STATE OF MAINE BOARD OF NURSING

IN RE: Alan D. Reilly, 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 February 14, 2000 for the purpose of determining whether Alan D. Reilly, R.N. engaged in unprofessional and or incompetent conduct as a registered nurse while primarily employed at Mid Coast Hospital. A quorum of the Board was present during all stages of the proceeding. Participating Board members were Richard Sheehan, R.N., Acting Chairman, Margaret Hourigan, R.N., Kathleen Dugas, L.P.N., Betty Kent-Conant, R.N. and Monica Collins, R.N. John Richards, Ass't. Attorney General, presented the State's case. Mr. Reilly appeared without counsel although had been represented prior to the hearing. James E. Smith, Esq. served as Presiding Officer. The hospital records regarding various patients were placed under a protective Order and further dissemination prohibited without a Court Order. Additionally, patient records were identified by substituting letters for names.

The parties met with the presiding officer prior to the opening of the Record. Since there did not appear to be much dispute regarding the majority of the allegations, the Presiding Officer requested that the Assistant Attorney General state to the Respondent and his wife the specific detailed testimony that he would adduce from the State's 12 witnesses were they to each testify. This presentation was accomplished in a room separate from the Board and out of the Board members' range of hearing. Both the State and the Respondent agreed to the following procedure that was utilized on the Record before the Board. The State's attorney, under oath, gave his offer of proof detailing the testimony of the State's witnesses and the Respondent, under oath, testified as to whether he admitted the allegations or, if not, his reasons for disputing some of the testimony. One additional witness testified for the State and two additional witnesses testified for the Respondent.

The following documents were admitted into the Record as exhibits: 1) Notice of hearing; 2) Voluntary surrender of license by nurse Reilly on December 9, 1999; 3) Disciplinary notes regarding nurse Reilly and Medical records of patients' A-H excepting F; 4) Deposition of Dr. Matthew Carroll; 5) Deposition of Virginia Harrigan, R.N.; 6) Reports from Mid-Coast and Mr. Reilly's response; 7) Letter of Guidance. Respondent's June 3, 1999 letter was also admitted as Respondent's exhibit 1.

Following the taking of testimony, submission of exhibits, and closing arguments, 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

Alan Reilly, R.N. received his nursing degree March 11, 1993. He was employed at Mid Coast Hospital from December 7, 1998 until he was discharged on April 14, 1999. During that time, several events occurred which precipitated the instant action.

On January 23, 1999, nurse Reilly attended to **patient A** who had been hospitalized and operated on due to a broken wrist. An antibiotic had been prescribed for the patient, but the Respondent administered a different antibiotic to this individual. Additionally, the attending physician had ordered that a pain medication be administered to patient A. Although nurse Reilly followed through on the doctor's order, he failed to assess and document on patient A's chart the type of pain (ie. moderate, severe) that the patient was enduring that justified the dose of medication given to him. Moreover, there were no progress notes written by the Respondent regarding patient A. Finally, apparently patient A's vital signs were only taken once during nurse Reilly's shift. The Respondent testified that there was only one certified nurse's aide working on that shift and that he/she was probably too busy to take the additional vital signs. However, it was his responsibility to assure that the vital signs protocol was followed.

Patient B was in nurse Reilly's care on January 19, 1999. The physician's orders were to medicate this individual every 2 hours for discomfort. According to his notes, at 2330 hours, nurse Reilly administered the pain medication, Demerol, to patient B. Nurse Reilly's notes, however, in a separate area of the patient's care plan flowsheet, indicate that the patient has "No discomfort or distention and nontender" at the site of his abdominal dressing. Therefore, there does not exist any documented reason why patient B was medicated.

Patient C suffered from blood loss during his February 1999 hospitalization at Mid Coast. On February 23, this individual slumped to the bathroom floor of his hospital room due to the loss of blood following a bowel movement. A nurse informed the Respondent of patient C's vital signs and told him to call a doctor. The doctor was told by nurse Reilly that "C fell, he's o.k., vital signs stable." The physician then ordered a Complete Blood Count diagnostic test. Subsequently, the Respondent was ordered by the other nurse to call the doctor back and inform him that the patient's condition was more serious than had been stated. The physician then ordered additionally that a Hemoglobin and Hemacrit blood test be drawn to further evaluate the patient's condition. Nurse Reilly was also ordered to take patient C's vital signs every 15 minutes but the progress notes do not reflect that vital signs were taken after 03:45.

Patient D, a thin and frail 108 pound elderly woman, was the victim of the Respondent's mistake of giving too much medication too soon on April 6, 1999. On the shift prior to nurse Reilly's, 5 mgs. of Haldol, a potent substance, was administered orally to this cancer patient at 2300 hours for agitation and anxiety. Morphine, a controlled narcotic, was also given at 2300. Nurse Reilly began his shift at 2400 hours and administered the same dose of Haldol to this patient at 2430 and the same dose of morphine 15 minutes later. Thereafter, more morphine was administered without any notation in the progress notes to indicate the reason for its administration, the exact dosage or even that it had been rendered to patient D. As a result of the amount of Haldol being given to the patient, she was unable to be awakened until late that afternoon.

Nurse Reilly explained that patient D was suffering from severe dementia and needed to be restrained. Since the restraints were ineffective, he decided, for the safety of the patient, that she would benefit from another dose of Haldol in order to keep her from falling out of her wheelchair. Also, he needed to keep patient D under control so he could tend to his other 8 patients. He also testified that he gave her additional morphine due to her complaints of pain. However, he was unaware as to how the drugs interacted that had been administered to this patient. The Respondent further stated that there were no notes reflecting the condition of the patient between 0600-06:30 due to that being the busy time of the morning.

On March 7, 1999, **patient E** was in the care of nurse Reilly who was supposed to assess his oxygen needs every half hour. The Respondent failed to do so for a period of at least 2 hours when this patient was discovered gasping for air, sweating, and her oxygen saturation was in the low 70's. The policy at Mid Coast is for oxygen to be administered immediately if it falls below 90%. There were also no progress notes in order to aid in the assessment of this individual. Due to the intervention of two other nurses, the patient regained stability, although the Respondent couldn't recall why he didn't assess the patient earlier or why he didn't place her on oxygen until 0530.

On March 24, 1999, **patient G's** oxygen saturation rate was recorded at 70 at 2300. A nurse reported this and the fact that the patient had been placed on oxygen to nurse Reilly at shift change. Three hours later, nurse Reilly had still not checked on this patient in order to assess him. There were no progress notes to document nurse Reilly's observations or why the patient's oxygen saturation increased. Additionally, nurse Reilly was not adequately knowledgeable in the functioning of telemetry monitors which enable equipment to monitor a patient's status.

Nurse Reilly was instructed to receive the attending physician's orders and transfer them into a computer in order to have the lab perform various tests on **patient H**. Nurse Reilly did not do this since he did not feel adequately trained on the

computer. Additionally, he neglected to follow his practice of requesting other nurses to enter the information.

Two other incidents were also found by the Board to have taken place regarding nurse Reilly. First, at the time of a shift change, the Respondent had mistakenly entered the wrong names of patients on 4 of 7 patient plan flow sheets which would have resulted in an erroneous diagnosis regarding each had the mistake not been noticed by another nurse and then corrected by nurse Reilly. Second, an IV was inserted into a post-mastectomy patient on the side of the operation rather than on the opposite side. Nurse Reilly could not recall why he had violated this protocol, and his notes also did not reflect his reasoning.

Donna Thomas, R.N., testified on behalf of the Respondent. She has 30 years of nursing experience and is the regional director of nursing for a health care agency. She testified that nurse Reilly performed nursing staff relief from February 21, 1994 until August 6, 1999 when he went inactive with her organization. She noted that nurse Reilly's file did not contain any complaints and that he had attended to a variety of difficult patients.

Pauline Bussiere, a registered nurse with 35 years of experience, also testified on behalf of nurse Reilly. She stated that he had worked as an R.N. at Central Maine Hospital since June 1, 1999 and was being trained in surgical services in the operating room suite. He has performed well there without problems and the staff apparently think highly of him.

Darlene Chalmers, R.N., refuted some of the above testimony. She is a nurse manager at Mid Coast who hired nurse Reilly on December 7, 1998. This nurse testified that she counseled the Respondent regarding the above described incidents and offered him professional training in order to improve his performance. She fired him due to her concerns regarding his clinical competency.

Additional testimony by the Respondent revealed that he had received a General Discharge from the United States Air Force as a nurse in 1998. He testified that he had not received the necessary training as a nurse in the medical-surgical unit and therefore felt that he was "in over his head." On October 26, 1998, he received a Letter of Guidance from the State of Maine Board of Nursing expressing that body's concerns that he maintain his competence in the nursing field.

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:

B. Assuming duties and responsibilities within the practice of nursing without adequate preparation or when competency has not been maintained.

C. Performing new nursing techniques or procedures without proper education and practice.

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

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

The Board, by a vote of 5-0, concluded that Alan D. Reilly, R.N. violated the above rules governing nursing practice by:

1. Administering the wrong antibiotic to a patient (Rule F).
2. Not performing proper and complete patient assessments (Rule F,K).
3. Not documenting assessments (Rule F,K).
4. Failing to document the administration of medications and know their combined effect on a patient (Rule B,F,K).

5. Failing to document pain levels (Rule F, K).
6. Not communicating a patient's condition accurately to a physician (Rule F, K).
7. Not forwarding lab orders (Rule B, C, F, K).
8. Failure to be competent in the operation of telemetry equipment (Rule B,C).
9. Inaccurately recording patient names and diagnoses (Rule F, K).
10. Failing to document reason why IV inserted on wrong side of post-op patient (Rule F,K).

The Board further concluded by a vote of 5-0 that the above violations of the Board Rules also constitute violations of the named statutes.

The Board, by a vote of 5-0, imposed the following sanctions:

1. Suspension of the license of Alan D. Reilly, R.N. for a total of 365 days.
2. The suspension is to begin as of the date of the Hearing, February 14, 2000.
3. Referral of this matter to the Administrative Court for revocation of Mr. Reilly's license.

SO ORDERED.

Dated: February 14, 2000

Richard Sheehan, R.N. 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.