VERMONT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

In re:	Melanie Sartwell	}	
License No.	025-0008209	}	Docket No. NU 61-0405

FINDINGS OF FACT
CONCLUSIONS OF LAW & ORDER

Introduction:

On Monday 9 October 2006 the Board heard this contested case of alleged unprofessional conduct brought against Respondent Melanie Sartwell. Board members Kenneth W. Bush, Sandra Norton, Laurey M. Tyo, DeAnn Welch and Alan Weiss participated in the hearing of this matter. Board member Linda Rice recused herself. The Respondent appeared with counsel Beth Danon. Edward G. Adrian represented the State of Vermont. Board counsel Kevin F. Leahy presided.

The State brought a specification of charges (the "Charges" attached) against Ms. Sartwell (the "Respondent") alleging unprofessional conduct for administering two over the counter and one prescription medication to a patient without a physician's orders on 12 March 2005. The Respondent worked at Northwest State Correctional Facility (the "Facility") located in St. Albans, Vermont at the time of the March 2005 incident (the "incident"). As a prison nurse, she was employed originally by Correction Medical Services (CMS) beginning in the fall of 2003. CMS's prison healthcare contract was assumed by Prison Health Service (PHS) in February 2005.

The pertinent allegation the State charges, is that:

> Respondent documented that [an inmate] was exhibiting symptoms consistent with not having had a bowel movement in several days. The inmate had a temperature of 101°, stomach pains, had not had a bowel movement in three days, and had hypoactive bowel sounds in four quadrants.
>
> In response to these symptoms, Respondent administered Motrin, Metamucil, and 12.5 mg of Meclizine to the inmate. Respondent administered the medications without obtaining a physicians order.

Charges at ¶¶s 4-5.

Based on these allegations, the State makes four individual charges of unprofessional conduct against the Respondent claiming she violated:

(i) 26 V.S.A. § 1582(a)(7)(conduct of a character likely to deceive the public);

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

(iii) 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); and

(iv) 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 . . . failure to conform to the essential standards of acceptable and prevailing practice.)

Charges at ¶ 6 (i) - (iv).

Appearing as witnesses before the Board were the Respondent, Michael Saint Joseph, RN and Sharon MacBride, RN. Both Mr. Saint Joseph and Ms. MacBride previously worked at the Facility and both testified on behalf of the Respondent.

The Board accepted into evidence:

Respondent's Exhibit A.	24 hour shift log;
Respondent's Exhibit B.	Respondent notes from working shift;
Respondent's Exhibit C.	April 2005 letter from Respondent;
Respondent's Exhibit D.	emails to/from Respondent; and
Respondent's Exhibit E.	*In re: MacBride* NU 23-1004 (2005).

The Respondent did not contest the allegations in the Charges and the State did not therefore offer any exhibits.

Findings of Fact &
Conclusions of Law:

1. The Respondent does not contest the factual allegations set forth in the Charges filed by the State of Vermont on 7 December 2005.

2. The salient fact is that the Respondent administered medications to an inmate/patient without a physician's order to do so. The Respondent admits that she administered medications without a physician's order.

3. The legal issue facing the Board therefore is whether the State's uncontested allegations rise to the level of unprofessional conduct. If the admitted conduct is unprofessional, the issue for the Board is whether discipline is warranted.

4. To answer these two questions the Board heard testimony regarding the context in which Respondent "administered Motrin, Metamucil, and 12.5mg of Meclizine" to a constipated inmate at the Facility. *Charges,* at ¶5.

The incident:

5. On the night of the incident, the inmate to whom the Respondent administered medication displayed a fever and symptoms of constipation and stomach upset.

6. The medicines Respondent administered to the inmate (Motrin, Metamucil, and 12.5 mg of Meclizine) had previously been ordered for the patient. Meclizine is a prescription anti-nausea medication, and the other two are over the counter medications.

7. This particular inmate had orders for medications that were renewed from time to time. Typically inmates had their medication orders renewed biannually.

8. In March 2005, inmate medicine orders had yet to be updated and renewed due to the change in the Facility's medical contractor from CMS to PHS.

9. At the time of the incident described in the Charges, Ms. Sartwell worked 9:45 p.m. to 6:30 a.m. or "3rd shift," and she was the only nurse on duty.

10. Approximately two weeks after the medication administration incident, the Respondent was suspended and subsequently terminated.[1] The reason given to Ms. Sartwell by PHS, for her dismissal, related to the March 2005 administration of constipation medications. The March 2005 incident, however, came and went without Ms. Sartwell receiving any contemporaneous admonition or other feedback from PHS.

11. Witnesses Sharon MacBride and Michael Saint Joseph agreed that the Respondent is well qualified as a nurse and that she has a great deal of respect for the profession and that she cares well for her patients.

12. Mr. Saint Joseph testified that he would want Ms. Sartwell caring for him if he found himself in a hospital.

13. Ms. MacBride testified that despite the inherent difficulties of treating patients in a prison setting, Ms. Sartwell nonetheless earned the respect and appreciation of the inmates for being fair and reliable.

The Facility:

14. Respondent explained that a physician is always on call. However, the Board heard testimony that frequently pages to a physician from the Facility went unanswered

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1. In April 2005, immediately after she reported a PHS supervisor whom she suspected was diverting narcotics, PHS dismissed Ms. Sartwell from her position at the Facility. Prior to the Respondent's report of alleged misconduct, however, there was no indication that her following of expected Facility procedure warranted discipline. She was never asked not to do the act (administer medications without an order) for which she was reported. Supervisory personnel instructed her to administer the medications without an order and in the manner practiced on the day of the incident.

and sometimes multiple pages went unheeded. *See* Respondent Exhibit E (log of unanswered pages to on-call physician).

15. Respondent testified that, when she began working at the Facility, she would always ask for a physician's order before administering medication.

16. However, the on-call physician for the Facility, Audrey Kern, M.D., later instructed Respondent that if she knew what the inmate needed, then Respondent was to give it to the inmate and get the order in the morning.

17. Dr. Kern made it clear to the Respondent that she did not want to be contacted for routine medication administrations.

18. The Board heard that standard procedure at the Facility was to call the responsible physician in the morning, explain the medical history, explain what was done for the patient and then get the order, particularly during 3rd shift.

19. Mr. Saint Joseph testified that he worked as a per diem RN at the Facility for approximately two years until summer 2005. He worked mostly 2nd shift and also worked 3rd shift a few times. He occasionally worked with the Respondent.

20. He testified that the facility was chaotic, hectic, that there no training to speak of, constant changeover of employees occurred, and there was little to no chain of command to access. As part of orientation, he was instructed to dispense medications without a physician's order.

21. Mr. Saint Joseph testified that he complained to his nurse supervisor about the practice of administering medication without an order. He refused to administer medications pursuant to the protocol at the Facility as explained to him. He also testified that when he complained about the practice to the nurse supervisor, she acknowledged the practice and said she would do something about it. Mr. Saint Joseph testified that he was unaware that anything happened as a result of his complaints.

22. Mr. Saint Joseph explained that he stopped working at the Facility because, after nurses complained to prison administration about nursing practice, they were terminated.

23. Specifically he testified that he no longer wanted to work at the Facility after learning that several nurses were discharged around the same time the Respondent was discharged and "they [prison staff] felt it was retaliation for going to the commissioner" over medical practice issues.

24. He testified that Ms. Sartwell was among the nurses whom he learned had been "retaliated against."

25. Mr. Saint Joseph said he did not want to put himself in the same situation as the nurses whom he believed were terminated due to retaliation.

26. When nurses questioned or objected to the procedures of the prison, Ms. MacBride testified that they were "told this is the prison system this is not the outside world we do things different[ly] here. We are not surveyed by the state."

27. Ms. MacBride testified that providing medication with orders was not only done by 3rd shift nurses, but all the nurses had to perform that way.

28. She testified that on the day shift, which she worked, the nurses generally could not get a hold of a doctor. There was no doctor on site. Physicians would come in once or twice a week. The supervisors reviewed the paperwork infrequently.

29. Based on the testimony of the witnesses, it is clear nurses were required to follow a protocol best described as "administer medication first and get the order second."

30. Ms. MacBride further explained that following the medicine administration protocol was the only viable option since "if we did not meet the needs of the inmates, we would be reprimanded by [a supervisor]."

31. All three nurses testified that management within the prison system accepted this practice and chose to do nothing when nurses complained. Managerial acceptance of the practice included the Respondent's immediate supervisor Melanie Longden, RN who, ironically, brought this complaint against the Respondent to the Board.

32. In her testimony to the Board, Ms. Sartwell explained that she knew physician's orders were required prior to administering medication.

33. She testified that she attempted to call a physician whenever she needed to administer a medication, as required prevailing standards of practice.

34. Shortly after she began working at the facility and despite her training and practice of never administering medication without an order, the on-call physician instructed Ms. Sartwell *not* to call regarding medications during third shift. The *de facto* policy imposed on Respondent by Correctional Medical and then continued by PHS's on-call physician was to administer medications, such as Metamucil and Motrin, then receive an order for the medication in the morning.

35. The Respondent resisted this procedure but was effectively forced to choose between not treating the inmates and treating the inmates pursuant to the Dep't of Corrections and PHS's *de facto* policy.

36. She picked, as her least-worst option, following the instructions given to her by the physician ultimately responsible for the inmates. She reluctantly administered medications during her nighttime shift as instructed and then obtained orders the following morning.

37. The overall testimony before the Board was uncontested and credible that the Dept. of Corrections management, the responsible physicians, Correctional Medical and finally Prison Health Services were aware that this was standard practice for nurses at the Facility.

38. This situation created another dilemma for the Respondent. She faced a classic Hobbesian choice between her preference and instinct to follow the letter of the law applicable to nurses in her situation versus doing as instructed, treating inmates and keeping her job.

39. Therefore, if the Respondent followed Nursing Board dictates and Administrative Rules, this could lead to discipline by one State agency, the Dept. of Corrections. On the other hand, following the protocols of her employer and the Dep't of Corrections placed her in jeopardy with this State agency, which is precisely where she finds herself now.

40. While the Board sympathizes with Ms. Sartwell's seeming lack of viable options and the demands made of her by the Dep't of Corrections, her superiors and the on-call physician(s), the Board does not sympathize with the decision she made.

41. Nursing standards do not change with geography, with institutions, with patients nor are they changed by employers.

42. It is clear to the Board from Respondent's testimony that she knew this all along but succumbed to the pressure to act otherwise.

43. Title 3 V.S.A. §129a(b) recognizes that the failure to conform to the essential standards of acceptable and prevailing practice "on a single occasion or on multiple occasions may constitute unprofessional conduct."

44. The issue for the Board is whether this is a case of simple negligence, malpractice or a mistake in judgment, which does not warrant a disciplinary response from a State regulatory board, or does this breach of standards rises to the level of unprofessional conduct.

45. Based on the evidence received by the Board, we find that this case represents more than just negligence or a mistake in judgment. This matter crosses the threshold to unprofessional conduct due to the knowing deviation from practice standards that the Respondent does not dispute.

46. It is Board policy, it is a nurse's professional obligation and it is sound law that licensed practical nurses shall not administer medication to a patient without a valid order authorizing the prescribed treatment.

47. We cannot stress this point too much: it does not matter *where* a nurse is working. The professional obligations are the same to any patient, working for any employer and in all situations.

48. In Respondent's situation, the Board realizes that following the "letter of the law" could necessarily mean withholding treatment from a patient in need of care since there was an established failure of on-call correctional physicians to return pages. However, the Dep't of Corrections and Respondent's employer, PHS, were putting sick inmates in this situation, and the Respondent knew this *before* the 12 March 2005 incident.

49. The Respondent understood the gravity of her situation prior to the 12 March 2005 incident. This was not a new or unexpected emergency arising at 3:00 a.m.

50. Rather, the 12th of March incident was foreseeable and was the Respondent's obligation to address prior to taking her shift.

51. The Board recognizes that Respondent was under tremendous pressure to "go along to get along," as she described it, in her employment both for CMS and PHS. However, the concern here is for patient safety. While the Respondent's conduct did not endanger a patient and was even ratified and encouraged by her employer, this does not change our view that the procedures with which Respondent was complicit are a danger to patient safety.

52. It is that complicity that elevates this from a mere mistake or negligence, which professionals are able and expected to correct on their own outside of the disciplinary context, to a violation of 3 V.S.A. § 129a(b).

53. For these reasons, the Board finds Respondent's actions constitute unprofessional conduct.

The Charges:

54. In light of the evidence received, the Board rules as follows:

(i) 26 V.S.A. § 1582(a)(7) (conduct of a character likely to deceive the public). The Board concludes the State did not meet its burden of proof. There is no evidence that the Respondent attempted in any way to deceive any member of the public or any person under her care.

(ii) 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause). The Board concludes that the State did not meet its burden of proof. There is no evidence that Respondent is unable to practice nursing competently. In fact, the unopposed and credible testimony received by the Board indicated Respondent is a careful and competent nurse who approaches her duties professionally.

(iii) (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). The Board concludes that the State did not meet its burden of proof. Outside of the individual charges of unprofessional conduct brought against the Respondent, on which the Board rules individually, there are no factual allegations that Respondent violated any statutes or administrative rules.

(iv) (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 . . . failure to conform to the essential standards of acceptable and prevailing practice). The Board finds that Respondent failed to conform to the essential standards of acceptable and prevailing practice on one occasion as outlined in 3 V.S.A. § 129a(b) and as charged in subparagraph 6(iv) of the State's Charges.

55. Under Vermont law, a breach of standards under this statue "*may* constitute unprofessional practice." *Id.* (emphasis added). The Board further concludes, based on the facts as established in this case, the Respondent's lapse does constitute unprofessional conduct.

56. The State asks that the Respondent receive a conditioned license if the Board finds that she engaged in unprofessional conduct.

57. Counsel for the Respondent argues, if the Board finds that Respondent engaged in unprofessional conduct, that a warning or reprimand is adequate sanction and that anything further would be punitive.

58. Respondent's counsel argues a conditioned license would be punitive since it would affect her ability to keep her job and necessarily create an economic hardship.

59. The State's position is that a conditioned license is not a punitive sanction and that the Respondent's admissions warrant this sanction.

60. The Board agrees with the Respondent that a conditioned license would be punitive.

61. However, the Board disagrees with the Respondent that her current employment is relevant to whether the sanction is punitive. We find the State's recommendation punitive for other reasons.

62. The purpose of a Board sanction, as both parties agree, is remedial. It is to insure professional standards.

63. Anything more severe than a reprimand would be punitive in this situation since the State came forward with no evidence that the Respondent poses any risk to patients or the community at large.

64. Absent any evidence that a Respondent poses a risk to patients or that she is at risk to repeat her error, a prospectively applied sanction such as a conditioned license is unwarranted. An unwarranted sanction is, at the very least, punitive where it lacks for evidentiary support. Although the Respondent deviated from essential standards in March of 2005, there is nothing to indicate that she has done anything unprofessional since then or that she will repeat her error.

65. The Respondent is currently working in a nursing home. She had a good record prior to the incident and has had a good record since. Her work with patients since the incident is not in question.

66. The Respondent testified that she will never again administer medication without an order, and her record since the incident is consistent with that assertion making her testimony credible.

67. The Respondent has accepted responsibility for her failure to obtain a contemporaneous order while working at the Northwest Correctional Facility. Her understanding of the consequences makes it unlikely that this event will repeat itself.

Conclusion:

The Board's message to the Respondent, and to all nurses, is that it does not matter where you work, or whether you work in a prison, when determining the practice standards dictating your professionalism. The minimum standards are the same at all hospitals, prisons, nursing homes, school clinics or any other health care facility. Title twenty-six and the Administrative Rules of the Board of Nursing apply equally and fully regardless of place of employment.

ORDER

Based on the findings of fact set forth above, the Board of Nursing therefore REPRIMANDS the Respondent's license for failure to conform to the essential standards of acceptable and prevailing practice on a single occasion as charged in paragraph 6(iv) of the Specification of Charges.

Based on the findings of facts set forth above, the charges contained in paragraphs 6(i), 6(ii) and 6(iii) of the Specification of Charges are DISMISSED.

- END -

Vermont Board of Nursing:

By: Laurey M. Tyo Date: 11-2-06
Laurey M. Tyo, RN
Board Secretary

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 11/9/06

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, Vermont Secretary of State, 26 Terrace Street, Montpelier, Vermont 05609-1101 within 30 days of the entry of the 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 based on 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.

To request a stay of the Board's decision, please refer to the attached stay instructions.

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

IN RE:	)	
MELANIE L. SARTWELL	)	DOCKET No. NU61-0405
License No. 025-0008209	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Melanie L. Sartwell, L.P.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. Melanie L. Sartwell (the "Respondent") of Highgate Center, Vermont is a licensed practical nurse holding license number 025-0008209, issued by the State of Vermont. This license was originally issued on or about August 13, 2002 and is currently set to expire on January 31, 2007.

3. At all relevant times, Respondent was employed as a practical nurse at the Northwest State Correctional Facility located in St. Albans, Vermont.

4. On or about March 12, 2005 Respondent documented that inmate S.T. was exhibiting symptoms consistent with not having had a bowel movement in several days. The inmate had a temperature of 101°, stomach pains, had not had a bowel movement in three days, and had hypoactive bowel sounds in four quadrants.

5. In response to these symptoms, Respondent administered Motrin, Metamucil, and 12.5mg of Meclizine to the inmate. Respondent administered the medications without obtaining a physician's order.

STATE OF VERMONT

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

Charges

6. 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)(7) (engages in conduct of a character likely to deceive, defraud or harm the public) which includes, but is not limited to, performing acts beyond the limits of the practice of licensed practical nursing in 26 V.S.A. § 1572(3) pursuant to ARBN Chapter 4, Rule IV(II)(D)(1);

(ii) 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes, but is not limited to, 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); and

(iii) 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).

(iv) 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: (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice).

Relief Requested

WHEREFORE, the license of Melanie L. Sartwell should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

DATED at Montpelier, Vermont this 7th day of December, 2005.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

Prosecuting Attorney
Office of
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