

MAINE STATE BOARD OF NURSING

IN RE: Rena Daigle, LPN) DECISION
Disciplinary Action) AND ORDER

I. PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S. Sec. 2105-A (1-A) (D), *et seq.*, 5 M.R.S. Sec. 9051, *et seq.* and 10 M.R.S. Sec. 8003, *et seq.*, the Maine State Board of Nursing (Board) met in public session at the Board's hearing room located in Augusta, Maine at 2:00 p.m. on November 6, 2012 and continued at 4:00 p.m. on June 6, 2013. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether to take disciplinary action against Rena Daigle's license to practice as a Licensed Practical Nurse. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chair Pro Tem Susan C. Baltrus, MSN, RN, CNE; Robin Brooks (public representative); Carmen Christensen, RN; Elaine Duguay, LPN; Joanne Fortin, RN; and Peggy Sonesen, RN.¹ John Richards, Assistant Attorney General, presented the State's case on the first day and Christopher Mann, Assistant Attorney General, appeared on the second day. Nurse Daigle was present and represented by Attorney William Smith. James E. Smith, Esq. served as Presiding Officer.

The Board first determined that none of the Board members had conflicts of interest that would bar them from participating in the hearing. The Board then took official notice of its statutes and rules and subsequent to the parties' opening statements, State's Exhibits 1-3 and Respondent's Exhibits 1-9 were admitted into the Record. The Board then heard the testimony, reviewed the submission of exhibits, and considered the parties' closing arguments, after which it deliberated and made the following findings of fact by a preponderance of the credible evidence and conclusions of law regarding the alleged violations.

¹ The first five Board members listed above were present at both sessions. Nurse Sonesen was present at the second session. Each Board member received the transcript of the first session several weeks before the second session. Nursing Home Director of Nursing Lisa Bouchard was the sole witness, by telephone, at the first session, which was continued following her examination by the State. Ms. Bouchard was cross-examined in person at the second session so all Board members had the opportunity to observe her as a witness. Both parties agreed with these procedures.

II.

FINDINGS OF FACT

Respondent Rena Daigle, a 53-year-old resident of Sinclair, Maine, has been licensed in Maine as a Licensed Practical Nurse ("LPN") since August 3, 2009. Prior thereto, she had been on the CNA Registry as a Certified Nurse's Assistant for approximately 16 years. Her LPN license expires on October 5, 2014. Nurse Daigle was hired in her professional capacity by High View Rehabilitation and Living Center ("High View"), located in Madawaska, Maine, on January 18, 2010 and worked there until May 13, 2010. She was rehired on October 22, 2010 and worked at High View until her employment was terminated on August 11, 2011.

High View is a 51-bed facility with beds for 12 patients who require skilled care, with the remaining beds utilized for long-term care nursing patients. High View's Human Resources' policy required immediate termination if an employee received three warnings.² Nurse Daigle's termination occurred due primarily to the following incidents and warnings that took place at the facility.

Director of Nursing Lisa Bouchard met with Respondent Daigle on February 7, 2011 to discuss five questionable nursing practices performed by the Respondent. The first two occurred when Nurse Daigle placed a physician's order for Nitrobid in a patient's chart and processed the order without the required physician's signature. The patient was in need of an antibiotic for a urinary tract infection, whereas Nitrobid is prescribed for cardiac-related problems. Fortunately, a medication technician questioned the order, which the physician subsequently changed to an antibiotic. According to Nurse Bouchard, "Whether you're a licensed practical nurse or a registered nurse, that would be something that you would question immediately." Nurse Daigle should have called the prescribing physician and expressed her concerns, or she could have consulted a registered professional nurse ("RN") and/or the medication books located at the nurses' stations and at the medication carts.

The third incident concerned an elderly male who complained of chest pain. Nurse Daigle neglected to take this individual's vital signs or, if they were taken, they were not recorded in her nurse's notes. Nurse Daigle prematurely called the physician on duty, who discounted the patient as having a cardiac-related problem due to the patient's low blood pressure. Nurse Bouchard advised Nurse Daigle to postpone calling a physician until she had consulted with an RN. Nurse Bouchard instructed the Respondent that she should have followed the standing orders at High

² The "Employee Warning Record" forms each contained the statement: "The absence of any statement on the part of the EMPLOYEE indicates his/her agreement with the report as stated." Space is provided on the form for the employee's version of the events and signature, revealing that the employee has "read this 'warning' and understands it." All were signed by Rena Daigle, who did not give her version of events on the documents and therefore appeared to agree with them.

View that require a nurse to first take vital signs and symptoms. In this patient's case, he should have been administered Mylanta, oxygen and Tylenol, since he apparently ate his meals too quickly and suffered from epigastric discomfort. Nurse Bouchard's concerns regarding this incident were that Respondent Daigle did not call an RN or follow the standing orders to relieve the patient's discomfort. She testified that a physician, being told of an elderly patient's complaints of chest pain, may have ordered nitroglycerin tablets which could have dropped the patient's blood pressure significantly, thereby causing added symptoms.

The fourth incident recited in the February 7, 2011 notes of the above meeting concerned a patient's wife's request which had been granted that her husband receive the four prescribed doses of Ativan, an anti-anxiety drug, during the daytime since he slept through the night and did not need that medication during nighttime hours. Nurse Daigle amended the time of administering the Ativan to midnight and 6:00 a.m., which upset the patient's wife. The Respondent did not check with the nurses' notes or Nurse Bouchard prior to this change. Had she done so, she would have been informed of the reason for the original change limiting the administration of the drug to daytime hours.

The fifth concern raised by Nurse Bouchard at the February 7, 2011 meeting arose due to Respondent Daigle's treatment of a patient's rash with calamine lotion instead of the ordered poultice.

Director of Nursing Bouchard also met with Nurse Daigle on April 21, 2011. The first problem discussed revolved around the Respondent not placing original physicians' orders in the patients' charts right away, which would enable the succeeding nurse to have a current record of a patient's condition. The Respondent had left some of these orders in the unit secretary's and Nurse Bouchard's mailboxes.

The second incident involving Nurse Daigle occurred after the Respondent received an order for a patient's Tylenol to be given twice a day as needed; Nurse Daigle wrote in the patient's chart 8:00 a.m. and 8:00 p.m. Consequently, the medication was given by the medical technicians at those times, which disregarded the order that the medication be administered at the patient's request, not at specific times.

Nurse Daigle was also apprised of her mistake in sending to a physician a request for an order thickening certain liquids. Nurse Bouchard testified that the Respondent should have consulted with an RN before calling the physician; the request was also premature since a swallow evaluation and evaluation by a speech therapist ordered by the physician should have occurred first.

Lisa Bouchard also discussed an order placed by the Respondent for Ativan for two patients in the same evening. All nurses had been previously informed not to take orders for prn anxiolytics, hypnotics, or antipsychotics since the patients were limited to receiving no more than five doses in seven days. The Respondent was reminded to suggest other medications before the above were ordered.

Director of Nursing Bouchard assessed Nurse Daigle a total of three Written Warnings on three different dates. The first was issued on February 8, 2011. The reason for the formal Warning was that the Respondent FAXed a physician regarding a resident whose extremities were becoming progressively weaker, possibly due to a stroke. The physician did not respond. The Respondent should have telephoned the doctor or utilized other methods to ensure that the resident received proper medical attention. The resident was admitted to the emergency room the next day; the physician stated that the patient should have been admitted the day before.

The second Warning was issued on June 13, 2011. The reasons supporting the discipline were several. First, on June 12, 2011, the Respondent failed to follow through on a physician's order. Second, the Respondent brought at least one of her grandchildren to work. She then, while her 11-year-old grandson stood in a female resident's doorway, asked the resident if she would mind if the Respondent gave her a shot while the grandson watched. The resident found this request to be offensive and did not give permission.

Another complaint focused on urine samples taken from two residents on a Friday, which needed to be tested by the next day. The Respondent put the samples in a refrigerator located at work and falsely documented that they were sent out. She then wrote "error," crossed out the original telephone order, rewrote a second telephone order, and signed another nurse's name thereto. As a result, the samples were not delivered until Monday, which was too late for accurate test results and new specimens were required for analysis. The Respondent also was chastised for putting throat cultures in the nursing home's refrigerator on a Friday, which proved useless when delivered for testing on Monday.

Nurse Bouchard further cited as a basis for the second Warning the fact that the Respondent did not follow up on a resident's failure to void. On a different occasion, the Respondent was informed by a resident that she had not received the ordered treatment. The Respondent wrote a circle around the treatment and the other nurse's initials, which means that the treatment was not given; she did not contact the treating nurse. Nurse Bouchard contacted the treating nurse who revealed that she had, in fact, provided the resident treatment, which could have resulted in the administration of two treatments instead of the one ordered.

The third and final event leading up to the Respondent's termination on August 11, 2011 took place on August 6, 2011. Nurse Daigle was working the 3:00 p.m. - 11:00 p.m. shift, which included her being the supervisor on the second floor of the nursing home. She left the premises at 6:30 p.m. for her 30-minute dinner break and returned some 75 to 90 minutes later. She testified that she had gone to her daughter's home for supper, but her daughter was not at home, so she returned to High View's parking lot and ate in her car. She had ingested two hydrocodone tablets, a scheduled drug, due to severe leg pain, rested her leg on the seat, and fell asleep in her car. As a result, not only did Ms. Daigle return to work impaired, but she left one nurse to cover both floors with 48 residents, while also leaving several CNAs, CMAs, and non-direct personnel unsupervised, which upset the other nurse on duty and which Nurse Bouchard deemed to have been "a very unsafe action."

III. CONCLUSIONS OF LAW

Based on the above facts and those found in the record but not alluded to herein, and utilizing its experience and training, the Board, by a vote of 6-0, concluded that Rena Daigle, LPN violated the provisions of:

1. 32 M.R.S. Sec. 2105-A(2)(E)(1 and 2) and Board Rules Chapter 4, Sec. 1.A.(5)(a) and (b) (Incompetent Conduct... by engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed by a licensee to a client or patient or the general public and by engaging 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).

Nurse Daigle worked in pain, for which she took two prescribed hydrocodone pills and presumptively was incapacitated by that drug during at least a segment of her shift. Moreover, she did not appear to know when to call a physician for advice or to question a physician's suspect prescription. Also, she wrote an order twice and placed it in the patient's chart.

2. 32 M.R.S. Sec. 2105-A (2) (F) and Board Rules Chapter 4, Sec. 1.A. (6) (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).

Rena Daigle had her 11-year-old grandson wait in a patient's doorway while she asked the patient if he could observe the nurse performing an inoculation on the elderly patient. A patient could most likely feel pressure to unwillingly agree to this; it is, however, a breach of patient rights and confidentiality.

3. 32 M.R.S. Section 2105-A (2) (H) and Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A. (8). (A violation of this chapter or a rule adopted by the board).
4. Board Rule Chapter 4, Section 3(F) as evidenced by: Rena Daigle's failure to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard patients.

Rena Daigle signed another nurse's name on a telephone order on which she wrote "error" and crossed out the original order. Moreover, on the Treatment Administration Record [TAR], the Respondent circled another nurse's initials signifying that the nurse did not do a treatment when, in fact, she did. Additionally, Ms. Daigle left the nursing home for an excessive amount of time, thereby leaving one nurse to monitor some 48 residents, as well as several personnel improperly supervised.

5. Chapter 4, Disciplinary Action and Violations of Law, Sec. 3 (J). Rena Daigle violated the confidentiality of information or knowledge concerning a patient when she informed her 11-year-old grandson that a specific resident was going to receive an injection.
6. Chapter 4, Disciplinary Action and Violations of Law, Sec. 3 (K). Rena Daigle inaccurately recorded, falsified or altered a patient or health care provider record by circling another nurse's initials, crossing out another nurse's order, and substituting a new order. She then signed the other nurse's name to the amended order.

IV. SANCTIONS

The Board expressed its concern that Rena Daigle did not appear to be focused on her errant practices and neither did she appear to take responsibility for any of her acts or omissions regarding the allegations in the Notice of Hearing.

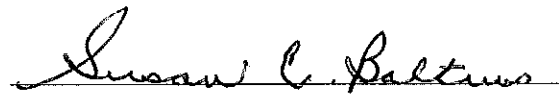
The Board also expressed its understanding that its actions are governed by the provisions of 5 M.R.S. Sec. 8008 which read as follows:

The sole purpose of an occupational and professional regulatory board is to protect the public health and welfare. A board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the regulated professions by examining, licensing, regulating and disciplining practitioners of those regulated professions. Other goals or objectives may not supersede this purpose.

Therefore, by the vote of 6-0, the Board ordered that Rena Daigle's license as a Licensed Practical Nurse is **HEREBY REVOKED**.

SO ORDERED.

Dated: July 18, 2013



Chair Pro Tem Susan C. Baltrus, MSN, RN, CNE
Maine State Board of Nursing

V.

APPEAL RIGHTS

Pursuant to the provisions of 10 M.R.S. Sec. 8003 (5)(G) and 5 M.R.S. Sec. 11002.3, any party that appeals this Decision and Order must file a Petition for Review in the District Court within 30 days of receipt of this Order. The petition shall specify the person seeking review, the manner in which s/he is aggrieved and the final agency action which s/he wishes 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 Attorney General.