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

PAUL R. LEPAGE
GOVERNOR

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

IN RE: Sheila Perry	)	**DECISION AND**
Disciplinary Action	)	**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 9:00 a.m. on February 8, 2012. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether to take disciplinary action against Sheila Perry's license to practice registered professional nursing. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chairman Dorothy Melanson, RN; Robin Brooks (public representative); Susan C. Baltrus, MSN, RNBC; Elaine Duguay, LPN; and Carmen Christensen, RN. John Richards, Assistant Attorney General, presented the State's case. Nurse Perry was present and not represented by an attorney. James E. Smith, Esq. served as Presiding Officer.

The Board first determined 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 State's opening statement, State's Exhibits 1-10 and 13 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.

II. FINDINGS OF FACT

Respondent Sheila Perry, 66 years old and a resident of Hampden, Maine, has been licensed in Maine as a registered professional nurse since February 17, 1967.[1, 2] On March 17, 2011, the Board received a Provider Report from Ross Manor, Bangor, Maine, dated March 15, 2011. The correspondence, written by Director of Nursing Rosemary Turgeon, RN, contained several serious allegations regarding Ms. Perry's nursing practices at that facility which provides care for 120 patients in a variety of settings including long term care, rehabilitation, and assisted living. The letter, in brief, stated that Sheila Perry had been hired into the position of RN Charge Nurse on March 2, 2011. She was terminated on March 15, 2011 due to her demonstrating difficulty and confusion in comprehending and retaining basic instructions during orientation and failing to provide competent, safe nursing practices to

[1] Sheila Perry's Registered Professional Nurse's license was suspended on June 1, 2011.
[2] Nurse Perry signed a Consent Agreement with the Board on January 18, 2001 in which she agreed that she failed to document a physician's order in compliance with her employer's policy. The documentation was incomplete, incorrect and untimely. Ms. Perry received a "Warning" for her violations.

patients. The Board forwarded the letter to Nurse Perry on March 28, 2011 and requested her to respond to the allegations by May 1, 2011.

On March 31, 2011, RN Perry sent her response to the Board. She explained therein that during her employment at Ross Manor, she was recovering from a respiratory infection which caused a hearing loss in her left ear. She further attributed her problems to a lack of training and/or orientation at Ross Manor, particularly as they related to her deficient computer skills. She explained that the medication nurse misunderstood her to say that she was going to administer to 100 units of insulin a patient rather than 15 units ordered. Nurse Perry further asserted that before the medication nurse took the syringe away from her, she was employing proper procedure when she "pulled up air to inject into the vial of [Toradol] prior to withdrawing the medication from the vial."

Subsequently, the Board reviewed the allegations and preliminarily determined that Sheila Perry's continued practice of nursing posed immediate jeopardy to the health and physical safety of the public. The Board then suspended respondent's license on June 1, 2011 and timely scheduled a hearing within 30 days to comply with the emergency suspension provisions of 5 M.R.S. Sec.10004(3). The hearing was moved from July 20, 2011 to February 8, 2012 at the request of the licensee whose license remained suspended.

At this hearing, the evidence revealed that Sheila Perry had an extensive and varied career as a registered professional nurse, but had not practiced nursing during the year prior to her interview at Ross Manor. Her interview at Ross Manor, during which she informed the interviewers that she had provided a variety of nursing services to patients, including mental health and rehabilitation care, went well. She was hired and began her orientation, both in and out of the classroom, on March 2, 2011. This was followed by more of the same on March 3, 7, and 8 for a total of approximately 32 hours. During her six days of employment at Ross Manor, RN Perry spent two days in the classroom and four days providing nursing services while attempting to become familiar with the layout of the facility. She was expected to provide care for 12-13 patients and to supervise the certified nursing assistants on her floor.

Ann Thibodeau, RN and floor nurse at the time, was selected to monitor/train Ms. Perry and to observe her nursing skills. However, it soon became apparent that Ms. Perry was having major difficulty in mastering the computer and its programs. For example, she found it hard to understand the steps in turning on the computer and, once on, following in sequential order the manual's instructions for use. The information stored on the computer was extremely important since it contained physicians' orders, incident reports regarding patients, patients' respiratory problems, and other information concerning the facility's patients. Moreover, the computer was used by the nurses to record the administration of medications.

On March 12, 2011, the Charge Nurse was supervising Ms. Perry. At that time, she discovered that there was air, but no medication (Toradol) in the syringe being prepared by Nurse Perry for a 72-year old patient. The bottle containing the Toradol was still full. The Charge Nurse stopped the respondent from administering air into the patient.

RN Perry was also observed on March 14, 2011 as being confused regarding the selection and administration of the medications. For example, the Medication Administration Record listed the medications to be given to a patient in Room 101. Instead of filling the order, the respondent randomly picked medications from the

medicine cart regardless of which patient the drugs were prescribed for. On at least one other occasion, the correct drugs were drawn, but almost given to the wrong patient by the respondent. The patient nearly received four tablets of Magnesium Oxide when she was supposed to receive one, and one Cardopa-Levidopa, when two were ordered. Nurse Thibodeau also recalled preventing the respondent on several occasions from delivering 100 units of insulin to a patient instead of 15 units.

Other nurses reported observing the respondent aimlessly walking in and out of the kitchenette. Nurse Perry was also observed attempting to gain entrance into the treatment room which was locked. She explained that she needed to go to the bathroom. On a related incident, Nurse Perry, on exiting the computer room, inquired where the computer room was located.

Similarly, RN Jessica Higgins oriented Sheila Perry on one of the six days at Ross Manor. Within minutes of parting at the end of the orientation, Nurse Perry met Nurse Higgins and the respondent began talking about Nurse Higgins without making the connection that she was talking to Nurse Higgins.

Nurse Perry basically reiterated the contents of her March 31, 2011 letter in response to the above-noted testimony and exhibits. She "feels good now" and testified that she could practice as a visiting nurse or in a medical setting.[3] She acknowledged difficulty regarding understanding some of the orientation, but blamed her problems on her infection which hampered her hearing. Nurse Perry offered to be placed on probation if that would enable her to continue nursing.

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, and further having observed the licensee's demeanor, the Board, by a vote of 5-0, concluded that Sheila Perry, RN violated the provisions of:

1. 32 M.R.S. Sec. 2105-A (2) (E) (1 and 2) (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) 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).
3. Board Rule Chapter 4, Sec. 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:

[3] Nurse Perry's current competency was further placed in serious doubt when she could not name the "Five Rights of Medication Administration" to wit: Right Patient; Right Medication; Right Dose; Right Route; and Right Time.

4. F. Failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient.
5. 32 M.R.S. Section 2105-A (2) (H). A violation of this chapter or a rule adopted by the Board.
6. Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A. (5) (a) (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).
7. 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.
8. Board Rule Chapter 4, Section 3(B) as evidenced by: Sheila Perry's assumption of duties and responsibilities within the practice of nursing without adequate preparation or when competency has not been maintained.
9. Board Rule Chapter 4, Section 3(F) as evidenced by: Sheila Perry's failure to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard patients.

IV. SANCTIONS

The Board, while sympathetic to Sheila Perry's situation, is nevertheless statutorily charged with protecting the public. Accordingly, the Board further concluded that if licensed as a nurse, Sheila Perry poses a threat of danger to the public. Therefore, the Board voted 5-0 to **REVOKE** Sheila Perry's Registered Professional Nurse's license **effective February 8, 2012.**

SO ORDERED.

Dated: February 29, 2012

Dorothy Melanson, RN/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.