandra J. Norton, Linda M. Y. Rice, Alan H. Weiss and DeAnn Welch participated in the hearing of this matter, the deliberation over the evidentiary and legal questions raised at the hearing and the consideration of this order. The Respondent appeared with counsel Peter Joslin. Edward G. Adrian represented the State of Vermont. Board counsel Kevin F. Leahy presided.

The State brought a specification of charges (the "Charges"), for unprofessional conduct, dated 25 May 2007 against the Respondent alleging the Respondent did not administer medications correctly. The Respondent worked at Franklin County Rehabilitation Center in St. Albans, Vermont (the "Facility") at the time of the alleged incidents.

Testifying before the Board in addition to the Respondent were Laura Barrett, nursing director at the Facility during the operative period; Patricia Ede, nurse educator at the Facility; Ida Alford (by telephone), former nurse at the Facility; Carla Quilliam (by telephone), Respondent's employer; and Laura Barrette who previously employed the Respondent at the Facility. The Board also admitted into evidence the deposition testimony of Frances Kelly, taken on 5 November 2007. Ms. Kelley worked at the Facility during the operative period and currently works at the Porter Health and Rehabilitation Center in Middlebury, Vermont.

Findings of Fact &
Conclusions of Law:

1. Respondent holds a State of Vermont registered nursing license.

2. This Board licenses the Respondent and may exercise disciplinary authority for alleged acts of licensee unprofessional conduct. 26 V.S.A. Chapter 28; 3 V.S.A. § 129(a); Admin. Rules for the Bd. of Nursing and the Admin. Rules for the Office of Prof. Regulation.

[1] Susan Farrell's term expired at the end of 2007. She participated in the deliberation of this matter and the consideration of this order.

129(a); Admin. Rules for the Bd. of Nursing and the Admin. Rules for the Office of Prof. Regulation.

3. In a disciplinary hearing, the State has the burden of proof. To satisfy its evidentiary burden before this Board, the State must "show by a preponderance of the evidence that [a licensee] has engaged in unprofessional conduct." 3 V.S.A. § 129a (c).

4. The basis of the State's case against the Respondent is allegations that she charted patients' medications on the Medication Administration Record ("MAR") "prior to the medication pass." *See* Charges at ¶5(a).

5. The State further alleges that the Respondent "was observed signing out [patient's] medications prior to administering them." *See* Charges at ¶5(b).

6. The State's position is that the Respondent's practice of charting patient's medications on the MAR prior to administration -- as charged in ¶¶ 5(a) and (b) -- constitutes a "failure to conform to the essential standards of acceptable and prevailing [nursing] practice" in violation of 3 V.S.A. §129a (b)(2).[2]

7. The State's position is that the essential standard of acceptable and prevailing [nursing] practice applicable to this situation would have required that the Respondent chart medications on the MAR contemporaneously with the medication administration to the patient. The State further takes the position that it is a violation of essential standards to sign off medications on the MAR prior to the actual administration of the medication.

8. In testimony before the Board, the Respondent acknowledged that she would document administration of a patient's medication on the MAR before giving the medication to a patient. The Respondent also acknowledged that, if the patient did not take a medication after she had signed off the medication on the MAR, she would subsequently circle the particular medication on the MAR to indicate that the patient, for whatever reason, did not take or receive the particular medication.

9. The State's position, as explained to the Board, is that the Respondent violated standards commonly followed by nurses in Vermont and that these violations constitute unprofessional conduct.

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[2] The State originally included a charge against the Respondent for failure to comply with laws governing the practice of the profession in violation of 3 V.S.A. § 129a(a)(3). In its statement of facts, however, the State did not allege that the Respondent failed to comply with any state or federal law(s) governing nursing practice, which would serve as the basis for an unprofessional conduct charge under §129a (a)(3). The State's charging document also referenced a violation of 26 V.S.A. § 1582(a)(3) by charging that the Respondent is "unable to practice the [nursing] profession . . ." At the hearing, the State did not argue the Respondent is unable to practice the profession nor did the Board receive any evidence suggesting that the Respondent could not practice the profession. There is therefore no need to address the charges of violating 3 V.S.A. § 129a (a)(3) and 26 V.S.A. § 1582(a)(3) other than to dismiss them.

10. Although the State does not contend the Respondent ever gave an incorrect medication or dosage to a patient, it is the State's position that the manner of medication administration ignored essential standards of acceptable and prevailing nursing practice.

11. The Respondent denies the factual allegations set forth in the Specification of Charges; and to the extent she admits certain facts, Respondent contends that her conduct does not constitute unprofessional conduct.

12. Respondent argues that she administered medicine pursuant to facility policy and that the facility policy was consistent with acceptable and prevailing practice.

13. It was the Respondent's testimony that, after initially checking the MAR, she would (1) then document the administration of the medication on the MAR, and (2) after documenting the medication administration on the MAR, Respondent would then administer the medication to the patient.

14. The Respondent acknowledged through her testimony that, although she first checked the MAR prior to administering patients' medication, she did not wait until administering the medication to the patient before documenting it on the MAR.

15. In light of the State's Charges that allege charting medications on the MAR prior to giving them (Charges at ¶5(a)) and signing off medications "prior to administering them" (Charges at ¶5(b)), the Board must determine the following evidentiary questions and decide the following legal questions:

(a) Does the Board find evidence that proves the State's factual allegations?

(b) What is the "essential standard of acceptable and prevailing nursing practice," as proved by the State, which is applicable to Respondent as an LPN in this particular clinical setting?

(c) Did the Respondent's patient care violate the "essential standard of acceptable and prevailing nursing practice" as demonstrated by the evidence?

(d) Finally, if the State proved that the Respondent violated the "essential standard of acceptable and prevailing nursing practice" in the circumstances of this case and as alleged in the Charges, the Board must look to the overall circumstances to determine if the violation rises to the level of unprofessional conduct? 3 V.S.A. §129a (b)(2) ("failure to practice competently . . . *may constitute* unprofessional conduct")(emphasis added).

In light of questions (a)-(d), the Board finds as follows:

16. First, the State meets its evidentiary burden of proof since the Respondent acknowledged that she documented the medications in the MAR before giving them to patients

17. Although she testified that her practice was consistent with what she understood to be prevailing practice and Facility policy, Respondent testified as follows:

> Q. "You shared with us that you signed out the medications as administered as you were pouring them. Is this what you were taught as part of your basic educational program?
>
> A. It is the way I was oriented at the facility. . . I was told you may sign the[medications] out before [the residents] take them because if they do not take the medications you circle[, on the MAR, the medication the resident did not take].
>
> Q "Did that [documenting the MAR prior to administration] go against what you were taught in your nursing program?"
>
> A. "It did not seem to because the medications [written in the MAR] were circled if they were not taken."
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> Hearing Record Disk 1 at 45:45 (Responses to question from Board Chair Susan Farrell).

18. Respondent thus acknowledged documenting medication administration in the MAR prior to the patient receiving it as alleged by the State.

19. The State presented evidence regarding medication documentation and administration via the testimony of Facility nurses including Patricia Ede, RN. Ms. Ede is the Facility's nurse educator, and she described the expectations for documenting the administration of medication.

20. The evidence presented to the Board proves that it is an essential requirement of acceptable and prevailing nursing practice for nurses (1) to administer medications after reviewing the MAR and (2) documenting the medication's administration on the MAR contemporaneously or immediately subsequent to administration.

21. The State's evidence therefore proves that documenting medications on a patient's MAR prior to administering the medication as alleged by the State in its Charges at ¶¶ 5(a) and 5(b) violates essential standards of acceptable and prevailing practice.

22. Based on the witnesses' testimony, the Board finds that charting medications on the MAR as given prior to administering the medication fails to conform to the essential standards of acceptable and prevailing nursing practice.

23. The Board finds that the Respondent violated this essential standard of acceptable and prevailing practice, and the Board further finds that this constitutes unprofessional conduct in violation of 3 V.S.A. §129a (b)(2).

24. Finally, in light of the finding of unprofessional conduct, the Board shall condition the Respondent's license as part of this order.

ORDER

Based on the factual findings and conclusions of law set forth above, the Board of Nursing ORDERS that the Respondent's license be CONDITIONED for a period of SIX (6) MONTHS, and

The Board further ORDERS that the conditions shall be as follows:

(a) The Respondent's license shall be conditioned for a period of six months.

(b) During the first three months of the conditioned period, the Respondent shall have direct supervision by a registered nurse in good standing during any medication administration. Direct supervision means a registered nurse must be present on the unit during any medication pass.

(c) For the remainder of the conditioned period, the Respondent must have periodic inspection of medication passes by an RN. Inspections shall be no less than twice a month.

(d) Respondent shall have her employer submit monthly employer reports on forms provided by the Board.

(e) The Respondent shall successfully complete a medication administration course approved by the Board of its designee within three months of the entry of this order.

Upon completion of the above conditions, the Respondent's license shall be reissued without conditions.

- END -

(signature page to follow)

Vermont Board of Nursing:

By: Linda Rice Date: 5-15-08
Linda M. Y. Rice, APRN
Board Chairperson

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 5/20/08

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 the decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Secretary of State's Office, National Life Building, FL2, 1 National Life Drive, Montpelier, Vermont 05602-3402 within 30 days of the entry of the order.

For more information about the procedure for filing an appeal, please see the Administrative Rules for the Office of Professional Regulation, which you can find at: http://www.vtprofessionals.org/opr1/opr/admnrule.pdf and the Rules are also available at the Office of Professional Regulation.

If you file an appeal, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The appellate officer will review the record (the tape recording, exhibits etc.) created before the board during the hearing of your case. In cases of alleged irregularities in procedure before the board, not shown in the record, proof related to that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a.