STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

January 10, 2008

Jean Lavin Caplan, APRN, RN
13 Harbour Close
New Haven, CT 06519

Re: Memorandum of Decision
Petition Nos. 2004-0126-012-003
2004-0126-010-004
License Nos. 001633
E53434

Dear Ms. Caplan:

Please accept this letter as notice that you have satisfied the terms of your license probation, effective January 1, 2008.

Notice will be sent to the Department's Licensure and Registration section to remove all restrictions from your license related to the above-referenced Memorandum of Decision.

Please be certain to retain this letter as documented proof that you have completed your license probation.

Thank you for your cooperation, and good luck to you in the future.

Very truly yours,

Bonnie Pinkerton

Bonnie Pinkerton, RN, Nurse Consultant
Practitioner Licensing and Investigations Section

cc: J. Filippone
J. Wojick

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STATE OF CONNECTICUT

BOARD OF EXAMINERS FOR NURSING

Department of Public Health

vs.

Jean Lavin Caplan, APRN, Lic. No. 001633
RN Lic. No.E53434
Respondent

Petition No. 2004-0126-012-003 - APRN
Petition No. 2004-0126-010-004 - RN

MEMORANDUM OF DECISION

Procedural Background

The Board of Examiners for Nursing (hereinafter "the Board") was presented by the Department of Public Health (hereinafter "the Department") with a Statement of CHARGES dated February 15, 2005. Dept. Exh. 1-A. The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Jean Lavin Caplan (hereinafter "respondent") which would subject respondent's registered and advanced licensed practical nurse licenses to disciplinary action pursuant to *Conn. Gen. Stat.* §§ 19a-17 and 20-99(b).

The Board issued a Notice of Hearing dated February 7, 2005, scheduling a hearing for September 21, 2005. Dept. Exh. 1.

Respondent was provided notice of the hearing and charges against her. The Notice of Hearing and Statement of Charges were delivered by certified mail to respondent and respondent's attorney. Dept. Exh. 1.

The hearing took place on September 21, 2005, March 15, 2006, and September 20, 2006, in Room 2-A, Legislative Office Building, Capitol Avenue, Hartford, Connecticut.

Respondent was present during the hearing and was represented by counsel.

Respondent submitted a written Answer to the Statement of Charges. Resp. Exh. 2.

On September 21, 2005, respondent filed a Motion to Dismiss on the basis of collateral estoppel. In the motion, she claimed that the department was estopped from continuing to prosecute the case because the board had earlier, in a prehearing review proceeding, recommended that the department withdraw the charges against her and instead issue her a warning letter. The board denied the motion on September 21, 2006, because its recommendation was nonbinding and was based on limited documentary evidence without the benefit of a full hearing of the evidence in the case. Tr. p. 8.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record, the law, and the Board's specialized professional knowledge in evaluating the evidence.

The Allegations and Responses

PARAGRAPH 1 of the Statement of Charges alleges that respondent, of New Haven, Connecticut is, and has been at all times referenced in this Statement of Charges, the holder of Connecticut APRN license number 001633 and Connecticut RN license number E53434.

Respondent admits this charge. Rt. Exh. 2.

PARAGRAPH 2 of the Statement of Charges alleges that at all relevant times, respondent worked as a head nurse manager at the Hospital.

Respondent admits this charge. Rt. Exh. 2.

PARAGRAPH 3 of the Statement of Charges alleges that as head nurse manager respondent's duties were primarily administrative, including mentoring new nursing staff.

Respondent admits this charge. Rt. Exh. 2.

PARAGRAPH 4 of the Statement of Charges alleges that at all relevant times, respondent had not completed the hospital's competencies in medicine administration and did not have a code to use the Pyxis machine.

Respondent admits this charge. Rt. Exh. 2.

PARAGRAPH 5 of the Statement of Charges alleges that on or about November 21, 2003, A.P. was a patient at the hospital. He was ventilator-dependent with a DNR order.

Respondent admits this charge. Rt. Exh. 2.

PARAGRAPH 6 of the Statement of Charges alleges that on or about November 21, 2003, Lisa Beradesca, R.N., was the primary care nurse assigned to A.P.

Respondent denies this allegation. Rt. Exh. 2.

PARAGRAPH 7 of the Statement of Charges alleges that on or about November 21, 2003, A.P.'s family and medical providers decided to withdraw him from ventilator support and to provide him with end-of-life/comfort care.

Respondent admits this allegation. Rt. Exh. 2.

PARAGRAPH 8 of the Statement of Charges alleges that on or about November 21, 2003, at approximately 10:43 a.m., an order was issued for a continuous morphine drip to start at 1mg per hour and titrate to comfort.

Respondent admits this allegation. Rt. Exh. 2.

PARAGRAPH 9 of the Statement of Charges alleges that at or about 11:30 a.m., Lisa Beredesca started the morphine drip.

Respondent neither denies nor admits this charge. Rt. Exh. 2.

PARAGRAPH 10 of the Statement of Charges alleges that at or about 1:30 p.m., the ventilator was withdrawn.

Respondent neither denies nor admits this charge. Rt. Exh. 2.

PARAGRAPH 11 of the Statement of Charges alleges that after the ventilator was withdrawn, A.P.'s vital signs were stable. He did not demonstrate agonal breathing or twitching.

Respondent denies this charge. Rt. Exh. 2.

PARAGRAPH 12 of the Statement of Charges alleges that between approximately 1:30 p.m. and 3:30 p.m., respondent who had no direct clinical responsibility for A.P., entered A.P.'s room and increased the rate of the morphine drip from approximately 2mg/hr to 999 mg/hr, the highest setting on the pump.

Respondent denies this charge. Rt. Exh. 2.

PARAGRAPH 13 of the Statement of Charges alleges that while respondent was increasing the rate of the morphine drip, she assured staff members that her actions were based on her experience with morphine drips used for end-of-life/comfort care.

Respondent denies this charge. Rt. Exh. 2.

PARAGRAPH 14 of the Statement of Charges alleges that at or about 3:30 p.m., respondent left the unit at the end of her shift with the pump setting at 999 mg/hr. At that time, she failed to give clinical instructions to Lisa Beradesca regarding further care for A.P.

Respondent denies this allegation. Rt. Exh. 2.

PARAGRAPH 15 of the Statement of Charges alleges that in her conduct regarding A.P. respondent:

a. improperly programmed the rate of morphine administered by the pump;
b. failed to document clinical findings in A.P.'s medical record to support her decision to rapidly increase the rate of the morphine drip;
c. failed to document her clinical interventions in A.P.'s medical record;
d. failed to give clinical instructions to the nurse assigned primary responsibility for A.P.'s care when respondent went off duty; and/or,
e. misrepresented the extent of her experience in the use of morphine drips for end-of-life/comfort care, thereby, inducing staff to rely on her expertise.

Respondent denies this charge. Rt. Exh. 2.

Findings of Fact

Based on the testimony given and the exhibits offered into evidence, the Board makes the following Findings of Fact:

1. Jean Lavin Caplan of New Haven, Connecticut is, and has been at all times referenced in this Statement of Charges, the holder of Connecticut APRN license number 001633 and Connecticut RN license number E53434.

2. At all relevant times, respondent worked as a head nurse manager at the Veterans Administration Hospital ("the Hospital"). Rt. Exh. 2.

3. As head nurse manager, respondent's duties were primarily administrative, including mentoring new nursing staff. Rt. Exh. 2.

4. At all relevant times, respondent had not completed the hospital's competencies in medicine administration and did not have a code to use the Pyxis machine. Rt. Exh. 2 ; Tr. 09/21/05, p. 113.

5. On or about November 21, 2003, A.P. was a patient at the hospital. He was ventilator-dependent with a Do Not Resuscitate ("DNR") order. Rt. Exh. 2.

6. The evidence is insufficient to establish that on or about November 21, 2003, Lisa Beradesca, RN, was the primary care nurse assigned to A.P. However, Ms. Beradesca provided care to A.P. Tr. 09/21/05, p. 100.

7. On or about November 21, 2003, A.P.'s family and medical providers decided to withdraw him from ventilator support and to provide him with end-of-life/comfort care. Rt. Exh. 2.

8. On or about November 21, 2003, at approximately 10:43 a.m., an order was issued for a continuous morphine drip to start at 1 milligram ("mg") per hour, and titrate to comfort. Rt. Exh. 2.

9. At or about 11:30 a.m., Lisa Beredesca started the morphine drip. Tr. 09/21/05, p. 102.

10. At or about 1:30 p.m., the ventilator was withdrawn. Tr. 09/21/05, pp. 102-103, 126.

11. The evidence is insufficient to establish that after the ventilator was withdrawn, A.P.'s vital signs were stable, and that he did not demonstrate agonal breathing or twitching. Tr. 09/21/05, p. 108.

12. The evidence is insufficient to establish that between approximately 1:30 p.m. and 3:30 p.m., respondent had no direct clinical responsibilities for A.P. However, the evidence demonstrates that respondent increased the rate of the morphine drip from approximately 2 mg/hour to 999 mg/hour, the highest setting of the pump. Tr. 09/21/05, pp. 100, 109, 128.

13. While respondent was increasing the rate of the morphine drip, she assured staff members that her actions were based on her experience with morphine drips used for end-of-life/comfort care. Rt. Exh. 4.

14. The evidence is insufficient to establish that at or about 3:30 p.m., respondent left the unit at the end of her shift with the pump setting at 999mg/hour, and that she failed to give clinical instructions to Lisa Beradesca regarding further care to A.P. Tr. 09/21/05, pp. 127, 154.

15. Respondent improperly programmed the rate of morphine administered by the pump. Tr. 09/21/05, pp. 44, 45.

16. Respondent failed to document clinical findings in A.P.'s medical record to support her decision to rapidly increase the rate of morphine. Tr. 09/21/05, pp. 108, 131.

17. Respondent failed to document her clinical interventions in A.P.'s medical record. Tr. 09/21/05, p. 131; Tr. 09/20/06, p. 34.

18. The evidence is insufficient to find that respondent failed to give clinical instructions to the nurse assigned primary responsibility for A.P.'s care when respondent went off duty.

19. Respondent misrepresented the extent of her experience in the use of morphine drips for end-of-life/comfort care thereby inducing staff to rely on her experience. Tr. 09/21/05, p. 117.

Conclusions of Law and Discussion

In consideration of the above Findings of Fact, the following conclusions are rendered: Jean Lavin Caplan held valid registered and advanced practice registered nurse licenses in the State of Connecticut at all times referenced in the Statement of Charges.

The Notice of Hearing and Statement of Charges provided sufficient legal notice as mandated by *Conn. Gen. Stat.* §§ 4-177(a) and (b), and 4-182(c). The hearing was held in accordance with *Conn. Gen. Stat.* Chapters 54 and 368a as well as §§ 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies.

The Notice of Hearing, Statement of Charges, and the hearing process provided respondent with the opportunity to demonstrate compliance with all lawful requirements for the retention of her licenses as required by *Conn. Gen. Stat.* § 4-182(c).

The Department bears the burden of proof by a preponderance of the evidence in this matter.

The General Statutes of Connecticut § 20-99 provides in relevant part:

> (a) The Board of Examiners for Nursing shall have jurisdiction to hear all charges of conduct which fails to conform to the accepted standards of the nursing profession brought against persons licensed to practice nursing. After holding a hearing . . . said board, if it finds such person to be guilty, may revoke or suspend his or her license or take any of the actions set forth in section 19a-17. . . .
> (b) Conduct which fails to conform to the accepted standards of the nursing profession includes, but is not limited to, the following: . . . ;
> (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions; . . . .

Based on its findings, the Board concludes that respondent's conduct as alleged in Paragraphs 1, 2, 3, 4, 5, 7, 8, 9, 10, 13, 15a, 15b, 15c, and 15e of the Statement of Charges is proven by a preponderance of the evidence presented. The Department partially met its burden of proof with regard to the conduct alleged in paragraph 12 of the Statement of Charges in that the Board finds that respondent increased the morphine drip from 2mg/hr to 999mg/hr. However, the Board finds that the evidence is insufficient to establish that respondent lacked any clinical responsibility for A.P. The Board further concludes that said conduct constitutes grounds for disciplinary action pursuant to *Conn. Gen. Stat.* §§ 20-99(b)(2).

Order

Pursuant to its authority under *Conn. Gen. Stat.* §§ 19a-17 and 20-99, the Board of Examiners for Nursing hereby orders the following:

1. That for Paragraphs 1, 2, 3, 4, 5, 7, 8, 9, 10, part of 12, 13, 15a, 15b, 15c, and 15e of the Statement of Charges, respondent's registered and advanced practice registered nurse numbers E53434 and 001633 respectively, are placed on probation for a period of one (1) year.
2. If any of the following conditions of probation are not met, respondent's registered and advanced practice registered nurse may be subject to disciplinary action pursuant to §19a-17 of the General Statutes of Connecticut.
   A. During the period of probation the Board shall pre-approve respondent's employment and/or change of employment within the nursing profession.
   Respondent shall not be employed as a nurse for a personnel provider service, assisted living services agency, homemaker-home health aide agency, or home health care agency, and shall not be self-employed as a nurse for the period of probation.
   B. Respondent shall provide a copy of this Memorandum of Decision to any and all employers if employed as a nurse during the probationary period. The Board shall be notified in writing by any employer(s), within thirty (30) days of the commencement of employment, as to receipt of a copy of this Memorandum of Decision.
   C. If employed as a nurse, respondent shall cause employer reports to be submitted to the Board, by her immediate supervisor during the entire probationary period. Employer reports shall be submitted commencing with the report due on the first business day of month following employment as a nurse. Employer reports shall be submitted quarterly during the probation.

D. The employer reports cited in Paragraph C above shall include documentation of respondent's ability to safely and competently practice nursing. Employer reports shall be submitted directly to the Board at the address cited in Paragraph I below.

E. Should respondent's employment as a nurse be involuntarily terminated or suspended, respondent and his employer shall notify the Board within seventy-two (72) hours of such termination or suspension.

F. During the probationary period respondent, at her expense, shall successfully complete a course in medication administration and documentation pre-approved by the Board. Respondent shall provide proof to the satisfaction of the Board of her successful completion of the course within thirty days of completion.

G. During the probationary period respondent shall not have any supervisory responsibilities.

H. The Board must be informed in writing prior to any change of address.

I. All correspondence and reports are to be addressed to:

Bonnie Pinkerton, RN, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
Board of Examiners For Nursing
410 Capitol Avenue, MS #12HSR
P. O. Box 340308
Hartford CT 06134-0308

3. Any deviation from the terms of probation, without prior written approval by the Board, shall constitute a violation of probation, which will be cause for an immediate hearing on charges of violating this Order. Any finding that respondent has violated this Order will subject respondent to sanctions under §19a-17(a) and (c) of the General Statutes of Connecticut, including but not limited to, the revocation of her license. Any extension of time or grace period for reporting granted by the Board shall not be a waiver or preclude the Board's right to take subsequent action. The Board shall not be required to grant future extensions of time or grace periods. Notice of revocation or other disciplinary action shall be sent to respondent's address of record (most current address reported to the Office of Practitioner Licensing and Certification of the Department of Public Health or the Board).

4. This Memorandum of Decision becomes effective, and the one (1) year probation of respondent's registered and advanced practice registered nurse licenses, Nos. E53434 and 001633 respectively, shall commence, on January 1, 2007.

The Board of Examiners for Nursing hereby informs respondent, Jean Lavin Caplan, and the Department of Public Health of the State of Connecticut of this decision.

Dated at Hartford, Connecticut this 20th day of December 2006.

BOARD OF EXAMINERS FOR NURSING

By _____

CERTIFICATION

I hereby certify that, pursuant to Connecticut General Statutes §4-180(c), a copy of the foregoing Memorandum of Decision was sent this 21st day of December 2006, by certified mail, return receipt requested, to:

Steven Errante, Esq.
Lynch, Traub, Keefe & Errante
52 Trumbull Street
PO Box 1612
New Haven, CT 06506-1612

Certified Mail RRR #70042510000753840831

and by Inter-Departmental Mail to:

Stanley K. Peck, Chief
Legal Office
Department of Public Health
410 Capitol Avenue, MS #12LEG
Hartford, CT 06134-0308

Jeffrey A. Kardys
Administrative Hearings Specialist/Board Liaison
Department of Public Health
Public Health Hearing Office