



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: Katherine M. Kelley, L.P.N.) DECISION AND
 Licensure 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. 8001, *et seq.*, the Maine State Board of Nursing (Board) met in public session at the Board's office located in Augusta, Maine on January 8, 2009 at 9:00 a.m. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether Katherine Kelley, L.P.N., violated Board statutes and Rules as a licensed practical nurse while licensed in Maine, as more specifically stated in the Notice of Hearing dated December 15, 2008. 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 Susan Brume, L.P.N. John H. Richards, Assistant Attorney General, presented the State's case. Katherine Kelley was present and not represented by legal counsel. James E. Smith, Esq. served as Presiding Officer.

Following the determination that none of the Board members had conflicts of interest which would bar them from participating in the hearing, the taking of official notice of its statutes and Rules, and subsequent to the opening statement by counsel, State's Exhibits 1-5 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 regarding the violations alleged in the Complaint.



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II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Katherine Kelley, L.P.N., has been licensed as a licensed practical nurse in Maine since May 28, 1991. Her current license expires on July 26, 2010. Ms. Kelley had been primarily employed as an agency nurse until her employment at Seaside Healthcare (Seaside), a skilled nursing facility located in Portland, Maine. Her employment at this facility began in March 2006; her last day of work was September 22, 2006.

On September 8, 2006, a nurse practitioner at Seaside ordered a chest x-ray and lab tests to be performed "stat"¹ on an 88-year-old patient, RK. The tests were ordered since RK's mental status was declining, as she appeared confused and unable to comprehend those around her. Additionally, RK's cardiac and kidney functions were cause for concern. The standard operating procedure at Seaside required a licensed practical nurse or registered nurse to report the results of a "stat" test to either the nurse practitioner or the patient's physician.

Apparently the nurse practitioner was no longer on duty when the test values were received by the Licensee that day at 5:11 p.m. Nurse Kelley's shift ended at 11:00 p.m. that evening. The test results revealed, among other serious findings, that RK's potassium level was elevated at 6.5 mEq/L, well outside the normal range of 3.5 - 5.5. The 6.5 potassium level was life threatening and could result in cardiac arrest if not reduced. Additionally, potential renal insufficiency was indicated by the Blood Urea Nitrogen (BUN) value of 43 mg/dL, far beyond the normal range of 6 - 19. Nurse Kelley brought the lab results to the attention of her superior, who was a registered nurse. Apparently Ms. Kelley believed that the registered nurse would contact RK's physician, whereas the supervisor thought that Nurse Kelley would relay the information to the doctor. Nurse Kelley did override the outstanding order for RK to receive potassium that evening and testified that she also left similar instructions with the evening nurse to so inform the day shift nurse who began her duty at 7:00 a.m.

The lab results were discovered by the day shift nurse at approximately 7:00 a.m. on September 9, 2006. That individual promptly called the attending physician, who

¹ "Stat" means on an immediate or urgent basis.

ordered that RK be transferred to the Emergency Department at Maine Medical Center, where she subsequently passed away early that afternoon.

Although there are several culpable parties who contributed to this failure to protect the health of patient RK, the Board was of the opinion that Nurse Kelley was responsible to some degree in that she should have followed up on her shift to ensure that the lab results were immediately communicated to the attending physician. Moreover, she violated a standard of professional behavior when she did not advocate for RK to ensure that she received the proper care.

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 Katherine Kelley violated the provisions of 32 M.R.S. Sec. 2105-A(2)(E) and Board Rule Chapter 4, Sec. 1.A.5.a. and b. 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. The Board further concluded by the same vote that Katherine Kelley violated the provisions of 32 M.R.S. Sec. 2105-A (2) (F) and Board Rule Chapter 4, Sec. 1.A.6 by engaging in unprofessional conduct.

III.

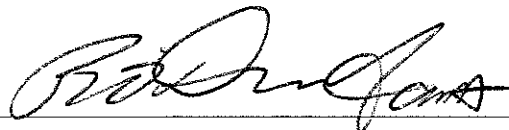
SANCTION

The Board, exercising its experience and training and based on the above findings and conclusions, hereby orders by the vote of 3-2 that Katherine Kelley receive a **REPRIMAND** as the sanction for the above violations. The minority vote would limit the sanction to a Letter of Guidance or Concern, which would not appear as discipline on Nurse Kelley's license. The Board has no record of other complaints regarding this Licensee.

SO ORDERED.

1-25-2009

Date



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

IV.

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 District 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.