



STATE OF MAINE
 BOARD OF NURSING
 158 STATE HOUSE STATION
 AUGUSTA, MAINE
 04333-0158

JOHN ELIAS BALDACCI
 GOVERNOR

MYRA A. BROADWAY, J.D., M.S., R.N.
 EXECUTIVE DIRECTOR

IN RE: Laurie M. Adams) **DECISION**
Licensure 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 office located in Augusta, Maine at 11:00 a.m. on April 23, 2009. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether Laurie Adams violated Board statutes and rules as a registered professional nurse while licensed in Maine. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chairman Bruce O'Donnell, C.R.N.A.; Robin Brooks (public representative); Susan C. Baltrus, M.S.N., R.N.C.; Carmen Christensen, R.N.; and Margaret Hourigan, R.N., Ed. D., C.N.A.A., B.C. John Richards, Assistant Attorney General, presented the State's case. Laurie Adams was neither present nor represented by legal counsel. James E. Smith, Esq. served as Presiding Officer.

The Board first found that Nurse Adams had been duly served with the Notice of Hearing by regular mail dated March 31, 2009. The Board subsequently found that none of the Board members had conflicts of interest which would bar them from participating in the hearing. The Board then took official notice of its statutes and rules, and subsequent to the opening statement by the State, State's Exhibits 1-7 were admitted into the Record. The Board then heard the testimony, reviewed the submission of exhibits, and considered the State's closing argument after which it deliberated and made the following findings of fact by a preponderance of the credible evidence regarding the alleged violations.



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II.

FINDINGS OF FACT

Laurie Adams, date of birth November 24, 1960, received her initial license to practice registered professional nursing in Maine on June 23, 1998. That license lapsed on November 24, 2007 and no renewal application has been received by the Board.

Eddie Welch has been a Nurse Manager at MaineGeneral Medical Center in Augusta, Maine since April 2004, at which time she assumed the responsibility of supervising Nurse Adams, who had been employed at the hospital for a number of years.

The record in this matter does not reveal significant problems regarding Nurse Adams's nursing practices until approximately November 2005. At that time, Nurse Adams was informed of concerns regarding her nursing practices, but she attributed those questionable practices to other nurses. As the months passed by, the number and frequency of Nurse Adams's violations of hospital policy increased. For example, on August 23, 2006, she gave pain medications to a patient who was not assigned to her without checking with the patient's nurse. Other nurses complained of Nurse Adams's giving medications to their patients without the nurses' prior consent.

On September 27, 2006, Nurse Adams was responsible for a patient who was receiving morphine intravenously. She placed an additional order for Oxycodone without first consulting with the patient's physician. The order appeared as though the physician had supplemented his original order. A separate order should have been written by Nurse Adams. Additionally, the records were clear that the physician had ordered that the patient not be awakened before 4:00 a.m. However, the Oxycodone was allegedly given prior to that time. Nurse Adams also failed to document any assessment for pain prior to giving the medication, and also absent was a focus note which would provide information as to the reason for the additional medication, as well as the reason for the patient's increased pain.

Supervisor Welch, on October 5, 2006, discussed with Nurse Adams her failure to chart pain medications. That discussion was prompted by the licensee's failure to chart two doses of narcotic medications regarding the same patient on September 26, 2006. It was additionally discussed that Nurse Adams consistently did not chart pain level and the site of the pain in her documentation. During Nurse Adams's shift on October 19, 2006, the issue of possible unaccounted for narcotic medications was brought to the attention of the hospital's management.

The first problem concerned the Pyxis medication dispensing machine, which requires an individual's code to be entered prior to accessing certain medications. Apparently, narcotic medication was taken from the Pyxis under Nurse Adams's code, but for the patient of another nurse. That patient communicated to the on-duty Charge Nurse that she did not receive the medication. Nurse Adams stated that she did not take the medication from Pyxis for that patient but, since Pyxis shuts down every 30 seconds after a nurse completes an order, there appeared to be only a very remote possibility that another nurse would have had the opportunity to withdraw medication using Nurse Adams's code. As a result, 20mg of Oxycodone was unaccounted for.

The second incident concerned another patient who was given a dose of Vicodin at 9:36 p.m., two Oxycodone pills at 9:50 p.m., and another two Oxycodone pills at 10:36 p.m. These doses should have been given not more frequently than four hours apart. Therefore, the hospital's "Best Practices" were not complied with, which required Nurse Adams to contact the Charge Nurse prior to giving this amount of medicine during the above time frame. The two possibilities considered by management to account for the licensee's actions and omissions in this instance were either overmedication of the patient or diversion of the medicine.

The third issue that was addressed regarding that shift was Nurse Adams's failure to have her patient's IV connected after the patient was returned to the floor four hours earlier. Supervisor Welch was also concerned that there were frequent removals of narcotic pain medications by Nurse Adams at the beginning of her shift. In Supervisor/Nurse Welch's opinion, it was unusual for each of the licensee's patients to be having severe pain issues at the same time.

As a result of the concerns expressed by Nurse Welch, as well as management, the former audited all medications ordered on the Pyxis by Nurse Adams from September 1, 2006 through October 22, 2006. The results of the audit revealed that Nurse Adams utilized her authority to override the normal Pyxis procedures which require that, prior to giving a patient certain medication, the pharmacy confirms both the correct usage and dosage of that medication. The 30 overrides, in Nurse Welch's opinion, were "a lot," especially considering that each was for Oxycodone, a controlled substance, during the period of the audit. Moreover, Nurse Adams's documentation did not support the need for the overrides.

Other concerns were raised by the audit. For example, there were 12 instances in which narcotic medications were removed from the Pyxis, but not charted and therefore unaccounted for. Additionally, in those situations where a physician was required to be consulted for

medication orders due to a patient's pain level, no focus notes were written by Nurse Adams to justify the medication. Although there were 145 transactions of narcotic medications signed out from the Pyxis by Nurse Adams, only 28 instances of pain level were charted. The remaining 117 situations were without documentation. Additionally, only 18 instances of the patient's pain site were charted, with the remaining 127 without documentation.

Concerns were also raised regarding Nurse Adams's practice after she administered pain medication. There were very few instances of the licensee ascertaining the effect that the medication was having on both the patient's pain level and the pain sites. Another instance was revealed where a patient's scheduled medications were unable to be given due to the patient's confusion and combativeness. However, during the same shift, there were two doses of pain medication taken out of Pyxis by Nurse Adams for this patient, but not charted as given. Moreover, there was no documentation of alternatives such as icepacks or repositioning prior to administering the narcotic medications.

Supervisor Welch also testified that during the first year of her supervision of Nurse Adams, the latter did a good job as a nurse, but had attendance issues. She was neat in appearance until approximately 2006, when she began losing weight, appearing tired, wearing wrinkled clothes and appearing disheveled when she arrived for duty.

MaineGeneral Medical Center terminated Nurse Adams's employment on November 2, 2006. The primary reason for her discharge was not being able to account for 12 missing narcotic medications out of 145 taken from Pyxis over a seven-week period along with the lack of patient documentation. Although Nurse Adams admitted that her documentation was problematic, she did not admit to the diversion of drugs.

III. CONCLUSIONS OF LAW

Based on the above facts and those found in the record, but not alluded to herein, the Board, by a vote of 5-0, concluded that Laurie Adams violated the provisions of:

1. 32 M.R.S. Sec. 2105-A. (2) (E) (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.

2. 32 M.R.S. Sec. 2105-A. (2) (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.

3. 32 M.R.S. Sec. 2105-A. (2) (H). Any violation of this chapter or a rule adopted by the Board.

4. Board Rule Chapter 4, Secs. 1. (A) (5) and (6) by engaging in incompetent and unprofessional conduct.

5. Board Rule Chapter 4, Sec. 3. (B) by assuming duties and responsibilities within the practice of nursing without adequate preparation and when competency has not been maintained.

6. Board Rule Chapter 4, Sec. 3(F) by failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient.

7. Board Rule Chapter 4, Sec. 3(K) Inaccurate recording, falsifying or altering a patient or health care provider record.

IV.

SANCTIONS

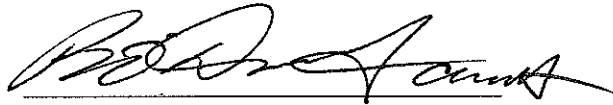
The Board, exercising its experience and training, and based on the above findings and conclusions, voted 5-0 to **REVOKE** the registered professional nurse license of Laurie M. Adams. The Board reasoned that Ms. Adams's nursing practices constitute a serious threat of harm to the public and therefore the revocation is warranted. The Board further voted 5-0 to assess Laurie M. Adams the **COSTS** of this hearing which shall be received by the Board **by October 23, 2009**. The costs total **\$913.42** (Hearing Officer: 1.45 hours to review the record and attendance at hearing, 4.30 hours to write decision @ \$115 per hour = \$718.75; Court Reporter: \$150; Sheriff's Deputy: \$44.67). The bank check or money order shall be made payable to: Treasurer, State of Maine and mailed to Myra Broadway, J.D., M.S., R.N., Executive Director, Maine State Board of Nursing, 158 State House Station, Augusta, Maine 04333-0158. Additional costs may be assessed in the event that Laurie Adams requests a transcript of the hearing. Costs shall be paid before the Board entertains any request by Laurie Adams for relicensure.

The costs are ordered since this hearing may have been avoided had the licensee signed the proffered Consent Agreement and/or attended this hearing to attempt to resolve the issues prior to the hearing. The costs are also in keeping with the Board's practice of assessing the costs to those who violate Board statutes and Rules as opposed to sharing the costs with those licensees who obey same.

SO ORDERED

3 June 2009

Date



Bruce O'Donnell, C.R.N.A., Chairman
Maine State Board of Nursing

V.

APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S. Sec. 10051.3 and 10 M.R.S. Sec. 8003(5)(G) and (5-A)(G), any party that appeals this Decision and Order must file a Petition for Review in the Maine District Court having jurisdiction 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 Maine Attorney General.