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

IN RE:	)	
AUDRA J. PITTS	)	
License No. 026.0033373	)	**Docket No. 2014-623 (RN)**
	)	

FINDINGS OF FACT CONCLUSIONS OF LAW AND ORDER

Participating Board Members:
Jeanine Carr, RN, Chair
Ellen Watson, APRN
William G. White, Jr., Public Member
Jennifer Laurent, APRN
Virginia Hudson, RN
Donarae Metcalf, LPN (ad hoc)
Michael Doyle, Public Member (ad hoc)
Ann Marchewka, RN (ad hoc)

Appearances:
Prosecuting the case: Elizabeth A. Jarvis, Esq.
Respondent: *pro se*

Presiding Officer:
George K. Belcher

Exhibits Admitted:
State Ex. 1: Nurses Notes of 9/15/14-9/19/14, Patient J.S.
State Ex. 2: Stipulation and Consent Order entered 11/9/10 with attachments A, B, and C
State Ex. 3: Default Order and Charges entered 2/12/03
State Ex. 4: Medication Record, September, 2014 for Patient J.S.

This matter was considered by the Vermont Board of Nursing on January 11, 2016. The Respondent, Audra J. Pitts, was present and represented herself. The State was represented by Elizabeth A. Jarvis, Esq. Evidence was taken. Upon the evidence and the arguments of the parties, the Board makes the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Vermont Board of Nursing has jurisdiction pursuant to 3 VSA Secs. 129 and 129a, 26 VSA Ch. 28, the Administrative Rules of the Vermont Board of Nursing, and the Administrative Rules of the Office of Professional Regulation.
2. The State filed charges against the Respondent, alleging that the Respondent is unable to practice nursing competently, failed to practice competently, and failed to comply with state or federal law.
3. The Respondent is a licensed Registered Nurse who holds license number 026.0033373. She was licensed and working as a Registered Nurse at the Green Mountain Nursing home in Colchester, Vermont on September 18 and 19, 2014.
4. The Respondent has also been licensed in the past in Vermont as a Licensed Nursing Assistant under the name of Audra Maly under license number 075-0004918 which was issued on June 17, 1994 and which expired on January 31, 2003.
5. The Respondent received her Registered Nurse License on or about June 28, 2006 and the license is set to expire in March of 2017.
6. On September 18 and 19, 2014 the Respondent was a supervising nurse at a nursing home in which Patient J.S. was a patient. The Respondent was scheduled to work the 11:00 PM to 7:00 AM shift. For personal reasons she left the nursing home at about 5:00 AM on September 19, 2014.
7. At about 3:00 AM, Licensed Nursing Assistant K.L. came on shift. K.L. had experience working in a hospice facility. She checked on patient J.S. at about 3:00 AM. There she discovered that the patient was not comfortable, was feverish, was actively dying, was in pain, was having labored breathing and, in her opinion, needed medication. Patient J.S. was unable to communicate. K.L. then spoke to some of the other LNA staff and asked about patient J.S. K.L. was told that the Respondent had been advised earlier about the condition of patient J.S. but had not checked on him.
8. K.L. went into "crisis mode" because she thought that the patient had not been checked upon recently. She went to get the supervising nurse who could administer medication to J.S. She found the Respondent sitting at the nurses' station facing the wall. She tried to call the Respondent several times but got no response. She clapped her hands and was then able to get the attention of the Respondent. The Respondent then went to the room of patient J.S. and found that he was having rapid breathing (indicating distress). The Respondent then administered a dose of morphine.
9. The Respondent testified that she checked on patient J.S. frequently, at least every hour. She recalled that he was prescribed morphine about every two hours. The Respondent stated in her answer that she was "informed of his [patient J.S.] distress symptoms at 2:45 am only" and that she "did in fact assess this resident every hour and not always with the LNA…" (See Respondent's answer). She also

stated in her answer that patient J.S. "had been on comfort care for at least a week where each night he had black residue in his mouth" (See Respondent's answer).

10. The Nurse's Notes for patient J.S. (State Ex. 1) show no entries by the Respondent whatsoever during her shift of September 18 and 19, 2014. The last entry on September 18, 2014 is at 9:00 PM by another nurse and the first entry on September 19, 2014 is at 5:20 AM, by another nurse. There is no documentation in the Nurse's Notes of the Respondent assessing the patient, the status of the patient during the shift, the patient's labored breathing, or of her administration of the medication at 3:00 AM.
11. The Nurse's Notes do indicate that Nurse RS asked the physician about a "comfort care" order at 11:30 AM on September 18, 2014 and that the "comfort care orders" were received at 2:55 PM on September 18, 2014 (not a week before as stated by the Respondent).
12. There is nothing in the Nurse's Notes about a black residue in the mouth of the patient from September 15, 2014 through September 18, 2014. There is a note by another nurse on September 19, 2014 at 5:20 AM stating that the patient was noted to have "some blood in mouth of unknown origin". State Ex. 1.
13. The Medication Record (State Ex. 4) does appear to show that the patient was administered a 5 mg dose of morphine on September 19, 2014 at "0300".[1]
14. The Nurse's Notes show that the patient J.S. was given a 5 mg dose of morphine at 9:00 PM on September 18, 2014 (before the Respondent came on shift) (State Ex. 1). Following the shift of the Respondent the patient was given doses of morphine at 5:15 AM, 6:35 AM, 8:00 AM, 9:00 AM and 10:05 AM. (State Ex. 4). The patient died at 10:36 AM on September 19, 2014.
15. The essential standards of acceptable and prevailing practice require frequent monitoring for patients who are on "comfort care" orders due to their instability or inability to ask for help or to express their needs.
16. The standard of care for documentation by a registered nurse, according to the Respondent, is that every action of the nurse should be documented including patient assessments, specific nursing procedures, and medication administration.
17. The Respondent admitted several times during the hearing that her documentation was poor. She once stated that her documentation and charting was "almost non-existent".
18. The Respondent stated to the investigator and to the Board that she did not immediately respond to LNA KL because she was "hard of hearing." The Respondent did not further explain the nature of her hearing problem, the degree of a hearing problem, whether she had been diagnosed or treated for a hearing impairment, or whether she was prescribed or used hearing aids.
19. One of the complaining Licensed Nursing Assistants, CE, told both the investigator and LNA KL, that she had informed the Respondent three times that the patient was in distress but that the Respondent had not taken action. The Respondent answered this allegation, in part, by stating that she had found CE sleeping during the shift in question, and therefore CE could not have known

[1] The Respondent testified that the entry in the Medication Administration Record showing the administration of morphine on September 19, 2014 at 3:00 AM was not made in her handwriting. (See Ex. 4, Page 2)

whether the Respondent checked on the patient or not. The Respondent admitted that she did not make a complaint to the nursing home administrator, or anyone else, about her finding CE sleeping during this shift.

20. Given the overall lack of nursing note charting by the Respondent, her inconsistent testimony, and her failure to adequately explain the evidence presented against her, the Board finds that the testimony of the Respondent was not credible.
21. The Respondent has a record of unprofessional conduct as both a registered nurse and as a licensed nursing assistant. By Default Order of June 25, 1997 the Board found that the Respondent had documented patient visits that she did not make and documented providing patient care that she did not provide. (State Ex. 2, Attachments A and B). By Board findings on January 24, 2003 it was determined that the Respondent had practiced incompetently and provided unacceptable patient care when a patient fell off a toilet while being assisted by the Respondent in March of 2002. The patient suffered a large contusion and laceration. (See State Ex. 2, Attachment C). By Default Order dated February 24, 2003 the Board found that the Respondent had intentionally placed a call bell out of the reach of a patient. (State Ex. 3). By Order entered on November 9, 2010, Board found that the Respondent, as a Director of Nursing, had allowed seven Licensed Nursing Assistants to work for a period of time while their licenses had lapsed. The underlying incident occurred in December of 2008. (State Ex. 2).
22. After considering the disciplinary history of the Respondent with the Board and the current facts as established, the Board finds that the Respondent has a pattern of unacceptable nursing practice and a pattern of inability to comply with basic nursing rules which are applicable to her licensed profession.

Discussion and Conclusions of Law

23. The burden of proof in a disciplinary matter is upon the State to show by a preponderance of the evidence that the Respondent engaged in unprofessional conduct. 3 VSA Sec. 129a(c).
24. It is the basic obligation of a registered nurse to practice nursing at the level of licensure required by the Board of Nursing Rules. See Board of Nursing Rule 14.2. Competent nursing requires performance of nursing functions skillfully and proficiently while demonstrating the interrelationship of essential knowledge, judgment and skills. See Board of Nursing Rule 2.5. Registered Nursing includes assessing the health status of patients, establishing a nursing diagnosis, implementing a strategy of care, managing and supervision the practice of nursing, and addressing patient pain. See generally 26 VSA Sec. 1572(2).
25. In several past cases the Board has found that inadequate charting to be unprofessional conduct. See In re Jessica Lennon, NU 37-1203 dated December 24, 2004 (failure to document conditions of patient or the results of a procedure), and In re Christopher Paul Marianne, NU 75-0404 dated February 25, 2005.
26. Because of the absence of any notation in the medical chart of patient J.S. that assessments were regularly performed or the results of those assessments, there is

strong evidence that the assessments were not done as testified by the Respondent.

27. The Board has considered the evidence and the arguments presented. The Board concludes that the Respondent committed unprofessional conduct by failure to practice competently during the shift of September 18-19, 2014, and that she performed unsafe and unacceptable patient care. Also she failed to conform to the essential standards of acceptable practice. 3 VSA Sec. 129a(b)(1) and (2). The Board also concludes that the Respondent appears to be unable to practice nursing competently given her history of unprofessional conduct. 26 VSA Sec. 1582(a)(3). The Board further concludes that the Respondent failed to comply with the provisions of the State of Vermont nursing statute and rules and therefore violated 3 VSA Sec. 129a(a)(3).
28. The Board considered the multiple, previous findings of unprofessional conduct and concluded that a pattern of professional misconduct has been shown. The Board contemplated whether the public could be reasonably be protected by a license suspension or conditions including supervision. The Board reluctantly concluded that no conditional disciplinary actions upon the license of the Respondent would adequately protect the public given the nature of this breach of professional standards, the Respondent's prior discipline cases and the facts shown in those cases. Accordingly, the Board determines that the nursing license of the Respondent should be REVOKED.

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

The license of AUDRA J. PITTS as a registered nurse is hereby **REVOKED**.

SO ORDERED.

Vermont Board of Nursing

Jeanine Carr

Jeanine Carr, Chair

1/11/16

Date

1/15/16

Date of Entry

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, 89 Main Street, Fl. 3, Montpelier, VT 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.