BEFORE THE BOARD OF NURSING
STATE OF MONTANA

	)	**Docket No. CC-01-392-NUR**
IN THE MATTER OF THE PROPOSED	)	**Hearings Bureau Case No. 2022-2002**
DISCIPLINARY TREATMENT OF THE	)	
LICENSE OF TERRENCE BRICK,	)	**FINDINGS OF FACT;**
License #LPN 6022	)	**CONCLUSIONS OF LAW;**
	)	**AND ORDER**
	)	

I. INTRODUCTION

This matter stems from a complaint issued by the Screening Panel of the Montana Board of Nursing. The complaint found probable cause to believe that Terrence Brick, a licensed practical nurse (LPN), had engaged in unprofessional conduct in violation of Mont. Code Ann. § 37-1-316(18) (engaging in conduct that does not meet generally accepted standards of practice) and Admin. R. Mont. 8.32.413(2) (engaging in conduct that fails to conform to accepted standards of the nursing profession and which could jeopardize the health and welfare of a patient). The complainant cited three instances of alleged inappropriate conduct: (1) that the licensee watched a female patient while the patient was showering, (2) that the licensee failed to chart the female patient's subsequent complaint that she had been watched by the licensee while showering, and (3) that the licensee failed to maintain appropriate boundaries with female patients in that he let female patients braid his hair.

Prior to the hearing, the licensee filed two motions, one to change the venue of the hearing, and one to preclude expert testimony. The hearing examiner denied each of these motions.

This matter proceeded to contested case hearing before the hearing examiner on October 18, 2002 and December 3, 2002. Lori Ballinger, agency legal counsel, represented the licensing bureau of the Department of Labor and Industry. Evan Danno, Attorney at Law, represented the licensee. The Department's Exhibits 1 and 2 were admitted into evidence. The licensee's Exhibits A, A-3, A-4, and B were also admitted into evidence.

Ron Burns, an investigator for the Montana Board of Nursing, Bob Rose, a licensed social worker, Mina Crenshaw, and Barbara Swehla, the Executive Director of the Montana Board of Nursing, testified under oath for the Department. Jim Hislop, a certified nursing assistant (CNA), the licensee, and Jane Morrison, a registered nurse, testified under oath on behalf of the licensee. At the conclusion of the Department's case in chief, the Department

abandoned its contention that the licensee had failed to maintain appropriate boundaries by allowing female patients to braid his hair. The hearing examiner found, and the Department conceded, that there was no factual basis for this allegation. Having considered the evidence and arguments of the parties, the following findings of fact, conclusions of law, and recommended order are made.

II. FINDINGS OF FACT

1. Licensee has been licensed as an LPN in the state of Montana since 1982 or 1983. He is employed by Pathways Treatment Center (Pathways) in Kalispell, Montana, and has been since 1994. Pathways is a chemical dependency treatment center that houses both adult and adolescent patients.

2. Crenshaw was a 16-year-old patient at Pathways during August 1999. At that time, Pathways required its nursing staff, including the licensee, to conduct regular periodic checks of patients. The nursing staff completed this task by knocking on the door of the patient's room and/or entering the patient's room to verify both that the patient was present and that the patient was okay. The frequency of these checks was dependent upon a patient's acuity level, i.e., the particular patient's risk for self-injury or flight from the center. Crenshaw presented a moderate level of risk for self-injury or flight and, accordingly, nursing staff verified her presence every 30 minutes. Pathways also used a "team" approach during this time in caring for patients. Members of the team, which include the nurses attending the patients, utilized a flow sheet to note the presence of the patients who had to be accounted for periodically. Team members relied on communications from other members to monitor the patients.

3. Crenshaw alleged that the licensee entered her private bathroom on August 23, 1999, and watched her through a broken shower curtain while she was taking a shower. Crenshaw's medical chart did not contain any notation that the incident had occurred, nor did it contain any notation that Crenshaw had made the allegation.

4. The compelling physical evidence introduced at the hearing fails to show that the licensee entered Crenshaw's bathroom and viewed her while she was showering. The photographs admitted into evidence demonstrate that Crenshaw could not have seen what she claimed to have seen. The photographic evidence is corroborated by the testimony of Jane Morrison and Jim Hislop. The licensee could not have opened the door to the bathroom in the manner described by Crenshaw and been able to observe Crenshaw while she was showering.

5. The credible evidence shows that on August 23, 1999, at 10:30 p.m., the licensee was in the process of completing his evening shift. At that time he observed Crenshaw standing at the nurse's station. Because he saw Crenshaw there, he counted that as one of his required 30-minute checks on Crenshaw.

6. At 11:00 p.m., the licensee knocked on the door to Crenshaw's room. He received no acknowledgment to his knock. He then opened the door to Crenshaw's room just enough to make a visual scan of the living area. He did not see Crenshaw. He called her name three times while standing outside the room by the open door. He got no answer.

7. Pursuant to Pathways' protocol, the licensee checked the rooms of the male patients housed in the treatment center (located on the same floor as Crenshaw) to see if he might locate Crenshaw. He did not find her in any of those rooms.

8. The licensee then walked back toward the nurse's station located on the floor in order to find a female nurse to begin searching the rooms of the female patients of the center to try to find Crenshaw. While walking back to the nurse's station, the licensee observed Jim Hislop, another Pathways staff member, at the door to Crenshaw's room speaking to a person in the room. From the conversation, and the fact that Hislop did not indicate that anything was amiss, the licensee assumed that Hislop was talking to Crenshaw. The licensee did not actually see Crenshaw, but under the circumstances described by Hislop and the licensee, the licensee not only correctly concluded that Hislop was talking to Crenshaw, but his decision to rely on that inference was reasonable.

9. The only medical charting that the licensee completed on the evening of August 23, 1999 was to "check off" on Crenshaw's medical flow sheet that she was present at the 11:00 p.m. check.

10. After noting Crenshaw's presence on the flow sheet, the licensee left and went home as his shift had ended. No allegation had been made against him at that time, so the licensee could not have charted anything about any such allegation.

11. On the following day, Crenshaw informed Chris Crager, a Pathways staff member, of her allegation involving the licensee's conduct. A meeting between Crager, Crenshaw, the licensee, and Morrison took place at that time. During the meeting, Crenshaw admitted that she was not sure that the licensee had actually viewed her while she was showering.

III. CONCLUSIONS OF LAW

A. <u>The Department Has Failed to Demonstrate Any Violation</u>

1. Mont. Code Ann. § 37-1-316 provides in pertinent part:

> The following is unprofessional conduct for a licensee . . . governed by this chapter:
>
> * * *
>
> (18) conduct that does not meet the generally accepted standards of practice.

2. Admin. R. Mont. 8.32.413(2), among other things, defines unprofessional conduct to include:

> (a) failing to utilize appropriate judgement in administering safe nursing practice based on the level of nursing for which the individual is licensed (Admin. R. Mont. 8.32.413 (2)(a));
> (b) failing to follow policies or procedures defined in the practice situation to safeguard patient care (Admin. R. Mont. 8.32.413 (2)(c));
> (c) failing to safeguard a patient's dignity and right to privacy (Admin. R. Mont. 8.32.413 (2)(d));
> (d) failing to chart (Admin. R. Mont. 8.32.413 (2)(h));
> (e) intentionally committing any act that adversely affects the physical or psycho-social welfare of the patient (Admin. R. Mont. 8.32.413(2)(k).

3. The Department bears the burden of proof in this matter to show by a preponderance of the evidence that the licensee committed an act of unprofessional conduct. Mont. Code Ann. § 37-3-311; *Ulrich v. State ex rel. Board of Funeral Service*, 289 Mt. 407, 961 P.2d 126 (1998).

4. The Department has failed to demonstrate by a preponderance of the evidence that the licensee entered Crenshaw's bathroom and watched her while she was showering. As indicated in the findings of fact, the photographs, along with the testimony of Hislop and Morrison, demonstrate the physical impossibility of the scenario alleged by Crenshaw.[(1)]

5. Because the Department has failed to show that the licensee entered Crenshaw's bathroom and watched her shower, the Department has failed to show a violation of Admin. R. Mont. 8.32.413(2)(a), (d), or (k).

6. The Department has also failed to show by a preponderance of the evidence that the licensee failed properly to chart. The Department's expert witness, Barbara Swehla, conceded that if the alleged viewing of Crenshaw in the shower did not occur, there would be no "negative event" to chart, and the only charting required would be to verify Crenshaw's presence in her room in accordance with Pathways' procedures in place at the time. The licensee comported with these requirements, checking off on the flow chart and thereby properly noting Crenshaw's presence during the 11:00 p.m. rounds. Swehla's comments about "late entry" charting regarding Crenshaw's purported "negative experience" do not apply in this case. Crenshaw did not tell

anyone of the alleged incident until the next morning, so the licensee knew nothing of her "negative experience" until the next morning when he was called to a meeting with Morrison, Crenshaw and Krager. The Department presented no evidence to show that at that point in time the licensee carried any responsibility to chart Crenshaw's negative experience.

7. Because the Department has failed to show by a preponderance of the evidence that the licensee failed properly to chart, the Department has failed to show a violation of either Admin. R. Mont. 8.32.413(2)(a), (c), or (h).

8. Because the Department has failed to show either that the licensee either watched Crenshaw while showering or failed properly to chart, there has been no showing that the licensee violated Mont. Code Ann. § 37-1-316(18).

B. The Failure to Demonstrate a Violation Requires Dismissal

9. If a licensee is found not to have violated a provision of Mont. Code Ann. Title 37, Chapter 1, Part 3, then the Department shall prepare and serve the board's findings of fact and an order of dismissal of the charges. Mont. Code Ann. § 37-1-311.

10. Because the Department has failed to demonstrate that the licensee engaged in conduct that violated Title 37, Chapter 1, Part 3, MCA, dismissal of the charges is appropriate.

IV. RECOMMENDED ORDER

Based on the foregoing, the hearing examiner recommends that the Board enter its order dismissing the allegations contained in the complaint filed against the licensee as the Department has failed to prove any violation contained in the complaint.

DATED this 19th day of March, 2003.

DEPARTMENT OF LABOR & INDUSTRY
HEARINGS BUREAU

By: /s/ GREGORY L. HANCHETT
GREGORY L. HANCHETT
Hearing Examiner

NOTICE

Mont. Code Ann. § 2-4-621 provides: (1) the Board may not make a proposed order adverse to the licensee final until after service upon each of the parties and after the party adversely affected by the proposed order is given an opportunity to file exceptions and present briefs and oral argument to the Board; (2) the Board may not modify or reject the findings of fact herein without first determining from a review of the complete record and stating with particularity in its order that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law; (3) the Board may accept or reduce the recommended penalty but may not increase the recommended penalty without a review of the complete record.

1. Licensee's counsel attempted to impeach Crenshaw's testimony by suggesting, through the introduction of testimony and exhibits, that Crenshaw had lied about the reasons she was placed in Pathways and further that Crenshaw might have been under the effects of withdrawal from methamphetamine use. These methods of impeachment were not persuasive and do not at all bear on the examiner's determination that Crenshaw's description of the alleged event was impossible.