STATE OF VERMONT
BOARD OF NURSING

In re: Gabrielle Tiffany License No. 026-19326	} } Docket No. }	NU90-0408 2008-170

Decision on
UNPROFESSIONAL CONDUCT CHARGE

Participating Board Members:
Ellen W. Leff, RN, Chair
Alan Weiss
Sandra Norton, LNA
Donarae Metcalf, LPN
Kenneth W. Bush, RN
William G. White Jr.
Deborah Robinson, RN
John Todd, APRN

Decision on Unprofessional Conduct Charges

Appearances:
for Petitioner, State of Vermont: Edward G. Adrian
for Respondent: Richard R. Goldsborough

Presiding Officer: Larry S. Novins

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Vermont Board of Nursing held a hearing in the above matter on September 14, 2009 at the National Life Building in Montpelier, Vermont.

The prosecution has the burden of proof in this matter. To prevail on any unprofessional conduct charge, it must prove the charge by a preponderance of the evidence.

Background

The prosecution alleges in its Specification of Charges that Ms. Tiffany, in violation of Vermont Statutes,1) administered Propofol which was not in her scope of practice, 2) did so improperly, and 3) administered an improper amount of the drug to the patient.

Findings of Fact

Based on the evidence presented, the Board finds as follows:

1. Ms. Tiffany is licensed as a registered nurse and is therefore subject to the regulatory authority of this Board. 3 V.S.A. §§ 129, 129a, 26 V.S.A. § 1582(a), the Administrative Rules of the Board of Nursing, and the Rules of the Office of Professional Regulation.
2. At all times relevant Ms. Tiffany was employed as a registered nurse in the Post Anesthesia Care Unit at the Northwestern Medical Center in St. Albans, Vermont.
3. On November 19, 2007 patient O.B. suffered from nausea after knee surgery. Ms. Tiffany had been with the patient for five hours with no bathroom, lunch, or coffee break. The patient was on oxygen. Respondent had tried everything she knew to alleviate the patient's nausea. The patient was yelling loudly for help.
4. When other hoped for remedies failed, Dr. E.P. suggested that the patient be given Propofol. He asked Ms. Tiffany if she could administer it, meaning was she available to administer it. She said "yes," and he told her to give O.B. 10mg./1cc. of Propofol. Giving the patient Propofol was not Ms. Tiffany's idea.
5. Ms. Tiffany repeated the drug order back to the doctor to ensure that she had the order correct.
6. At the time there may have been a protocol at NWMC regarding the use of Propofol and its administration by nurses there. There was no evidence presented at the hearing to inform what exactly the protocol may have been, if there was one. Neither Doctor E.P. nor Ms. Tiffany was aware of any hospital policy or protocol on the administration of Propofol. In May of 2008 the hospital announced a new Propofol policy. We do not find that Ms. Tiffany violated any hospital policy on Propofol.
7. Ms. Tiffany felt there was no reason she could not administer Propofol. She had seen it used, and from her observation believed it to be safe under the circumstances. Ms. Tiffany had not been trained in its proper use.
8. Propofol is typically used for light sedation during short procedures, but it can also have an anti-nausea effect when administered in small doses.
9. Ms. Tiffany took a 10cc syringe, the one she had seen used by others administering Propofol. She didn't realize she was about to draw a dose that was 10 times the amount the Doctor ordered. She mistakenly prepared to administer 10cc. of Propofol. She filled the syringe and began to administer the drug to O.B.
10. When Ms. Tiffany had administered approximately 7cc., O.B. began to get drowsy. Ms. Tiffany hadn't expected drowsiness with 10cc. It was then that she realized her error and stopped the Propofol. She dialed up the oxygen the patient was already receiving and called for assistance. She made sure the patient had an open airway. When Doctor E.P. arrived, the patient was already moving and sitting up. Ms. Tiffany told Doctor E.P. that she had given the wrong dose, not the 1cc. that he had ordered.
11. Dr. E.P. testified that Ms. Tiffany had handled her error and its results correctly.
12. Before this date, Ms. Tiffany had never before administered Propofol to a patient. She had seen it administered before by doctors and sometimes by nurses. She had seen others use a 10cc. syringe to administer Propofol. Beyond her own observations and recently seeing a journal article, she had no training about the drug, its proper dosages, or administration. She did not look up the drug to educate herself on its proper use and administration. She did not ask for assistance before administering what for her was a

new drug. Ms. Tiffany was insufficiently familiar with the Propofol to know that the dose she was drawing was too big.

13. Ms. Tiffany testified this was her first mediation error in 25 years of nursing. She is a magna cum laude graduate of the nursing program at St. Anselm College. She has no prior disciplinary history.

Conclusions of Law

Based on the evidence presented and Facts found above we conclude as follows:

1. **Re: Alleged Violation of 26 V.S.A. § 1582(a)(3):** The State has not proved by a preponderance of the evidence that Ms. Tiffany is unable to practice nursing competently by reason of any cause. This charge is dismissed.

2. **Re: Alleged Violation of 3 V.S.A. § 129a(a)(13)**: The State has not proved by a preponderance of the evidence that Ms. Tiffany performed treatments or provided services which beyond the scope of her scope of practice. This charge is dismissed.

3. **Re: Alleged Violation of 3 V.S.A. § 129a(b)(1) and (2)**: The State has proved by a preponderance of the evidence that Ms. Tiffany failed to practice competently. We find that Ms. Tiffany's conduct as found above constituted a failure to conform to the essential standards of acceptable and prevailing practice. 3 V.S.A. § 129a(b)(2). This is unprofessional conduct.

4. **Re: Alleged Violation of 26 V.S.A. § 129a(a)(3)**: 3 V.S.A. § 129a(a)(3) defines unprofessional conduct to include failing to comply with provisions of federal or state statutes or rules governing the practice of the profession. Any allegation of failure to comply with statutes or rules has been addressed above. This statute does not provide an independent grounds for discipline. There is no violation of this statute. This charge is dismissed.

Order

For the violation above, to protect the public, health, safety and welfare, the following sanction is necessary.

1) Ms. Tiffany license shall be **warned.**
2) Ms. Tiffany shall be conditioned. The sole condition is that Ms. Tiffany shall successfully complete within 6 months a Board approved course on proper preparation and administration of medications. When Ms. Tiffany has completed the course, the condition will be removed.

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, Office of Professional Regulation, National Life Bldg., North, FL2, Montpelier, Vermont 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.

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

Vermont Board of Nursing

By: _____
Ellen Leff, RN, Chair

Date September 16, 2009

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 9/24/09