

MAINE STATE BOARD OF NURSING

IN RE: Susan A. Lecomte, 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 July 19, 1999 for the purpose of determining whether Susan Lecomte, R.N. engaged in unprofessional and or incompetent conduct as a registered nurse while employed at Marshwood Nursing Care Center (Marshwood) in Lewiston, 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., Chairman, Karen Tripp, (public representative), Margaret Hourigan, R.N., Kathleen Dugas, L.P.N., Hazel Rand, (public representative), Monica Collins, R.N., Betty Kent-Conant, R.N. and Jeanne Delicata, R.N. John H. Richards, Ass't. Attorney General, presented the State's case. Ms. Lecomte 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 on Ms. Lecomte by certified mail on June 9, 1999; 2) Exhibits A-M. 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

Candice Greenwood, R.N. since 1971, was employed at Marshwood from January 1994 until June 1999 primarily as the admissions coordinator and in the field of marketing. On March 21, 1996, she admitted female patient M who had respiratory illness. The treatment plan was for Ms. M to be discharged home after learning ventilator care in order that she could become self sufficient in operating the ventilator which would allow her to breathe when having pulmonary related difficulty. At the time of admission, this patient was alert and competent to begin the learning/treatment program.

Kathy Labbe, L.P.N., testified that she cared for patient M periodically between May 21 and May 27, 1996. During that time, the patient was dependent on the ventilator which assists in breathing and insures that oxygen is inhaled deep into the lungs. During her stay, patient M became gradually weaned for short periods of time

from the ventilator during the day. However, if M's oxygen saturation level (saturation level) fell below 90/91%, use of the ventilator (portable unit) would be resumed. During M's stay, L.P.N. Labbe would often bring work related problems to the attention of Ms. Lecomte who would choose not to address them. Additionally, Ms. Lecomte would seldom assess the condition of patient M.

On May 27, 1996, Ms. Labbe punched in at Marshwood around 6:45 a.m. for her 7:00 a.m. shift. Prior to assuming her daily rounds, she attended the daily reporting session where the prior shift would relay patient related information to the next shift. This helped to insure the continuity of patient care. Nurse Lecomte was not present although was at work by 6:50 a.m. M had had a restless night since she was anxious regarding a change of her leaking tracheostomy tube the next morning at a local hospital. The transporting ambulance was to arrive for her at 8:30 a.m.

Although M's oxygen levels were noted to be at 91% before 7:45 a.m., the level began to drop between 7:45 a.m. and 8:00 a.m. Ms. Labbe attempted to get M to relax and perform a breathing technique to assist her. M specifically stated that she did not want to go back on the ventilator. The patient's condition and statement were relayed by nurse Labbe to Ms. Lecomte who did not respond. Ms. Labbe then returned to M who was becoming more anxious while her saturation level dropped to 81% and soon into the 70% range. Nurse Labbe then informed the Respondent of the reduction in the saturation level and that M was becoming incoherent, her color was changing and that her skin had become pasty and clammy. Ms. Lecomte replied that nurse Labbe should "keep doing what she was doing." Nurse Lecomte did not come to patient M and assess her condition but rather continued to remain at her desk writing notes and performing routine tasks. In similar situations, other R.N.'s had assessed their patients.

Nurse Labbe returned and took another saturation level reading which was recorded at 65%. This level is an acute one which prompted nurse Labbe to once again attempt to summons R.N. Lecomte to attend to the patient. This time, nurse Lecomte responded by walking to M's doorway, looking at her from that vantage point, and declaring words to the effect that M "really didn't look good." The Respondent then said she would attempt to call a doctor. Since no instructions had been received from nurse Lecomte, L.P.N. Labbe did not reestablish the ventilator despite the fact that M's lips were now blue. She testified that she would have placed a breathing bag over M's face in order to assist her to breathe had she been ordered to do so.

To make matters worse, a family friend was present helplessly observing M slowly die. This individual was apparently aware that M had requested not to be placed back on the ventilator and that nurse Labbe was awaiting further orders from nurse Lecomte. The ambulance service was called at 08:49 a.m. for a routine transport of M to the hospital for her tracheostomy tube to be replaced. The crew was unaware of M's critical condition when they arrived at Marshwood at 08:55 a.m. on May 27, 1996. Nurse Lecomte did not relate any news to M's family and when the ambulance crew arrived, pointed to M's room.

Paul Farrington, licensed paramedic with 25 years of emergency medical services experience, arrived at M's room and found her to be hypoxic. He attempted to obtain information from the staff at Marshwood but they did not make themselves

available. He wanted to know why M was not on the ventilator, why the emergency number 911 had not been utilized, why he was not informed that M was not a routine transfer. According to paramedic Farrington, nurse Lecomte gave him no directions or information regarding M and there was no bag available to assist her in restoring her breathing. Mr. Farrington and his crew intubated M which resulted in a temporary increase in her saturation level to 90%. Shortly thereafter, despite the attempts of the four trained emergency crew members, M's saturation level dropped significantly and subsequently she passed away.

Andrea Otis-Higgins, R.N., testified by deposition. She was the Director of Nursing at Marshwood for three years during which time the above events transpired and subsequently served as the Administrator of Marshwood for almost five months. She testified that it is the registered nurse's duty to oversee the quality of care provided on her unit. Susan Lecomte was assigned the skilled nursing unit that M was located on. Susan Lecomte had received training on the utilization of the ventilator type that M was prescribed and also had access to a pulmonary care guide and policy and procedure manual.

Ms. Otis-Higgins stated that assessments are done by registered nurses. She testified that the standards of nursing practice would dictate that an assessment be performed by a R.N. if the saturation level dropped to a low range. (Exhibit L at 41, 49-51). Additionally, she stated that Ms. Lecomte had been disciplined around issues related to poor communication and poor leadership with her staff but had not demonstrated poor clinical management.

Timothy S. Clifford, M.D., Medical Director of the Department of Human Services Bureau of Medical Services and a practicing physician, gave his opinion that nurse Lecomte violated applicable standards of care in the following manner:

1. By not placing M back on the ventilator when her saturation level was less than 91%;
2. By not promptly notifying M's physician of her deteriorating condition;
3. By not assessing M and abandoning her without a professional staff to inform the ambulance service when they arrived.

Dr. Clifford further testified that M's cause of death was due to neglect in that she was not placed back on the ventilator in a timely manner.

Diane Williams, R.N. was the final witness in this matter. At the time of the above incident, she was employed as a surveyor/investigator for the Maine Department of Human Services' Division of Licensing and Certification. She is currently a nurse epidemiologist for that Department. Following her investigation including M's medical records and interviews with Marshwood personnel, Ms. Williams rendered her opinion that Susan Lecomte violated nursing standards of care at least by:

1. Failing to supervise her staff during M's deteriorating condition;
2. Demonstrating negligence and unprofessional conduct by not performing an assessment of M's condition.

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;

E. Failing to supervise persons to whom nursing functions have been delegated;

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.

N. Practicing nursing when unfit to perform procedures and make decisions in accordance with the license held because of physical, psychological or mental impediment.

The Board, by a vote of 8-0, concluded that Susan A. Lecomte, R.N. violated the above standards of nursing practice by:


1. 32 M.R.S.A. Sec. 2105 - A.(2)(E). Demonstrating incompetence by failing to call 911 or M's physician or any physician.
2. 32 M.R.S.A. Sec. 2105 - A.(2)(E). Demonstrating incompetence by failing to attend morning reporting sessions.
3. 32 M.R.S.A. Sec. 2105 - A.(2)(F). Unprofessional conduct as demonstrated by violating the following Rules:
4. Rule 3 (E). Failing to supervise.
5. Rule 3 (F). Failing to make an assessment of M.
6. Rule 3 (G). Abandonment of M and failing to make continuation of nursing care by others when the paramedics arrived.
7. Rule 3 (H). Negligently causing physical injury to M.

The Board, by a vote of 8-0, imposed the following sanctions:

1. Suspension of the license of Susan A. Lecomte, 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 Ms. Lecomte's license.

SO ORDERED.

Dated: July 19, 1999


Richard Sheehan, Chairman
Maine State 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.