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

IN RE: ALLAN C. WHITE, RN	)	**DOCKET NO. NU06-0703**
License No. 026-0027659	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COMES the State of Vermont, through State Prosecuting Attorney, Edward G. Adrian, and Respondent Allan C. White, R.N., who stipulate and agree as follows:

Board Authority

1. The Vermont Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129, 129a, 814; 26 V.S.A. Chapter 28 and; the rules of the Board (the "ARBN") 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 upon which the Board can base 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, careful, 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 upon which the Board can base disciplinary action. 3 V.S.A. § 129a(a)(12).

4. Being unable to practice nursing competently by reason of any cause is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. § 1582(a)(3).

5. Performance of unsafe or unacceptable patient care is unprofessional conduct upon which the Board can base disciplinary action. ARBN Chapter 4, Rule IV, II, B, 1.

6. Performing acts beyond the limits of the statutory definitions of the practice of nursing in 26 V.S.A. § 1572(2), (3) and (4) is unprofessional conduct upon which the Board can base disciplinary action. ARBN Chapter 4, Rule IV, II, D, 1.

7 Performing duties and assuming responsibilities within the scope of the definitions of nursing practice, 26 V.S.A. § 1572(2) and (3) when competence has not been achieved or maintained is unprofessional conduct upon which the Board can base disciplinary action. ARBN Chapter 4, Rule IV, II, D, 2.

8. Failing to take appropriate action to safeguard a patient from incompetent health care is unprofessional conduct upon which the Board can base disciplinary action. ARBN Chapter 4, Rule IV, II, D, 5

Statement of Facts

9. Allan C. White (the "Respondent") of Lancaster, Pennsylvania is a licensed registered nurse holding license number 026-0027659, issued by the State of Vermont. His license was originally issued on or about October 11, 2002 and is set to expire on March 31, 2005.

10. At all relevant times the Respondent was practicing as a registered nurse and worked at Fletcher Allen Health Care ("FAHC" or the "Hospital") located in Burlington, Vermont. The Respondent was working at FAHC as an RN after completing a five month critical care internship program.

On or about July 3, 2003, the Respondent was assigned to the care of patient S.C. a sixty-four year old female with muscular dystrophy. S.C. was located in FAHC's intensive care unit. There were five other occupied beds in S.C.'s room, divided by curtains.

12. At approximately 7:00 p.m. on July 3, 2003, the Respondent started his shift with S.C. as one of two patients that he was responsible for during the shift. As per the orders of the attending physician, S.C.'s previous nurse had started a Propoful IV drip at 2.5 cc. At the time that the Respondent took over, the bottle of Propoful contained approximately 85- 95cc's, as only 2.5 cc's had been administered at 6:00 p.m. and another 2.5 cc's at 7:00 p.m, from a new 100 cc bottle.

13. Respondent subsequently reduced the Propoful drip to a rate of 1 cc at 8 p.m. and kept the same rate at 9:00 p.m. and 10:00 p.m. Therefore, only 8 cc's of a 100 cc bottle had been utilized by 10:00 p.m, although approximately 10 cc's had been used to prime the IV line..

Sometime between 10:00 p.m. and 11:00 p.m. the Respondent administered a "bolus" to S.C. of approximately 2 cc's of Propoful. A bolus is a rapidly injected volume of medication administered directly into a patient. The person administering a bolus does not have direct control over the rapidity of the amount of medication administered. Respondent never received an order for a bolus of Propoful for S.C. However, the Respondent did receive an order to titrate S.C.

to Ramsey IV. When medication is titrated, the person administering the medication has direct control over the rapidity of administration.

15. After administering the bolus, the Respondent reset the volume on the IV pump, however he incorrectly reset the rate on the pump. This in turn caused the pump to administer a large dose of Propoful. Approximately 50 -70 cc's of Propoful were administered to S.C. within two or three minutes. The Respondent was present and attending to S.C. while this large dose was administered. Although the alarm on the pump was working, no other Hospital employee heard the alarm go off. On information and belief, the Respondent shut off the alarm immediately after it sounded and reset it while starting an NIBP cuff with the patient.

16. As a result of the bolus delivery of the Propoful, S.C.'s blood pressure dropped to 30/18, a life threatening level. The Respondent alleges that the next blood pressure reading was 54/24. Although there were other experienced nurses present in the room when S.C.'s blood pressure dropped, the Respondent left the patient in the room, without sounding an alarm and sought the assistance of a first year intern physician. The Respondent alleges that he did not see anyone else to turn to for help in the immediate area of the patient.

17. After the first year intern physician was alerted, several other physicians and nurses came to the scene in an attempt to revive S.C. The medical staff was ultimately successful in reviving S.C. after the administration of several medications and by maneuvering S.C.'s bed into the "Trendelenburg position". At this time nurse Therese Hewitt noted that approximately 20 cc's remained in the Propoful bottle, the Respondent alleges that the amount was closer to 30 cc's.

18. S.C.'s blood pressure was ultimately brought back to a normal level and S.C.'s cognitive and physiological functions appeared to be within normal parameters.

19. The Respondent continued working the rest of his shift on July 3, 2003, however the Respondent failed to document the administration of Zofran, Versed, Neosynephrine and Vecuronium to S.C on her CMAR. In addition, he failed to document S.C.'s blood pressure dropping to 30/18.

20. On or about July 15, 2003, the Respondent was terminated from employment at the Hospital.

Charges

21. The above described acts, omissions and/or circumstances constitute grounds for discipline because the Respondent violated:

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).

ii. 3 V.S.A. § 129a(a)(12) (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, careful, 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).

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

iv. ARBN Chapter 4, Rule IV, II, B, 1 (performance of unsafe or unacceptable patient care).

v. ARBN Chapter 4, Rule IV, II, D, 1 (performing acts beyond the limits of the statutory definitions of the practice of nursing in 26 V.S.A. § 1572(2), (3) and (4)).

vi. ARBN Chapter 4, Rule IV, II, D, 2 (performing duties and assuming responsibilities within the scope of the definitions of nursing practice, 26 V.S.A. § 1572(2) and (3) when competence has not been achieved or maintained is unprofessional conduct upon which the Board can base disciplinary action).

vii. ARBN Chapter 4, Rule IV, II, D, 5 (failing to take appropriate action to safeguard a patient from incompetent health care is unprofessional conduct upon which the Board can base disciplinary action).

Understandings

22. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.

23. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.

24. Respondent voluntarily enters this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.

25. Respondent voluntarily waives his right to charges and a contested hearing before the Board of Nursing.

26. Respondent agrees that the State has sufficient evidence for the Board to find that Respondent has engaged in unprofessional conduct and that the Order set forth below may be entered by the Board.

CONSENT ORDER

Based upon the stipulation above, it is **ORDERED AND ADJUDGED** as follows:

A. Respondent's actions described above demonstrate grounds for discipline because Respondent violated:

i 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).

ii. 3 V.S.A. § 129a(a)(12) (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, careful, 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).

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

iv. ARBN Chapter 4, Rule IV, II, B, 1 (performance of unsafe or unacceptable patient care).

v. ARBN Chapter 4, Rule IV, II, D, 1 (performing acts beyond the limits of the statutory definitions of the practice of nursing in 26 V.S.A. § 1572(2), (3) and (4)).

vi. ARBN Chapter 4, Rule IV, II, D, 2 (performing duties and assuming responsibilities within the scope of the definitions of nursing practice, 26 V.S.A. § 1572(2) and (3) when competence has not been achieved or maintained is unprofessional conduct upon which the Board can base disciplinary action).

vii. ARBN Chapter 4, Rule IV, II, D, 5 (failing to take appropriate action to safeguard a patient from incompetent health care is unprofessional conduct upon which the Board can base disciplinary action).

B. The Board of Nursing hereby **CONDITIONS** the Respondent's license to practice nursing for a minimum period of **TWO (2) YEARS** from the date of entry of this Consent Order and the following conditions shall apply:

(1) Re-issue of License.

Upon the imposition of these conditions, Respondent shall be issued a license labeled "conditioned".

(2) Length of Time Conditions Imposed.

The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes two (2) years of supervised nursing practice in which he works at least forty (40) hours every two (2) weeks as a nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week. Respondent's license is additionally conditioned as follows. **At the discretion of the Board, the Respondent may receive credit toward his conditioned period for all time spent in nursing school. If the Board approves this credit, the Respondent may be given .5 hours of credit for every 1 hour spent in an educational nursing program both class work and clinical work.**

(3) Reports from Employers.

Within one (1) month of the date of entry of this Consent Order and **monthly** thereafter, Respondent shall cause every employer Respondent has worked for during the month to submit to the Board an evaluation of Respondent's performance and attendance during that month. This report shall be submitted in writing on forms issued by the Board.

In the event the Respondent is **attending a nursing program**, Respondent shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Consent Order and ability of the program to comply with the conditions in the Consent Order during clinical experience.

(4) Research Paper.

Respondent must submit to the Board a research paper completed by the Respondent in which the Respondent describes the need to learn the institutional policies and practices of a medical facility, particularly when practicing as a traveling nurse. The research paper must also set forth a description of the uses and functions of Propoful, who may administer the drug by bolus and what skills a nurse must possess to be able to bolus Propoful. The research paper must be type-written and include cited references. The research paper must be submitted to the Board within ninety (90) days of the date of entry of this Consent Order.

(5) Practice Under Supervision.

Respondent shall practice only in a setting where Respondent has on-site supervision for the entire shift by a Registered Nurse that is licensed and in good standing with the Board.

(6) Types of Employment Prohibited.

Respondent shall be prohibited from being a supervising nurse during the effective period of the Consent Order. Respondent shall not work for a nurse registry, float-pool, home health care agency, temporary nursing employment agency, or as a personal care provider during the effective period of this Consent Order.

(7) Out of State Practice/Residence.

Before any out-of-state or Canadian practice or residence can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board. If Respondent fails to receive such approval, none of the time spent out-of-state will be credited toward the fulfillment of the terms and conditions of this Consent Order. The

Board will approve the out-of-state practice so long as the Respondent can still comply with the provisions of this Consent Order.

(8) Notification of Place of Employment/ Personal Address/Telephone Number.

Within five (5) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of his current place of nursing employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in nursing employment, personal address, or telephone number. During the conditioned period, Respondent shall provide a copy of this Consent Order to all nursing employers , current and future, and shall inform them of the conditional status of his license.

(9) License Renewal.

If the Respondent's license expires while this Order is still in effect, this Order does not automatically extend the license. In that situation, in order to continue to practice nursing, the Respondent must timely apply for renewal, pay the applicable fee and demonstrate that he has otherwise complied with the requirements for license renewal.

(10) Costs.

The Respondent shall bear all costs of complying with this Consent Order.

(11) Violation of this Order.

If the Respondent violates the terms of this Order in any respect, the Board, after giving the Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against the Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

(12) Completion of Conditional License Period.

After the conditional license period, the Respondent may petition the Board to remove any and all conditions on his license. The Respondent must present proof that he has fully complied with the terms of this Order.

C. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.

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

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

F. The Respondent may apply to have the conditions removed from his license after he has completed a minimum of one year of the conditioned period.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

Dated: May 5, 2004

By: _____
Edward G. Adrian
State Prosecuting Attorney

ALLEN C. WHITE
RESPONDENT

Dated: 3 May 2004

By: _____
Allen C. White

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: May 10, 2004

By: _____
Chairperson

Date of Entry: 5/12/04

nu.white.stip2.wpd

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

IN RE: ALLAN C. WHITE, RN	)	**DOCKET NO. NU06-0703**
License No. 026-0027659	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont by and through its State Prosecuting Attorney, Edward G. Adrian and makes the following Charges against the Respondent Allan C. White, R.N.:

Board Authority

1. The Vermont Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129, 129a, 814; 26 V.S.A. Chapter 28 and; the rules of the Board (the "ARBN") 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 upon which the Board can base 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, careful, 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 upon which the Board can base disciplinary action. 3 V.S.A. § 129a(a)(12).

4. Being unable to practice nursing competently by reason of any cause is unprofessional conduct upon which the Board can base disciplinary action. 26 V.S.A. § 1582(a)(3)..

5. Performance of unsafe or unacceptable patient care is unprofessional conduct upon which the Board can base disciplinary action. ARBN Chapter 4, Rule IV, II, B, 1.

6. Preforming acts beyond the limits of the statutory definitions of the practice of nursing in 26 V.S.A. § 1572(2), (3) and (4) is unprofessional conduct upon which the Board can base disciplinary action. ARBN Chapter 4, Rule IV, II, D, 1.

7. Preforming duties and assuming responsibilities within the scope of the definitions of nursing practice, 26 V.S.A. § 1572(2) and (3) when competence has not been achieved or maintained is unprofessional conduct upon which the Board can base disciplinary action. ARBN Chapter 4, Rule IV, II, D, 2.

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

8. Failing to take appropriate action to safeguard a patient from incompetent health care is unprofessional conduct upon which the Board can base disciplinary action. ARBN Chapter 4, Rule IV, II, D, 5

Statement of Facts

9. Allan C. White (the "Respondent") of Lancaster, Pennsylvania is a licensed registered nurse holding license number 026-0027659, issued by the State of Vermont. His license was originally issued on or about October 11, 2002 and is set to expire on March 31, 2005.

10. At all relevant times the Respondent was practicing as a registered nurse and worked at Fletcher Allen Health Care ("FAHC" or the "Hospital") located in Burlington, Vermont. The Respondent was working at FAHC as an RN after completing a five month internship program.

11. On or about July 3, 2003, the Respondent was assigned to the care of patient S.C. a sixty-four year old female with muscular dystrophy. S.C. was located in FAHC's intensive care unit. There were five other occupied beds in S.C.'s room, divided by curtains.

12. At approximately 7:00 p.m. on July 3, 2003, the Respondent started his shift with S.C. as one of two patients that he was responsible for during the shift. As per the orders of the attending physician, S.C.'s previous nurse had started a Propoful IV drip at 2.5 cc. At the time that the Respondent took over, the bottle of Propoful contained 95cc's, as only 2.5 cc's had been administered at 6:00 p.m. and another 2.5 cc's at 7:00 p.m, from a new 100 cc bottle.

13. Respondent subsequently reduced the Propoful drip to a rate of 1 cc at 8 p.m. and kept the same rate at 9:00 p.m. and 10:00 p.m. Therefore, only 8 cc's of a 100 cc bottle had been utilized by 10:00 p.m.

14. Sometime between 10:00 p.m. and 11:00 p.m. the Respondent administered a "bolus" to S.C. of approximately 2 cc's of Propoful. A bolus is a rapidly injected volume of medication administered directly into a patient. The person administering a bolus does not have direct control over the rapidity of the amount of medication administered. The Respondent had never been taught or instructed concerning how to bolus Propoful. In addition, the Respondent never received an order for a bolus of Propoful for S.C. However, the Respondent did receive an order to titrate S.C. to Ramsey IV. When medication is titrated, the person administering the medication has direct control over the rapidity of administration.

15. After administering the bolus, the Respondent reset the rate on the IV pump, however he incorrectly reset the volume on the pump. This in turn caused the pump to administer a large dose of Propoful. Approximately 72 cc's of Propoful were administered to S.C. within two or three minutes. The Respondent was present and

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

attending to S.C. while this large dose was administered. Although the alarm on the pump was working, no other Hospital employee heard the alarm go off. On information and belief, the Respondent shut off the alarm immediately after it sounded.

16. As a result of the bolus delivery of the Propoful, S.C.'s blood pressure dropped to 30/18, a life threatening level. Although there were other experienced nurses present in the room when S.C.'s blood pressure dropped, the Respondent left the patient in the room, without sounding an alarm and sought the assistance of a first year intern physician.

17. After the first year intern physician was alerted, several other physicians and nurses came to the scene in an attempt to revive S.C. The medical staff was ultimately successful in reviving S.C. after the administration of several medications and by maneuvering S.C.'s bed into the "Trendelenburg position". At this time nurse Therese Hewitt noted that only 20 cc's remained in the Propoful bottle.

18. S.C.'s blood pressure was ultimately brought back to a normal level and S.C.'s cognitive and physiological functions appeared to be within normal parameters.

19. The Respondent continued working the rest of his shift on July 3, 2003, however the Respondent failed to document the administration of Zofran, Versed, Neosynephrine and Vecuronium to S.C on her CMAR. In addition, he failed to document S.C.'s blood pressure dropping to 30/18.

20. On or about July 15, 2003, the Respondent was terminated from employment at the Hospital.

Charges

A. The above described acts, omissions and/or circumstances constitute grounds for discipline because the Respondent violated:

i 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).

ii. V.S.A. § 129a(a)(12) (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, careful, 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).

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

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

iv. ARBN Chapter 4, Rule IV, II, B, 1 (performance of unsafe or unacceptable patient care).

v. ARBN Chapter 4, Rule IV, II, D, 1 (preforming acts beyond the limits of the statutory definitions of the practice of nursing in 26 V.S.A. § 1572(2), (3) and (4)).

vi. ARBN Chapter 4, Rule IV, II, D, 2 (preforming duties and assuming responsibilities within the scope of the definitions of nursing practice, 26 V.S.A. § 1572(2) and (3) when competence has not been achieved or maintained is unprofessional conduct upon which the Board can base disciplinary action).

vii. ARBN Chapter 4, Rule IV, II, D, 5 (failing to take appropriate action to safeguard a patient from incompetent health care is unprofessional conduct upon which the Board can base disciplinary action).

WHEREFORE, the license of Allan C. White should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

DATED at Montpelier, Vermont this 13th day of December, 2003.

STATE OF VERMONT
SECRETARY OF STATE

By:

State Prosecuting Attorney

STATE OF VERMONT

Prosecuting Attorney
Office of
Professional Regulation
Montpelier, VT 05602

NU004.soc.wpd