

STATE OF VERMONT

HUMAN SERVICES BOARD

In re ) Fair Hearing No. 15,501  
 )  
Appeal of )

INTRODUCTION

The petitioner appeals a decision of the Department of Aging and Disabilities substantiating a report of abuse against her involving an elderly resident of a nursing home where the petitioner was employed. The petitioner seeks to have the report destroyed and not entered on the Department's registry.

FINDINGS OF FACT

1. The petitioner has been a registered nurse for twenty-two years and is licensed to practice in both Vermont and New Hampshire. She has an associate's degree in nursing and is currently working toward her B.S.N. which she will achieve after completing two more courses. She has worked as a nurse's aide or nurse for over twenty-five years. Twelve of those years have been spent in long-term care. At least two of her jobs placed her in positions of directing nursing at residential care homes for the elderly.

2. In August of 1997, the petitioner was employed by a skilled nursing home as a shift supervisor. The "C" wing in which the petitioner worked contained residents who were in need of a high level of nursing care or rehabilitation because of acute medical conditions.

3. At the end of November or early December of 1997, D.M, an eighty-eight-year-old-woman, was transferred to the intensive nursing wing following a stroke. She was diagnosed as having receptive aphasia--the inability to understand what was being said to her--and nursing notes indicated that her speech was slurred and unintelligible except for occasional periods of alertness. The records indicated that during the beginning of December she had been crying and moaning for several days but was unable to communicate the reason for this. Her right hand and arm appeared to be red and hot, and in consultation with her doctor there were attempts made by the medical staff to relieve the pain through oral pain medication. However, the petitioner refused to take oral medicines and kept spitting them out. She was also refusing to eat. Although two of the aides testified that D.M. was alert and understood all that was said to her, experiencing only occasional difficulty in communicating her wishes, the nursing progress notes for this same period paint quite a different picture.

The notes describe a woman who was often confused and disoriented and frequently spouted gibberish. Her moaning at times was so loud as to disturb her neighbors on the unit and she screamed at times when her arm was touched. The petitioner was also experiencing a very fragile skin condition, the possible dislocation of her shoulder and severe constipation.

4. On December 5, 1997, the petitioner was "charge nurse" on C Wing and was responsible for D.M.'s care. At 9:30 P.M., as she was finishing her charting at her desk near the end of her shift, she was approached by an aide, B. Aide B. told her that she had been summoned by D.M.'s roommate and found D.M. in her room moaning and that she appeared to be in a lot of pain and needed some medication. The petitioner referred B. to the nurse in charge of medications but was told by B. that she was too busy to help right then. The petitioner then went to D.M.'s room and observed that D.M. was moaning loudly and shaking her head back and forth. Her noises had awakened her roommate who was very concerned about her. D.M. was unable to communicate her problem but the petitioner believed that she was likely feeling pain from her arm or bladder. The petitioner tried to give her an oral dose of Tylenol which she refused.

5. The petitioner decided she needed to get some medication into D.M. to alleviate her pain. D.M.'s physician had given her an order for an anal suppository of Tylenol and the petitioner decided she needed to attempt that method although she had had little or no success in such an attempt on an earlier occasion. She had a young aide, M., who had worked as a licensed nursing assistant for two years, come into the room to assist her with the procedure.

6. When the two entered the room, the petitioner was observed grimacing and saying "oh please, please" but was unable to say anything else about her pain. The aide, M., turned her up on one of her sides (the evidence is inconclusive as to which side) at which point D.M. winced in pain. The aide M. held D.M. while the petitioner stood on the opposite side and attempted to insert a Tylenol suppository into her rectum. When she did this, the petitioner found that D.M.'s rectum was filled with soft and hard stool which thwarted her attempts to insert the suppository next to the rectum wall which positioning was necessary for it to be efficacious.

7. The petitioner decided that insertion would be easier, more efficacious, and more comfortable for D.M. if she "disimpacted" her or manually removed some of the stool. This is a commonly performed procedure in certain circumstances which normally does not cause pain but which may be uncomfortable for the patient.<sup>1</sup> The aide M. continued to hold D.M. on her side while the petitioner got a bedpan and began the disimpaction procedure. As the petitioner started this procedure, D.M. began flailing her arm and started to scream "stop, stop". Her screams were

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<sup>1</sup> Much testimony was offered as to whether this was the correct medical procedure to employ for placing a suppository. It can be concluded that it could be in certain circumstances but that any definitive conclusion on this issue would be probative of medical competence rather than abuse since the petitioner sincerely believed it was appropriate.

loud enough to be heard by the aide B. who was outside of the room at that time and by others in the facility. B. called into the room, but did not enter, to see if any help was needed. When she got no reply, she continued with her duties, taking vital signs in nearby rooms. The aide M. became upset by the screams and told the petitioner that she needed to stop because D.M. seemed to be in pain. The petitioner did stop but began the procedure again after a minute saying that she had to get the medication into D.M. to stop the pain according to her doctor's orders. When the screaming began again, the aide M. said she could not stand it anymore, refused to hold the patient and left the room. After she left the room, the petitioner was unable to continue the disimpaction.

8. The petitioner was aware that D.M. was screaming but said she had not noticed that it was any more intense than her usual moans of pain or any different from screaming she had engaged in over the last few days. She did not believe that she was hurting D.M. but that the screaming was a result of her original problem and probably disorientation and confusion. She stated that the whole event lasted less than two minutes during which time she felt torn between the expressed protestations which she felt were probably incompetent and uninformed expressions arising from her confused mental state (rather than there result of pain from the procedure) and her obligation to follow her doctor's

order and do something to relieve her pain. At that point, she had no other methods available to her and was reluctant to call her physician so late at night to obtain a different order for a matter that was non-emergent since the physician had discouraged the nurses from taking that action in the past.

9. At that point, the petitioner summoned the medication nurse, D.K., to assist her in getting the medication into D.M. The medication nurse came into the room, observed D.M. and concluded that she was too upset to be subjected to any further procedures. She persuaded the petitioner to abandon the procedure. It was her opinion that the petitioner was "over-confident" that she could relieve her pain in this manner.

10. Thereafter the aide, M., went to the aide B. to complain about the procedure. M. was crying and very upset and B. said she would cover for her while she went to a break room and got a hold of herself. B. also was upset about hearing the screams. G.B., the charge nurse from the A and B wings who knew the resident D.M. well was advised about the occurrence and went to D.M.'s room to see if she could calm her. She confirmed that D.M. was very upset and seemed to be in pain although she guessed that a lot of her reaction seemed to be fear of not understanding what was happening to her.

11. The aide B. and another aide, C., went to D.M.'s

room to clean her up. They observed that she was hysterical and refused to be touched. They noted that her bedclothes were covered with feces. They also observed a small bleeding tear on D.M.'s arm. They had to spend considerable time calming her down. The petitioner in the meantime had called D.M.'s physician and obtained an order for a morphine shot which she administered to D.M. at about 11:00 p.m.

12. Both the medication nurse and the other charge nurse testified that as a matter of practice they would have ceased the procedure as soon as the patient protested. They were reluctant to characterize the petitioner's action as malpractice although one characterized her action as medically "aggressive" and the other as probably going beyond what should have been done. The matter was reported by the nursing home to SRS as possible abuse and the petitioner was discharged from service.

13. An experienced public health nurse surveyor employed by DAD investigated the matter in January of 1998, by speaking to everyone involved except D.M. herself who at that time was hospitalized and in poor condition (she died shortly thereafter). It was the investigator's conclusion that abuse had occurred when the petitioner manually disimpacted soft stool (which she felt could have been dealt with in some other way, i.e. through a stool softener) and when she continued the procedure when the patient had asked her to stop. That recommendation was adopted by the

Commissioner of DAD and the petitioner was notified that she had been determined to have abused the resident, D.M.

14. The evidence above indicates that the procedure being performed on the patient by the petitioner was for the sole purpose of providing her relief from pain. This procedure may cause discomfort but is not expected to cause harm or physical suffering. The conflicting evidence on whether the disimpaction procedure was appropriate or necessary makes it easy to credit at least the petitioner's belief that this process was needed to get her patient relief from her pain. Subsequent records showed that at least one other disimpaction performed by another medical provider was difficult and messy as well. It cannot be concluded from any of the above facts that the procedure chosen by the petitioner or the way that she performed it was likely to cause unnecessary harm, pain or suffering to the resident. It also cannot be found that any actual harm, pain or suffering resulted from the procedure itself with the exception of a tear on the skin of her arm which happened in the course of movement of that arm either by the patient or someone else. The number of people involved in the procedure and the patient's own thrashing behavior make it impossible to conclude with any certainty who caused the tear to her skin, which was, nevertheless, minor and transitory.

15. The screams of the patient were most likely the

result of a combination of the original pain which she was suffering and fear and disorientation with regard to the disimpaction procedure. The petitioner continued the procedure either because she was unaware that the resident was signaling a new emotion of fear and a desire to stop the process or because she was aware of it but believed it was necessary to proceed to carry out the physician's order to give her anal suppositories for pain. In either case, it cannot be said that the petitioner recklessly inflicted unnecessary suffering since she genuinely believed the process was necessary to relieve the resident's pain as her doctor had ordered. Some of her professional colleagues and the administrator of the nursing home felt that the petitioner's choice was an error in judgment with regard to the patient's dignity and rights. While this may be so, it cannot be concluded that this error caused unnecessary suffering, was malicious or was a part of a pattern of conduct that might trigger a finding that the patient had been emotionally abused. This event appears to have been an isolated incident in which the petitioner had an intent to help the resident, did what she thought was necessary to help her, and in the process, unfortunately, frightened this disoriented woman.

ORDER

The Department of Aging and Disabilities' decision is

reversed.

REASONS

The Commissioner of the Department of Aging and Disabilities is required by statute to investigate reports regarding the abuse of elderly persons and to keep those reports which are substantiated in a registry under the name of the person who committed the abuse. 33 V.S.A. § 6906, 6911(b). Persons who are found to have committed abuse may apply to the Department for expungement of his or her name from the registry. 33 V.S.A. § 6911 (d). A denial of this application is appealable to the Human Services Board pursuant to 3 V.S.A. § 3091(a).

In this matter, after investigation, DAD concluded that the petitioner had caused unnecessary harm, suffering or pain to the patient due to the reckless disregard with which she treated the patient while giving her an anal suppository on the evening in question. The petitioner appealed that finding.

The statute which protects elderly adults, 33 V.S.A. § 6902, defines "abuse" as follows:

As used in this chapter:

(1) "Abuse" means:

(A) Any treatment of an elderly or disabled adult which places life, health or welfare in jeopardy or which is likely to result in impairment of health;

(B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering to an elderly or disabled adult;

(C) Unnecessary confinement or unnecessary restraint of an elderly or disabled adult;

(D) Any sexual activity with an elderly or disabled adult by a caregiver; either, while providing a service for which he or she receives financial compensation, or at a caregiving facility or program;

(E) Any pattern of malicious behavior which results in impaired emotional well-being of an elderly or disabled adult.

The Department relied at the hearing on paragraph (B) above as the basis for its finding that abuse occurred. However, the findings set out above, particularly those in paragraphs 13 and 14, do not meet that definition. There is not sufficient evidence to conclude that the petitioner intentionally or recklessly performed a procedure on this elderly patient in such a way which was likely to cause her unnecessary pain, suffering or harm. Neither can it be concluded under paragraph (E) that the petitioner engaged in a pattern of malicious conduct resulting in an impairment of the emotional well-being of an elderly or disabled adult.

Because the petitioner's conduct does not rise to the level of "abuse" as defined in the statute, the Department's determination is reversed.

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