STATE OF MAINE BOARD OF NURSING

IN RE: Jerry A. Copp, 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 May 18,1999 for the purpose of determining whether Jerry Copp, R.N. engaged in unprofessional and or incompetent conduct as a registered nurse while employed at Edgewood Rehabilitation and Living Center (Edgewood) in Farmington, Maine. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Richard Sheehan, R.N., Acting Chairman, Karen Tripp, (public representative), Margaret Hourigan, R.N., Kathleen Dugas, L.P.N., Hazel Rand, (public representative), and Jeanne Delicata, R.N. Catherine Bunin-Stevenson, Ass't. Attorney General, presented the State's case. Mr. Copp did not appear either personally or by counsel. James E. Smith, Esq. served as Presiding Officer.

Subsequent to the opening statement by counsel, the following documents were admitted into the Record as exhibits: 1) Proof of service by certified mail; 2) Synopsis of events addressed to Jean Caron, R.N. dated 12/10/97 and forwarded by Valerie Farrington, R.N.; 3) Response by Jerry Copp, R.N. received by the Board on Jan. 10, 1998. Following the taking of testimony, submission of exhibits, and closing argument, 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

Antoinette Bowering has been employed as the administrator at Edgewood since January 1996. In that capacity, she testified that Edgewood patient records revealed that on August 18, 1997, Mr. Copp was the charge nurse on the skilled care unit. During his shift, it was noted that many patient assessments, including the administration of medication, had not been performed. Additionally, beds left unmade, 3 residents remained unbathed, a portion of opening paperwork was not complete and a new admission had not been examined. Mr. Copp admitted that "[A]t times due to the hectic pace, I did forget to sign the appropriate books."

The charge nurse is required to perform certain tasks per shift. The established protocol requires that if any task is not completed, there is a need to communicate that fact to the next shift in order to assure continuity of patient care. Furthermore, regarding

new admissions, a patient's physical condition on entry into the facility cannot be fully assessed with his/her clothes on. Moreover,the failure to document multiple medications constitutes a serious violation of protocol. There is always the possibility of duplication of drugs being given to a patient which, if a narcotic, can be especially harmful. The possibility also exists of a drug overdose or harm from no medication if same is vital to the patient's health.

Ms. Bowering further testified that during the week of September 7-13,1997, Mr. Copp utilized a patient's tube of antibiotic ointment to spread the ointment over buttock wounds without gloves. He then replaced the tube's cover and used that to smear the medication on the wound and subsequently placed the tube back into the general facility treatment box. On September 17,1997, nurse Copp applied antibiotic ointment to leg wounds on both legs of the patient using the tube tip of the ointment pack. He did not wear gloves and proceeded to wipe his hands on his pants following treatment of the wounds. The risks inherent in the above actions include the possibility of spreading bacteria, etc. on the tube tip if that tube is used again as well as the threat of exposing a person to infection or disease, in particular, hepatitis. Ms. Bowering additionally testified that gloves were available in all locations of the facility and that it is standard operating procedure to wear same in the above circumstances.

In his response to these charges which are contained in Exhibit 3, Mr. Copp stated, among other things, that: "I freely admitted to not wearing gloves."

On September 22, 1997, a skilled nursing assessment was not done and treatment records were not up to date on a patient. Mr. Copp recorded in the facility's Report Book that he had called Dr. Fuson regarding the patient. This physician's office had no record or knowledge of any such call.

On September 26, 1997 Mr. Copp compromised the safety of a patient and staff by improperly performing a transfer. A gait belt is required for lifting in some instances including this one. The gait belt was not adjusted properly and slipped. Mr. Copp then manually lifted the patient while a certified nurses aid cleaned him. The lift should have been done by two individuals and failure to do so put both the resident and the lifter in jeopardy of injury. In fact, the patient was sent to the hospital one or two days later for treatment suspected to be related to this lift. In his response, Mr. Copp stated that the patient was transported to the hospital on the same day but this is not found as credible based on the facility's records of the incident.

On October 8, 1997, Mr. Copp took and noted 2 coumadin (blood thinner) orders on two patients with a follow-up to draw blood for testing. Mr. Copp admitted in his response that he had neglected to write the future lab slips regarding one of the patients on the desk calendar. This act, if performed, would have informed other care givers that the patient needed blood to be drawn. The correct dose of medicine for that patient was contingent on the lab draw orders which were not properly recorded.

On October 9, 1997, Mr. Copp notified a patient's next of kin's place of employment that the patient had sustained a "significant decline in status." In actuality, the patient's condition had not seriously declined. The patient had not been adequately assessed and the inaccurate message resulted in the patient's family being upset by Mr. Copp's actions.

Ms. Bowering concluded her testimony by stating that Mr. Copp was fired from his employment due to the above actions and those recorded in the facility's records. She stated her opinion as a nursing home administrator that Mr. Copp was incompetent and posed a safety threat to the facility's patients.

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:

F. Failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient.

G. Abandoning or neglecting a patient requiring nursing care; ...

H. Intentionally or negligently causing physical or emotional injury to a patient.

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

The Board, by a vote of 6-0, concluded that Jerry A. Copp, R.N. violated the above standards of nursing practice by:

1. Not abiding by universal nursing precautions regarding infectious control.
2. Not performing proper and complete patient assessments.
3. Not recording need for appropriate blood work.
4. Improperly utilizing the gait belt and causing harm to a patient.
5. Misleading the Board in his response that the gait belt patient was transported to the hospital on the day of the incident rather then one or two days later.
6. Failed to document the administration of medications.
7. Unprofessional conduct by not calling Dr. Fuson when he stated that he had.
8. Not recognizing the seriousness of his actions.

The Board, by a vote of 5-1, imposed the following sanctions:

1. Suspension of the license of Jerry Copp, R.N. for 4 consecutive 90 day periods for a total of 360 days.
2. Referral of this matter to the Administrative Court for revocation of Mr. Copp's license.

SO ORDERED.

Dated: June 8, 1999

Richard Sheehan, Acting Chairman
Maine 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 Administrative Court, P.O. Box 7260, Portland, ME. 04112-7260.

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.