VERMONT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

In re	Darlene J. Reid	}
License No.	02-0029281	}
Docket No.	NU 40-1106	}

FINDINGS OF FACT
CONCLUSIONS OF LAW & ORDER

On Monday 13 October 2008, the Vermont Board of Nursing (Board) heard this contested case of alleged unprofessional conduct. The State of Vermont brought a Specification of Charges (the "Charges") dated 29 April 2008 against Respondent Darlene Reid.

Board members Jeanine Carr, Donarae Metcalf, Sandra J. Norton, Linda M. Y. Rice (Chairperson), Deborah Robinson, Alan H. Weiss and William White were present and participated in the hearing. Board member Kenneth Bush recused himself from the proceedings.

The Respondent appeared on her own behalf. Edward G. Adrian represented the State of Vermont. Board counsel Kevin F. Leahy presided.

Summary:

This matter arises out of allegations of unprofessional conduct related to Respondent's employment at the Vermont Veteran's Home located in Bennington, Vermont (the "Facility") November 2006.

After a review of the full evidentiary record in this matter, the Board found that Respondent engaged in unprofessional conduct. The Board determined that the Respondent violated 3 V.S.A. §129a (b).

The Board found that the record did not support three of the State's charges and it therefore dismissed charges of violating 3 V.S.A. § 129a(a)(3) (violating laws governing nursing); 26 V.S.A. § 1582(a)(3) (licensee not competent to practice nursing); and 26 V.S.A. § 1582 (a)(7) (fraud or deception against the public).

In light of the Board's findings of fact and conclusions of law, it voted to give the Respondent a warning.

Findings of Fact &
Conclusions of Law:

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

2. The Board licenses the Respondent and may exercise its disciplinary authority if the Board finds that the State has proven allegations of licensee unprofessional conduct. 26 V.S.A. Chapter 28; 3 V.S.A. § 129(a); the Admin. Rules for the Bd. of Nursing and the Admin. Rules for the Office of Prof. Reg.

3. The Respondent admits a substantial amount of the factual allegations set forth in the Specification of Charges filed by the State of Vermont although she did deny certain key allegations, which the parties addressed at the hearing.

4. The State's Charges make two factual allegations of unprofessional conduct against the Respondent:

(a) On 2 November 2006, Respondent offered a patient at the Vermont Veteran's Home in Bennington, Vermont (the "Facility") either Tylenol or Vicodin for leg pain. The Respondent did not check Patient M's leg visually, utilize the pain assessment tool or adequately chart the request and follow-up.

(b) On 2 November 2006, Respondent was advised by an LNA at the Facility that the same patient requested his PRN cough syrup with codeine. Upon learning of the patient's request, the Respondent did not complete an assessment or chart a cough.

See Charges at ¶¶ 4-5.

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

6. The Board must therefore decide whether the State met its evidentiary burden at the hearing. If so, the Board must decide whether the facts determined by the evidence received at the hearing demonstrate a violation of the unprofessional conduct statutes governing the Respondent's license.

7. The State brings four (4) separate statutory charges of unprofessional conduct. The State argues that the allegations constitute violations by the Respondent of:

(i) 26 V.S.A. § 1582(a)(3) (unable to practice nursing competently by reason of any cause);

(ii) 3 V.S.A. § 129a(b) failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct. Failure to practice competently includes provision of inadequate patient care . . . or failure to conform to the essential standards of acceptable and prevailing practice.)

(iii) 3 V.S.A. § 129a(a)(3) (failure to comply with state or federal laws governing nursing practice); and

(iv) 26 V.S.A. § 1582(a)(7) (engages in conduct likely to harm the public).

Charges at ¶7 (i) - (iv).

8. The Board will dismiss the charges at ¶7(i), (iii) & (iv). The State's evidence did not suggest that the Respondent was not competent to practice. 26 V.S.A. §1582(a)(3). It did not she suggest that she practiced in a manner that would likely harm the public. 26 V.S.A. §1582(a).

9. The Charges of allegedly violating 3 V.S.A. § 129a (a)(3) will also be dismissed for failure of the factual allegations to identify a state or federal law governing nursing practice that the Respondent allegedly violated.

10. The evidence presented to the Board demonstrated related to two separate patient interactions and the Board makes the following findings:

11. First, relative to the first medication pass, the Respondent testified and the evidence showed that the patient referenced in the Charges was upset because Respondent would not give him both acetaminophen (Tylenol) tablets and Vicodin tablets, which also contains acetaminophen.

12. The Respondent knew that the patient had a chronic pain condition and confirmed that both medications were prescribed, as needed, for the patient. The Respondent also confirmed that the medications were not prescribed to be dispensed together.

13. The Respondent explained this to the patient and explained the difference between the two medications. The patient accepted the Respondent's explanation, chose one of the medications and did not have further pain complaints during Respondent's shift.

14. The Board received no evidence indicating that Respondent handled this patient interaction unprofessionally.

15. Second, the Board next looks to the evidence relative to the evening patient interaction, of the same day, involving the same patient's request for codeine cough syrup.

16. The evidence demonstrated that the Respondent based her decision not to dispense the medication on statements made by and LNA and a determination that she had not heard the patient coughing while she was completing the evening medication pass.

17. The State alleges that the Respondent "did not chart a cough" and did not assess the patient when he asked for his PRN codeine cough medication following the evening medication pass.

18. The evidence demonstrated that neither the Respondent nor any of the other nursing or health care personnel working the evening shift of 2 November heard the patient cough. It thus stands to reason that the Respondent did not chart a cough.

19. Respondent testified that she asked another nurse and a licensed nursing assistant

if anyone had heard the patient cough and no one had. The Respondent had been in the patient's room earlier when her medication pass began and the patient was not coughing.

20. Upon hearing of the patient's request for cough syrup later on in the evening's medication pass, the Respondent asked the nursing assistant who informed her of the patient's request whether she had heard the patient cough. The LNA indicated not hearing a cough.

21. There is no indication that the patient received inadequate care from the Respondent. However, based on the lack of an adequate patient assessment by the Respondent, there is no indication that the Respondent had enough information to determine whether the patient should have received the codeine cough syrup.

22. Had the Respondent returned to the patient's room when informed of the request for cough medicine and made an adequate assessment, her decision to refuse the patient his PRN codeine cough syrup may have been defensible.

23. Instead, the evidence showed that the Respondent did not adequately assess the patient prior to determining whether to refuse his request for PRN codeine cough syrup.

24. The issue for the Board is therefore whether the facts constitute a violation of 3 V.S.A. §129a (b) (unacceptable patient care or failure to conform to the essential standards of acceptable and prevailing practice on one or more occasions may be unprofessional conduct.)

25. The Board finds that the State's evidence demonstrated that essential standards of acceptable and prevailing practice required a more complete assessment under the circumstances presented.

26. The Board finds that, under the facts of this case, the lack of a more adequate assessment constitutes unprofessional conduct.

ORDER

Based on the findings of fact and conclusions of law set forth above, the Board of Nursing issues a WARNING to the Respondent.

- END -

(signature page to follow)

Vermont Board of Nursing:

By: Linda Rice APRN Date: 3-18-09
Linda M. Y. Rice, APRN
Board Chairperson

OFFICE OF PROFESSIONAL REGULATION
DATE OF ENTRY: 3/23/09

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.

- END -

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

IN RE: **DARLENE J. REID** **License No. 026-0029281**	)))	**Docket No: NU40-1106**

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Darlene J. Reid, R.N.:

Board Authority

1. The Vermont State Board of Nursing ("the Board") has authority to issue warnings or reprimands, suspend, revoke, limit, 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 ("ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. The Respondent, Darlene J. Reid, is licensed in the State of Vermont as a registered nurse under license number 026-0029281. This license was originally issued on or about March 11, 2004 and is currently set to expire on March 31, 2009.

3. At all times relevant, the Respondent was employed as a registered nurse at the Vermont Veteran's Home located in Bennington, Vermont.

4. On or about November 2, 2006 the Respondent offered patient W.M. either Tylenol or Vicodin for leg pain. The Respondent did not check W.M.'s leg visually, utilize the pain assessment tool or adequately chart the request and follow-up.

5. On or about November 2, 2006 the Respondent was advised by LNA W.B. that patient W.M. was in need of his PRN cough syrup. Respondent did not do an assessment or chart the cough. The Respondent told LNA W.B. that another nurse had just been down there and had not heard him coughing and to tell W.M. to "suck on a cough drop."

6. When interviewed on October 23, 2007, the Respondent indicated that she believed that W.B. had been over-medicated and complained because he was accustomed to receiving the medications that he requested, rather then following the prescribing physician's orders.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
9 Baldwin Street
Montpelier, VT
05609-1107

Charges

7. The acts, omissions and/or circumstances described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

i. 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes performing unsafe or unacceptable patient care and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Rule IV(II)(B)(1) and (2);
ii. 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. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice);
iii. 3 V.S.A. §129a(a)(3) (failing to comply with the provisions of state statutes or rules governing the practice of the profession); and
iv. 26 V.S.A. § 1582(a)(7)(engages in conduct of a character likely to deceive, defraud or harm the public.

Relief Requested

WHEREFORE, the license of Darlene J. Reid should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

DATED at Montpelier, Vermont this 29th day of April, 2008.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

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STATE OF VERMONT

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