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

IN RE:	)	
AMY LYNN SHEALY, R.N.	)	Docket No. NU 02-0700
License No. 026-0021956	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

Introduction

The Vermont Board of Nursing (Board) held a disciplinary hearing on the Specification of Charges filed in this case on October 30 and November 6, 2002, at 81 River Street in Montpelier, Vermont. Board Members Susan Farrell, RN; Laurey M. Tyo, RN; Patricia Rock, RN; Alan Weiss, Public Member; Sandra Norton, R.N.; Margaret Luce, Ad Hoc Member; and Louise Lucchina, Ad Hoc Member, attended the hearing and participated in the decision. George C. Haegele, IV, Assistant Attorney General, appeared on behalf of the State of Vermont. Charles N. Hurt, Jr., Esq. appeared on behalf of the Respondent, Amy Lynn Shealy. Amy Lynn Shealy (Respondent) was present at the hearing. Phillip J. Cykon, Esq. served as Presiding Officer on behalf of the Board.

Respondent had filed a Motion to Sever and a Motion to Recuse, both dated September 6, 2002. Both motions had been preliminarily denied on September 18, 2002, by Presiding Officer Larry S. Novins. Prior to the disciplinary hearing on October 30, 2002, the Board reviewed and approved the preliminary denials and denied both motions.

Findings of Fact

1. Respondent is a Registered Nurse (RN) holding license number 026-0021956 issued by the State of Vermont.

2. At all times relevant to the allegations regarding this case, Respondent practiced nursing at the Northeast Regional Correctional Facility in St. Johnsbury, Vermont, including the work camp. Respondent was responsible for providing proper and competent nursing care to inmates.

3. On or about April 1, 2000, R.P. was an inmate at the Northeast Regional Correctional Facility (NRCF). On or about April 21, 2000, R.P. was transferred from the correctional center to the work camp.

4. In a series of letters dated from February 24 to March 15, 2000, R.P.'s wife communicated information concerning R.P.'s diabetic condition to the Superintendent of the NRCF. The letters referred to R.P.'s medications and his glucometer, and asked several questions concerning these matters. By letter dated March 20, 2000, the Superintendent of the NRCF acknowledged receiving these letters and stated that the facility was more than equipped to deal with diabetes.

5. R.P.'s medical records were delivered to the Northeast Regional Correctional Facility and were available to Dr. Strenio and all nursing care providers. R.P.'s medical records showed that R.P. had a prior history of circulation problems and other medical conditions.

6. At all times relevant to the allegations regarding this case, Jonathan Strenio, MD, practiced medicine and provided medical care to inmates in several correctional centers, including the NRCF and the work camp. Dr. Strenio's goal was to provide such medical care in the manner of a community health center.

7. Dr. Strenio provided medical care to R.P. at the correctional center and at the work camp. Based upon his initial visit with R.P., and his review of R.P.'s medical history, Dr. Strenio issued several orders concerning R.P.'s medical care, including medications and regular blood sugar and blood pressure checks.

8. Dr. Strenio ordered that R.P. receive a Glucometer test every Monday, Wednesday, and Friday. In May and June of 2000, Respondent failed to administer to R.P. several of the doctor-ordered Glucometer tests. Respondent did not write in R.P.'s file or medical records any explanation of why the tests were not administered.

9. In addition, Dr. Strenio had ordered that R.P. receive Glucophage, twice daily, at 6:30 A.M. and 9:00 P.M. In April and May of 2000, Respondent, on several occasions, failed to administer Glucophage to R.P. as the doctor had ordered. Respondent did not write in R.P.'s file or medical records any explanation of why the medication was not administered as ordered.

10. On June 9, 2000, during a visit with Respondent, R.P. complained that he was cramping in his calf muscle and that his right foot felt colder than his other foot. Respondent noted that a pedal pulse was present and that R.P.'s leg should be monitored. She did not document the color of the leg, the temperature of the leg, or the pedal pulse count.

11. In R.P.'s Progress Notes, a June 10, 2000, entry by Nurse Carl Martin indicates that the facility received a call from an outside physician concerning R.P. and the condition of his leg. Nurse Martin further noted that after an examination of R.P. that evening, R.P.'s right leg was possibly slightly cooler than the left leg, and that a pedal pulse was present. Nurse Martin referred R.P. to the physician.

12. On June 13, 2000, Respondent issued a Med Pass to R.P. excusing him from work for that day. Respondent made no notation whatsoever in R.P.'s Progress Notes concerning the Med Pass or the reasons why it was issued.

13. R.P. did not see a physician until June 14, 2000, when he was examined by Dr. Strenio. Dr. Strenio found R.P.'s lower leg to be extremely cold with no pedal pulse. Dr. Strenio diagnosed an acute arterial occlusion and issued an emergency Consultant Request Form.

Conclusions of Law

A. Based on all the evidence, Respondent has shown that she is unable to practice nursing competently, in violation of 26 V.S.A. § 1582(a)(3), in that she performed unacceptable patient care and failed to conform to the essential standards of acceptable and prevailing nursing practice. As a practicing nurse at the correctional facility, Respondent was responsible for providing proper and competent nursing services to inmates. As found above, Respondent failed to administer the Glucometer tests and failed to administer Glucophage as ordered by the physician. Documentation regarding these tests and medications was either nonexistent or seriously deficient. Regarding the problem with R.P.s leg that continued from around June 9 through June 14, Respondent failed to properly assess R.P.'s condition. She compounded this deficiency by failing to record any of her observations concerning his complaint and condition. As a result, R.P. had to wait too long to receive proper medical care for his leg. Respondent's actions as a practicing nurse fell below acceptable and prevailing nursing practice whether such practice occurs inside or outside of a correctional facility.

Order

Based upon the above Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED by the Board of Nursing that:

1. Respondent's license to practice as a nurse in the State of Vermont is SUSPENDED, for a period of six (6) months, effective as of the date of entry shown below. In addition, her license is CONDITIONED for a period of one (1) year as follows:

   a. Respondent must attend and successfully complete a Board-approved program in nursing education. The program must cover the following components:

      1. documentation and record-keeping
      2. pharmacology
      3. legal ethics
      4. assessments

b. Respondent must obtain approval of the program from the Board or the Executive Director, as designee of the Board, prior to attending the program.

2. Upon Respondent's demonstration, to the Board's satisfaction, that she fully complied with all the terms of this Order, Respondent may petition the Board to remove any and all conditions on her license and after formal review by the Board, Respondent's nursing license may be fully restored by appropriate Board action.

3. Notwithstanding any provision of this Order, Respondent must meet all Nursing Board requirements for license renewal and license reinstatement.

4. Respondent shall bear all costs of complying with this Order.

5. This document is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a).

6. This Order takes effect as of the date of entry shown below.

Appeal Rights

This is a final administrative determination by the Vermont Board of Nursing. You may appeal by sending a notice of appeal in writing to the Director of the Office of Professional Regulation within 30 days of the date of entry below. If you wish to request a stay of the Board's decision, please refer to the attached stay instructions.

BOARD OF NURSING

Susan Farrell Date: January 18, 2003
Susan Farrell, RN
Chair

OFFICE OF PROFESSIONAL REGULATION

Date of Entry: 1/24/03