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

March 13, 2012

Richard Hawksley
1375 Forest Avenue, D-3
Portland, ME 04103

Dear Mr. Hawksley:

Pursuant to your meeting with the Board on February 29, 2012, this will confirm that you have met all of the conditions cited in the Board's Decision & Order dated May 21, 2011. Your RN license will be reinstated as single state status on April 6, 2012.

If you have any questions, please do not hesitate to contact this office.

Sincerely,

Jayne Winters

Jayne Winters
Probation Compliance

pc: Amy Tardy, Case Manager – Medical Professionals Health Program
John H. Richards, Asst. Attorney General

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: Richard Hawksley	)	**DECISION &**
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 1:00 p.m. on April 6, 2011. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether to take disciplinary action against Richard Hawksley'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, R.N.; Robin Brooks (public representative); Bruce O'Donnell, C.R.N.A.; Margaret Hourigan, R.N., Ed.D.; and Susan C. Baltrus, M.S.N., R.N.B.C., C.N.E. Dennis Smith, Assistant Attorney General, presented the State's case. Nurse Hawksley 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 1-5 and Respondent's Exhibit 1 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 Richard Hawksley, a 51-year old resident of Mars Hill, Maine, has been licensed in Maine as a registered professional nurse since July 30, 2003. His license was most recently renewed on October 27, 2010, but it was subsequently suspended by the Board on March 3, 2011. The suspension was issued for primarily two reasons. First, The Aroostook Medical Center (TAMC), Nurse Hawksley's employer since 2003, filed a report with the Board on November 23, 2010. The hospital therein stated that it had given him notice on November 18, 2010 that the hospital was seriously contemplating terminating his employment. That action was being considered due to the Respondent's "on-going unacceptable job performance, specifically related to a lack of attention to detail and safety when administering medications, including documentation."

The record in this matter reveals a history of similar problems during the past few years. For example, Richard Hawksley was counseled by TAMC on April 1, 2005 "over concerns of medication errors." Two and one-half months later, he was informed in his evaluation that he needed improvement in the areas of administering medications, including documentation, chart checks and passing on pertinent information. He was further counseled on October 17, 2005 regarding dosages of drugs withdrawn, but not documented, and on May 17, 2006 for incorrect procedures regarding chest tube/suction incidents. On May 23, 2007, his evaluation noted the need for improvement in the area of medication administration and one year later, TAMC noted that he still had not met the standards in that area. On May 1, 2010, Nurse Hawksley's evaluation noted a "rise in med [ication] errors and poor attention to detail."

On July 15, 2010, TAMC gave the Respondent a "Final Warning." The hospital assigned another registered nurse to witness and co-sign medication administrations for two months with Nurse Hawksley to assure that he completed all patient steps per policy, including documentation. He was also encouraged to consult with his colleagues and shift supervisor if in doubt regarding his nursing practices. These efforts were mostly successful during those two months, but the substandard practice returned soon thereafter as reflected by the following notations. On October 3, 2010, Nurse Hawksley under-dosed a patient and on October 19, he removed a patient's narcotic medication without documenting that fact on the Medication Administration Report. On November 2, an IV with Fentanyl was not attached to the patient, but the pump was running at the prescribed rate. The family filed a complaint since the individual was a comfort care (terminally ill) patient who was restless without the narcotic. On November 3, a patient missed a dose of medication because although an IV was signed out and hung, it was not connected to the patient. On November 5, a patient's narcotic medication was removed without documenting that fact on the Medication Administration Report.

Additionally, Nurse Hawksley performed a Point of Contact Glucose on two patients, but manually entered the incorrect FIN # instead of scanning. Subsequently, the lab was unable to confirm which result belonged to which patient, so the results were not recorded for either and the Respondent could not recall the details of the events. Another example occurred on November 9, 2010, when a patient was discharged without receiving his vaccine as ordered. TAMC's administration believed that they and Richard Hawksley's co-workers had provided him with remedial action and educational support, but his practice still did not meet the standards of expected Registered Professional Nurse performance. Nurse Hawksley decided to resign on November 19, 2010 and is currently unemployed.

The second reason for the Board's suspension involved Respondent Hawksley's 2003 original application for nurse licensure in which he was asked whether he had ever been convicted of any crime other than minor traffic violations. He answered "Yes" and provided copies of his 1994 conviction for Assault (Class D) and his 1999 conviction for Operating Under the Influence ("OUI"). However, he neglected to list his 1985 OUI conviction and his 1987 Theft of Utility Services conviction. Furthermore, his October 2008 on-line renewal application made no mention of his third OUI conviction on May 18, 2007 for the offense which occurred on October 17, 2006. The application contained his affirmation that, "I, the undersigned, being duly sworn, say that...the statements contained herein and on all attachments are true and correct in every respect."

Richard Hawksley testified that "it never crossed my mind" to list the 1987 Theft of Utility Services conviction on his licensure application. He further stated that he had "no idea why" he didn't disclose the two OUIs on his licensure applications. He stated that he has not consumed alcohol for 2½ years nor has he used prescription drugs without a prescription. Nurse Hawksley also let his nurse's license lapse in the fall of 2006 since the two-year licensing period "went by faster than I thought."

Nurse Hawksley subsequently, in his testimony, revisited his failure for not disclosing the most recent OUI conviction on his October 25, 2008 renewal application. He explained that maybe his girlfriend filled out the on-line application. He then questioned whether he may have filled it out, and then offered that perhaps he thought it was civil and not criminal, even though it was pointed out to him that he was incarcerated for seven days, fined $700, and lost his motor vehicle license for 60 days.

The Respondent further testified that he resigned from TAMC because he "didn't want to be there any more," even though he had contemplated working in that hospital's emergency room. He said that he didn't know why he failed to document and admitted that his failure to document his patients' records and sign for the dispensed medications constituted incompetency and that his failure to list all of his convictions constituted unprofessional conduct.

III. CONCLUSIONS OF LAW

The Board voiced its collective concern that Richard Hawksley's most recent mistakes in his practice of nursing are similar to those for the past several years. He does not appear to have made a serious effort to correct his documented deficiencies and maintains he doesn't know why. His believed that if he didn't chart the changes in medication, then someone else would. His reasons for not revealing some of his convictions were implausible and served to further demonstrate his cavalier attitude. 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 5-0, concluded that Richard Hawksley 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:

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

4. 32 M.R.S. Section 2105-A (2) (A). Fraud or deceit in obtaining a license.

5. 32 M.R.S. Section 2105-A (2) (B). Habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of patients.

6. 32 M.R.S. Section 2105-A (2) (H). A violation of this chapter or a rule adopted by the Board.

7. Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A. (1) Fraud or deceit in obtaining a license.

8. Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A.(2) Habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of patients.

9. Board Rule Chapter 4, Disciplinary Action and Violations of Law, Sections 1.A. (5) (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).

10. 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.

11. Board Rule Chapter 4, Section 3 (B) as evidenced by: Richard Hawksley's assumption of duties and responsibilities within the practice of nursing without adequate preparation or when competency has not been maintained.

12. Board Rule Chapter 4, Section 3 (F) as evidenced by: Richard Hawksley's failure to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard patients.

13. Board Rule Chapter 4, Section 3 (H) as evidenced by: Richard Hawksley intentionally or negligently caused physical or emotional harm to a patient.

14. Board Rule Chapter 4, Section 3 (K) as evidenced by: Richard Hawksley inaccurately recorded, falsified or altered a patient or health care provider record.

15. 32 M.R.S. Section 2105-A (2) (G). Richard Hawksley, on his Maine State Board of Nursing Application for Examination and License as a Registered Professional Nurse received by the Board on May 30, 2003, failed to disclose 1) a February 6, 1985 Driving Under the Influence conviction; and 2) a March 27, 1987 Theft of Utility Services conviction.

16. 32 M.R.S. Section 2105-A (2) (A). Richard Hawksley failed to disclose a May 2007 conviction for OUI on his Maine State Board of Nursing 2006-2008 Renewal Application.

IV. SANCTIONS

The Board voted 5-0 to order the following sanctions for the above violations.

1. Richard Hawksley's Registered Professional Nurse's license is hereby suspended for a period of one year from April 6, 2011 until midnight of April 5, 2012.

2. Richard Hawksley shall serve a five-year term of probation from April 6, 2012 until April 5, 2017 unless modified by the Board. During the probation, he shall, by April 5, 2012: (1) be evaluated for substance abuse by a professional selected by him from the Board's approved list; (2) successfully complete a course on assessment and administration, pathophysiology and pharmacology, all pre-approved by the Board's Executive Director; and (3) attend AA meetings and have a sponsor at AA.

3. Any violation of the terms of probation shall be grounds for further disciplinary action.

SO ORDERED.

May 21, 2011
Date

Dorothy Melanson
Dorothy Melanson, Chairman
Maine State Board of Nursing

V. APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S. 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 Superior Court having jurisdiction. 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.