

MAINE STATE BOARD OF NURSING

IN RE: Linda J. Cookson, R.N.)
) **DECISION AND ORDER**
Licensure Disciplinary Action)

PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S.A. Sec. 2105-A(1-A)(D), *et seq.*, 5 M.R.S.A. Sec. 9051, *et seq.* and 10 M.R.S.A. Sec. 8001, *et seq.*, the State of Maine Board of Nursing (Board) met in public session at the Board's offices located in Augusta, Maine on November 30, 2001 for the purpose of determining whether Linda Cookson, R.N. engaged in unprofessional and or incompetent conduct as a registered nurse while employed at Woodlawn Rehabilitation and Nursing Center (Woodlawn) in Skowhegan, Maine. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Acting Chairman Monica M. Collins, Ed.D., R.N.C., Kathleen A. Dugas, L.P.N., Hazel M. Rand, (public representative), Jody L. Deegan, M.S.N., R.N.C., and Jeanne B. Delicata, R.N.C. John H. Richards, Ass't. Attorney General, presented the State's case. Ms. Cookson appeared *pro se*. James E. Smith, Esq. served as Presiding Officer.

Subsequent to the opening statement by counsel, State's Exhibits 1-10 were admitted into the Record. Following the taking of testimony, submission of exhibits, and closing arguments, the Board deliberated and made the following findings of fact by a preponderance of the credible evidence regarding the violations alleged in the Complaint.

FINDINGS OF FACT

Linda Cookson has been a registered nurse for the past 12 years. She was hired in that capacity by Woodlawn on or about July 4, 2001. Woodlawn is a 46 bed skilled and long term nursing facility whose residents range in age from 40-102 years of age. The vast majority of patients have different needs and most have multiple diagnoses including healing fractures, congestive heart disease, diabetes, etc. Some of the patients' rooms are private while others provide for 2 individuals. Additionally, several rooms do not contain a means by which a patient can ring for assistance and therefore require frequent monitoring by the staff. On the evening of July 12, 2001, Ms. Cookson was the charge nurse supervising 2 certified nursing assistants (c.n.a.) and the care of 40-43 residents. She had received an orientation at Woodlawn and that night was her first without another registered nurse on duty.

Nurse Cookson was scheduled to begin work on the 12th at 10:30 p.m. She arrived 15 minutes late and, around midnight, called her supervisor, the Director of Nursing (Director), and said that she had lost the set of master keys that allow access

to not only every room at Woodlawn but also the medicine cabinets which contain over the counter and scheduled drugs (narcotics). The keys were located approximately one-half hour later by the Respondent's former husband, Lloyd, who was employed by Woodlawn as a c.n.a. Since Woodlawn's policy prohibits a husband-wife from working on the same shift, and because there was no need for Lloyd to be working since he had completed his 3-11:00 p.m. shift, he was sent home on the order of the Director. Apparently, Lloyd had returned to Woodlawn to ascertain whether Ms. Cookson had arrived at work.

At approximately 5:00 a.m. on the morning of July 13, 2001, Woodlawn's housekeeper-laundry supervisor called the Director. She expressed concern that nurse Cookson "can't function" and appeared to be under the influence of drugs or some other agent. The Director arrived at Woodlawn around 6:00 a.m. and noted that nurse Cookson's physical appearance looked terrible. The Respondent's speech was slurred, her eyes were droopy, she could not stay focused and needed to be told several times to go to the Director's office. She was nodding off and was unable to follow basic commands, and her manner was described by the Director as "bizarre." The Respondent explained her condition as being "just tired."

Other witnesses at Woodlawn testified that during the early morning hours, nurse Cookson's balance and gait were off, she was staggering, her speech was thick and slurred, and her hands were "shaking quite badly." Moreover, she appeared to be uncoordinated and had to be told three times from whom to take blood sugar specimens. Ms. Cookson was also observed by staff during the morning to be on her hands and knees picking up spilled paper cups which were to be filled with medications and, at a different time, papers were "all over the floor" and coffee had been spilled on patient charts by nurse Cookson.

A count of drugs and comparison with residents' charts revealed the possibility that several drugs were unaccounted for. The Respondent was able to recall that she had given medications to three residents but couldn't remember when. A review of three residents' records demonstrated that Ms. Cookson violated Woodlawn's and the nursing profession's standards of practice by failing to record the time that the medicine was removed from the medicine cabinet, the patient's name and the time and reason for giving the medication.

A review of one of the three affected patients' charts showed that he was a cardiac patient suffering from congestive heart failure. The narcotics record revealed that he had not received medication for one week. Nurse Cookson apparently medicated him with percocet, a narcotic drug, and stated that she had done so because he was in pain. However, she wasn't sure where physically he was feeling the pain, no notation of "pain" was listed on either the patient assessment sheet or nurse's notes, and the amount of medication given was not recorded. The above are required since the location of the pain may reveal potential or real problems such as blood clots, etc. and the amount may indicate the level of pain that the patient was suffering at the time. Moreover, this patient had not received percocet since June 22, 2001 so the unanswered question remains as to the necessity to medicate him. Indeed, the accepted practice is to administer a lesser drug such as Tylenol for a pain

problem and then reassess the patient's condition.

Another example of nurse Cookson's inability to competently and professionally perform her duties on the night of the 12th and morning of the 13th involved a female patient at Woodlawn. Her records reveal that this woman had last received vicodin, a scheduled drug, on June 22, 2001 at which time that narcotic had been discontinued and percocet substituted as part of her care. However, during the time in question, the Respondent gave this patient vicodin without explanation and additionally failed to document her action at the time. When the patient was later visited, the pill was found resting on her chest.

Although there was no documented harm to any patient as result of nurse Cookson's acts and omissions on the evening and morning in question, considerable concern was exhibited by the Director and staff at least due to her inability to competently function coupled with the fact that the medicine cabinet remained unlocked during most of the Respondent's shift and her failure to remember, in at least one instance, whether she gave the correct drug to the wrong patient or the wrong drug to the right patient. Additionally, the lack of record keeping also caused considerable anxiety. The Director suspended Linda Cookson on July 13, 2001.

In her defense, nurse Cookson testified that she made a mistake by giving the female patient vicodin. She denied staggering but recalled dropping a coffee cup. The Respondent didn't believe that she put the spilled medicine cups back on the cart since hospital floors are filthy. Linda Cookson's most revealing and damaging statement to the Board was to the effect that "she didn't think that she was ill prepared to nurse that night" and that she "thinks that she did a satisfactory job that night." Those statements lead to the finding that nurse Cookson basically assumed and continues to take little or no responsibility for her actions or omissions on the evening and morning of July 12-13, 2001, even though she resigned from her Woodlawn employment on July 15.

CONCLUSIONS OF LAW

The relevant statutory and regulatory provisions regarding the above matter and as stated in the Complaint/Notice of Hearing are as follows:

32 M.R.S.A. Sec. 2105-A.2. Grounds for discipline. The board may suspend or revoke a license pursuant to Title 5 section 10004. The following are grounds for an action to issue, modify, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

E. Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has:

1. Engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or
2. Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed.

F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed.

H. A violation of this chapter or a rule adopted by the board.

Rules and Regulations of the Maine State Board of Nursing, Chapter 4.

3. Definition of Unprofessional Conduct. Nursing behavior which fails to conform to legal standards and accepted standards of the nursing profession, and which could reflect adversely on the health and welfare of the public shall constitute unprofessional conduct and shall include, but not be limited to, the following:

K. Inaccurate recording, falsifying or altering a patient or health care provider record.

N. Practicing nursing when unfit to perform procedures and make decisions in accordance with the license held because of physical, psychological or mental impediment.

The Board, by a vote of 4-1, based on the above recited facts, concludes that Linda J. Cookson, R.N. violated the above statutory and regulatory standards of nursing and that her license to practice as a registered nurse is hereby revoked pursuant to 10 M.R.S.A. Sec. 8003. 5. A-1.(2-A).

SO ORDERED.

Dated: November 30, 2001



Monica M. Collins, Acting Chairman
Maine State Board of Nursing

APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S.A. Sec. 10051.3, any party that decides to appeal this Decision and Order must file a Petition for Review within 30 days of the date of receipt of this Order with the District Court having jurisdiction. The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Maine State Board of Nursing, all parties to the agency proceedings, and the Maine Attorney General.