STATE OF VERMONT
BOARD OF NURSING

IN RE:	)	
Cristine Smith	)	Case File No. NU88-0502
License No. 26-22218	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Introduction

The Vermont Board of Nursing ("the Board") held a hearing in this case on Monday, June 14, 2004, at 81 River Street in Montpelier, Vermont. Board members Laurey Tyo, De-Ann Welch, Linda Rice, Sandra Norton, Alan Weiss, Elayne Clift, Ellen Leff and Donarae Metcalf participated in the decision. Edward Adrian, Prosecuting Attorney, appeared for the State. Cristine Smith ("the Respondent") was present and was represented by attorney Charles Hurt. Christopher Winters was the Presiding Officer.

State's Exhibits 1-7 were admitted at the start of the hearing.

Findings of Fact

1. The Respondent is a registered nurse holding license number 026-0022218 issued by the State of Vermont. Respondent's license was issued on June 26, 1995 and is set to expire on March 31, 2005.

2. At all times relevant to these charges, the Respondent was practicing as a registered nurse employed by Correctional Medical Services at Marble Valley Regional Correctional Facility in Rutland, Vermont.

3. On or about October 20, 2001, Respondent administered Clonidine 0.1mg to client C.S. when client C.S. was to receive Clonidine 0.05 mg. The Respondent immediately realized what had occurred and self-reported the error. She then monitored C. S. For low blood pressure and dizziness. No harmful effects were noted.

4. On or about February 21, 2002, Respondent erroneously transcribed the ordered dosage of Baclofen 10mg instead of Baclofen 20mg for client C.G. on the February Medication Administration Record ("MAR"). She later realized the mistake, filled out a medication error report, and corrected the MAR. C.G. received the 10 mg dose for approximately 20 days.

5. On or about May 17, 2002, Respondent administered Prednisone 10mg instead of the ordered 20mg to client P.S. Respondent self-reported the error and suggested an

alternative way of writing the amount on the MAR, in "20 mg" rather than "10 mg" combined with a dot and dash method used to indicate the number of tablets to be taken.

6. On or about June 7, 2002, Respondent administered Clonidine 0.1mg at 0800 to client R.B. when the order read "HS" medication, or hour of sleep medication. Respondent discovered her error, self-reported it, and informed the oncoming shift to be sure R.B. did not get a double dosage.

7. On or about June 2002 through July 2002, Respondent erroneously transcribed an order for client A.T. on the Medication Administration Record omitting Vasotec 2000.

8. All of the above errors were self-reported and resulted in a written medication error report which was reviewed by Respondent's superiors. In each report is appears that corrective action was taken and that the errors were reported immediately upon discovery.

9. These medication error reports were discovered by the Board investigator while investigating other unrelated allegations which were not proven or charged by the State.

Conclusions of Law

A. The Vermont Board of Nursing (the "Board") has the jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129 and 129a; 26 V.S.A. Chapter 28 and; the rules of the Board and the Vermont Office of Professional Regulation.

B. By engaging in the conduct set forth above, including the five self-disclosed medication administration errors from October 2001 to July 2002, the Respondent has committed unprofessional conduct in violation of:

(1) 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).

(2) 3 V.S.A. §129a(a)(10) (In the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a client, patient or customer has occurred).

(3) 3 V.S.A. §129a(b)(2) and the Administrative Rules of Nursing, Chapter 4 Rule IV(II)(B)(2)(Failure to conform to the essential standards of acceptable and prevailing practice).

Opinion

The Board encourages nurses to self-disclose medication errors. Errors do occur due to either human error or systems failures. However, there does come a point when the level of errors is unacceptable and will need to be brought to the attention of the Board in the interest of protecting the public.

Generally, self-disclosed errors can be handled within the institution and there is no need for a complaint to the Board unless a pattern emerges or serious harm or potentially serious harm results. Typically, such an occurrence should lead to some restriction upon the nurse's ability to practice within the institution. At that point, the nurse's practice becomes a situation requiring mandatory reporting under 3 V.S.A. §128. However, in this instance, it appears the institution had not yet reached that point as there were no reports of harm to inmates. The errors were brought to the Board's attention through an unrelated investigation. Because they are now before the Board, the Board must deal with them. By the sanction issued below, the Board creates a public record to be relied upon in the event future errors by the Respondent are brought to their attention, contributing to what may be an overall pattern.

All nurses are to be commended for being honest about their mistakes and for the corrective actions they are obligated to take on behalf of patient safety, as well as their ethical obligations as licensed professionals. It is those nurses who try to cover up their mistakes who receive the most serious disciplinary sanctions given by the Board. Discipline is imposed not only for their errors but for their lack of honesty and for jeopardizing patient safety.

In this instance, although the Board is not condoning the errors made by the Respondent, it is a significantly mitigating factor that she did self disclose them all and take the appropriate steps to remediate them, including suggestions to improve nursing care, such as having a "double-check" system for reviewing transcription orders for errors. As a result, she has received the minimum sanction allowed under law.

Order

A. In light of the above findings and conclusions, the Board hereby WARNS the Respondent's license, effective as of the date of entry, below.

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

C. This Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

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 of this order. If you wish to request a stay of the Board's decision, please refer to the attached stay instructions.

By: Linda Rice Date: 6-22-04

Linda Rice
Acting Chair

OFFICE OF PROFESSIONAL REGULATION

Date of entry: 6/30/04

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

IN RE: Cristine Michelle Smith License No.: 026-0022218	))	Docket No.:NU88-0502

SPECIFICATION OF CHARGES

Board Authority

1. The Vermont Board of Nursing (the "Board") has the jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129 and 129a; 26 V.S.A. Chapter 28 and; the rules of the Board and the Vermont Office of Professional Regulation.
2. Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. 3 V.S.A. §129a(a)(3).
3. In the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a client, patient or customer has occurred is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. 3 V.S.A. §129a(a)(10).

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Office of
Professional Regulation
Montpelier, VT 05602

4. Failure to conform to the essential standards of acceptable and prevailing practice is unprofessional conduct and is a basis upon which the Board can impose disciplinary action. 3 V.S.A. §129a(b)(2).
5. Inability to practice nursing competently by failure to conform to the essential standards of acceptable and prevailing nursing practice is unprofessional conduct and is a basis upon which the Board may impose disciplinary action. Administrative Rules of Nursing, Chapter 4, Rule IV(II)(B)(2).

Statement of Facts

6. Cristine Michelle Smith ("Respondent") of Castleton, Vermont is a registered nurse holding license number 026-0022218 issued by the State of Vermont. Respondent's license was issued on June 26, 1995 and is set to expire on March 31, 2005.
7. At all times relevant to these charges, the Respondent was practicing as a registered nurse employed by Correctional Medical Services at Marble Valley Regional Correctional Facility in Rutland, Vermont.
8. On or about September 13, 2001, Respondent administered Potassiun 10mg to client J.C. The order for this client had expired on September 12, 2001.
9. On or about October 20, 2001, Respondent administered Clonidine 0.1mg to client C.S. when client C.S. was to receive Clonidine 0.05 mg. The mistake resulted in client C.S. having low blood pressure and dizziness.

Stricken by State at the hearing CW 6/14/04

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Office of
Professional Regulation
Montpelier, VT 05602

10. On or about February 2002, Respondent erroneously transcribed the ordered dosage of Baclofen 10mg instead of Baclofen 20mg for client C.G. on the February Medication Administration Record.
11. On or about May 17, 2002, Respondent administered Prednisone 10mg instead of the ordered 20mg to client P.S.
12. On or about June 7, 2002, Respondent administered Clonidine 0.1mg at 0800 to client R.B. when the order read HS medication.
13. On or about June 2002 through July 2002, Respondent erroneously transcribed an order for client A.T. on the Medication Administration Record omitting Vasotec 2000.

Charges

14. By committing the above act(s), circumstance(s) and/or omission(s), the Respondent has:
    a. Committed unprofessional conduct by failing to comply with provisions of federal or state statutes or rules governing the practice of the profession in violation of 3 V.S.A. §129a(a)(3);
    b. Committed unprofessional conduct by in the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual

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Montpelier, VT 05602

injury to a client, patient or customer has occurred in violation of 3V.S.A. §129a(a)(10)

c. Committed unprofessional conduct by failing to conform to the essential standards of acceptable and prevailing practice in violation of 3 V.S.A. §129a(b)(2);

d. Committed unprofessional conduct by failing to conform to the essential standards of acceptable and prevailing nursing practice in violation of Administrative Rules, Chapter 4, Rule IV(II)(B)(2).

Relief Requested

WHEREFORE, the nursing license of Cristine Michelle Smith should be revoked suspended or otherwise disciplined.

Dated at Montpelier, Vermont this 27th day of October 2003.

State of Vermont
Secretary of State

By: _____
Edward Adrian
State Prosecuting Attorney

rn.smith.soc

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Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602