BEFORE THE BOARD OF NURSING
STATE OF MONTANA

IN THE MATTER OF CASE NO. 2015-NUR-LIC-508 REGARDING:

THE PROPOSED DISCIPLINARY TREATMENT OF THE LICENSE OF AMANDA POEPPING, Registered Nurse, License No. 23598.	)))))	Case No. 2408-2015

PROPOSED FINDINGS OF FACT; CONCLUSIONS OF LAW; AND RECOMMENDED ORDER

I. INTRODUCTION

On June 5, 2015, the Screening Panel of the Montana Board of Nursing (Board) issued a "Notice of Proposed Board Action, Summary Suspension, and Opportunity for Hearing" regarding the license of Amanda Poepping, R.N. The "Summary Suspension Order" portion of the document was effective that same date. On June 5, 2015, the Department of Labor and Industry's Business Standards Division ("BSD") (tasked with and authorized to carry out the directions and decisions of the Panel and the Board, through Division's personnel including those in the Office of Legal Services) served a copy of the documents on Poepping, by deposit in USPS mail to Poepping's address of record. On Sunday, June 21, 2015, Poepping faxed a response that she wished to contest the proposed actions against her license, giving notice also that she had voluntarily entered treatment and that it would be necessary to postpone the hearing. She did not demand commencement of proceedings promptly instituted and determined regarding summary suspension of her license. Mont. Code Ann. § 2-4-631.

On Tuesday, June 23, 2015, BSD forwarded the documents to the department's Office of Administrative Hearings (OAH) with a cover letter requesting OAH to appoint a hearing examiner for the proceedings that licensee requested. OAH issued its "Notice of Hearing and Telephone Conference" on June 29, 2015 by depositing copies in the U.S. Mail, postage prepaid, addressed to Poepping at both her original address of record and her temporary residence in a treatment center, with a copy to the BSD attorney who would be prosecuting this contested case civil proceeding regarding the proposed discipline to Poepping's R.N. license. That notice appointed Terry Spear as Hearing Officer to preside over contested case proceedings, and set a telephonic scheduling conference for July 13, 2015, with Poepping

participating from her treatment center, as had been informally arranged before issuance of the notice.

The treatment facility where Poepping was located continued to cooperate with OAH, and on July 13, 2015, the Hearing Officer convened a telephone scheduling conference with Poepping, whose treatment counselor was with her, and with department counsel Kevin G. Maki participating on behalf of BSD. From the entire discussion in the July 13, 2015 telephone conference, as well as the documents in OAH's hearing file, the Hearing Officer concluded that Poepping understood her license has been summarily suspended pending proceedings for revocation or other action and understood she had the right to promptly instituted and determined proceedings on the suspension. Mont. Code Ann. § 2-4-631(3). Poepping did voluntarily waive her rights to prompt institution and determination of the proceedings against her license, including the summary suspension. Counsel for BSD then agreed with Poepping for delay in scheduling the contested case proceedings. With the summary suspension intact, any genuine risk to the public was obviated, so Licensee's potential rehabilitation justified postponement once she had waived her rights to prompt institution and determination of the proceedings. Poepping signed and returned the waiver. Based upon the interactions in that telephone conference, the Hearing Officer issued a "Minute Entry re Postponement and Waiver of Rights" on July 14, 2015.

On August 17, 2015, Veronica A. Proctor, Proctor Law PLLC, filed an appearance as counsel for Poepping in this proceeding. On August 24, 2015, Proctor filed the signature page from the "Waiver of Rights," which Poepping had signed. With the waiver on file, the Hearing Officer convened a telephonic scheduling conference on August 24, 2015 with counsel for the parties, and on August 28, 2015, the Hearing Officer issued the "Scheduling Order" herein.

On October 14, 2015, the Hearing Officer issued a stipulated protective order that essentially provided that any and all documents and information designated, in good faith, as "Confidential Information" would be sealed. On October 22, 2015, the Hearing Officer convened the final pre-hearing telephone conference with counsel. During that telephone conference, counsel agreed that the entire evidentiary hearing should be designated as "Confidential Information." On October 22, 2015, counsel having agreed upon its content, the "Final Pre-Hearing Order" issued. That same day, the Hearing Officer issued the "Procedure Notice and Sealing Order," which effectuated the agreement of counsel that the entire evidentiary hearing should be sealed.

On October 27, 2015, the Hearing Officer, in Helena, Montana, convened a combined in person and video conference contested case hearing, as scheduled. The hearing resumed the next day, October 28, 2015, for rebuttal testimony, with counsel for Poepping participating by telephone from her office in Billings, Montana. The

parties agreed to the mixed use of video conference and telephonic participation as well as in person participation. The evidentiary record closed on October 28, 2015.

The transcript of hearing is the official record of the testimony of the witnesses and any additional evidence proffered included the exhibits admitted. For the convenience of readers, the Hearing Officer believes the following witnesses testified and the following exhibits were admitted into evidence.

Deborah Malters, M.D. (Montana Psychiatry, PLLC); K.J. Poepping (Licensee's husband); Dawn Howard, R.N. (Billings Clinic); Lucille Alice Byrd, R.N. (Director of Nursing, Billings Clinic); Heidi Kaufman (Compliance Specialist, BSD); John Patrick Sauer, M.D.; Fermin Blanco, M.D. (Billings Clinic); Tifan Crane, R.N. (Billings Clinic); Emery Benton Jones (N.A.P. Director); Marilyn Wine-Olson; and Licensee Amanda Poepping testified under oath in the parties' cases in chief. Lucille Byrd and Dawn Howard were recalled and testified in rebuttal by BSD.

On October 27, 2015, by agreement of the parties, the witnesses appeared as follows. Dr. Malters, Dr. Sauer, Dr. Blanco, and Nurse Crane testified via GoToMeeting, with each witness appearing by video/audio and was examined and cross-examined under oath by the parties. Director Jones testified by telephone. Mr. Poepping, Nurse Howard, Director Byrd, and Ms. Wine-Olson all testified in person.

On October 28, 2015, again by agreement of the parties, the Hearing Officer convened a telephonic session of this hearing for the testimony of BSD's rebuttal witnesses, Director Byrd and Nurse Howard, both of whom had already appeared in person and testified the previous day.

Exhibits 1, 2, 5, 7 (pp. 1-3), 8, and A-Q were admitted into evidence by stipulation. Exhibit 6 was refused on hearsay and foundation objections. The Hearing Officer erroneously stated at one point that pages 5 through 10 of Exhibit 6 had been admitted by stipulation, but actually no part of Exhibit 6 was ever admitted. The last post-hearing briefs were received electronically December 21, 2015, and the matter was deemed submitted for decision. The Hearing Officer thanks and congratulates counsel for their zealous representation of their clients while also cooperating in the procedural necessities of this contested case hearing so that it could be timely heard and decided.

Later this week, the Hearing Officer's "Provisional Sealing Order" will issue, defining what portions of the record and hearings file will be sealed until such time as another tribunal exercising jurisdiction over the issue modifies the sealing. Because the Hearing Officer proposed this decision, for the consideration of the Board, the scope of the sealing may or may not dovetail with the contours of the decision. Thus, the sealing order is "provisional" in the sense that one or more of the parties may seek modification of the sealing order, so that the appropriate balancing is

achieved between the privacy rights at issue and the public's right to know "in the context of the facts of each case." Associated Press, Inc. v. Mont. Dept. Rev., ¶24, 2000 MT 160, 300 Mont. 233, 4 P.3d 5, quoting Missoulian v. Board of Regents (1984), 207 Mont. 513, 529, 675 P.2d 962, 971. The Hearing Officer expresses no view on whether the Board can and should modify the provisional sealing order.

II. ISSUE

This matter is before the Hearing Officer to determine: (1) whether Poepping committed unprofessional conduct and if so; (2a) whether the Panel's summary suspension of Poepping's R.N. license should remain in place until final action by the Board; and (2b) what appropriate disciplinary sanction, if any, is appropriate in addition to the summary suspension. Mont. Code Ann. § 2-4-631(3).

Based on the evidence at hearing and the post-hearing submissions of the parties, the following findings of fact, conclusions of law, and recommended decision now issue, for the Board's consideration.

III. FINDINGS OF FACT[1]

1. Amanda Poepping received a Bachelor of Science (B.S.) degree in nursing from Montana State University in Bozeman in 1996. On or about July 5, 1996, the Montana Board of Nursing (Board) issued to Amanda Poepping a registered nurse (RN) license, Number 23598. Poepping's license has been renewed through December 31, 2016.

2. Poepping has been a well-qualified and well-trained Registered Nurse with approximately 19 years of experience. She began work as an R.N. for St. Vincent's Hospital in Billings, Montana, working first in a Medical/Surgical and Oncology Unit in 1996. In 1999, she transferred to a Cardiac Unit at St. Vincent's and worked there until 2000. She then accepted a position at the Billings Clinic ("Clinic") in the Neonatal Intensive Care Unit ("NICU"), where she worked until 2015.

3. Poepping did well and did not receive any type of disciplinary action while working for the Clinic. She received pins for her dedication to service from the Clinic on her 5th, 10th, and 15th year employment anniversary. She became a Preceptor for Professional Development, thereafter orienting nursing students and new staff into the NICU. She also received Credential Level 1 and Level 2, accolades given at the Clinic when an R.N. becomes a resource nurse. She helped the E.R., radiology, and pediatrics in intravenous fluid (IV) starts and blood draws on babies, and mentored new staff. She "did a publication" on the Neonatal Intensive Care Parent Handbook. She authored a number of policies for the NICU.

---

[1] Statements of fact in the conclusions of law are incorporated herein by reference to supplement these findings of fact. Coffman v. Niece (1940), 110 Mont. 541, 105 P.2d 661.

4. Poepping is nationally-certified in Low Risk Neonatal Care, certified and an assistant instructor in the S.T.A.B.L.E. class in stabilizing neonatal infants, and is a Neonatal Resuscitator Provider.

5. Nurses working the NICU at Billings Clinic perform pain assessments on the unit's babies, taking into account physical observations (such as grimacing and muscle tone) as well vital statistics including blood pressure and heart rate. It is fairly common for NICU babies to be intubated, putting a breathing tube into the baby's trachea that is connected to a machine to assist with breathing. NICU nurses also perform skin care; monitor IV drips; administer medications to patients that are ordered; and communicate with babies' families, physicians, and therapists regarding physical assessments and the babies' status.

6. John Sauer, MD, worked with Poepping on the NICU at Billings Clinic for several years. He testified that she was a skilled and able nurse. Dr. Sauer never had concerns about Poepping caring for a seriously-ill baby on the NICU.

7. During the evening of April 17, 2015, Billings Clinic received an infant patient transfer into its NICU due to respiratory issues. Fermin Blanco, MD, a neonatologist at Billings Clinic, became this patient's attending medical doctor.

8. Dr. Blanco ordered what he called "a very small dose" of Fentanyl, a form of synthetic morphine much stronger than morphine itself, for pain-relief and for sedation of this patient during intubation, at a concentration of 20 micrograms per milliliter of Fentanyl. The prescribed concentration of Fentanyl was compounded and prepared in a syringe at Billings Clinic's pharmacy. This was the minimum dose to calm an infant and half the maximum dose for pain-relief for an infant. Testimony of Blanco, "Transcript of Public Hearing," In re License of Amanda Poepping, Vol. 1, p, 133, ln. 17 – p. 135, ln. 5 (October 27, 2015).[2] The syringe was placed in a "Smart" infusion pump. On the evening of April 17, 2015, this patient began to receive the Fentanyl at the prescribed dosage, through a continuous IV fluid drip using a "Smart" infusion pump.

9. At approximately 7:00 a.m. on April 18, 2015, Poepping started her shift on the NICU and she was assigned sole nursing care for the patient who was receiving the IV Fentanyl. The patient was now her patient, and her only patient for that shift.

10. At 9:53 a.m., Poepping stopped her patient's "Smart" infusion pump, restarting it one minute later. At 10:07 a.m., Poepping again stopped the "Smart" infusion pump and the pump's clamp was open for approximately two minutes and 21 seconds.[3] The "Smart" infusion pump records indicated the volume in the

---

[2] Hereafter cited as "Name, Tr., Vol. #," followed by page and line point citations.
[3] The machine records time stopped and times restarted.

Fentanyl syringe was higher when the pump was restarted after the second stoppage than it had been at 10:07 a.m.

11. Based upon the substantial evidence of record, including Poepping's testimony and written admission, before 10:07 a.m. on April 18, 2015, Poepping put some normal saline into a new 60-ml syringe. After turning off the "Smart" infusion pump at 10:07 a.m., Poepping removed her patient's syringe, containing the prescribed Fentanyl, from the pump and transferred some of the Fentanyl and saline mix from her patient's syringe into that new 60-ml syringe. She had now prepared a bogus syringe that looked like her patient's syringe, but that actually contained a smaller quantity of more diluted Fentanyl.

12. After fully preparing the bogus syringe, Poepping connected it to the IV line and the "Smart" infusion pump, replacing her patient's Fentanyl syringe with the bogus syringe. The substantial and credible evidence indicated that the bogus syringe contained only a little more than 1/6th as much Fentanyl as prescribed.[4]

13. Having switched the syringes, Poepping then turned the "Smart" infusion pump back on, and the "Smart" infusion pump began pumping the weaker Fentanyl dose out of the bogus syringe into the IV tubing. Poepping neither flushed nor changed the IV tubing when she switched the syringes. Therefore, the IV line between the "Smart" infusion pump and the patient still contained Fentanyl as prescribed by Dr. Blanco. When Poepping turned the pump back on, the liquid already in the IV line began to enter the patient, delivering Fentanyl at the prescribed dosage. <u>After</u> the patient had received all of the liquid in the IV line at the time of the restart of the pump, the patient began to receive the substantially weaker solution Poepping had prepared in the bogus syringe. According to Poepping that would happen in approximately three hours after the pump restarted. When that three hours had passed, Poepping's patient would start to receive barely more than 1/6th of the minimum dose of Fentanyl to calm an infant and a tiny bit more than 1/12th of the maximum dose of Fentanyl to relieve pain for an infant.

14. With her patient's Fentanyl syringe in her pocket, Poepping proceeded to the staff bathroom located behind the nurses' station in the NICU. That bathroom was not available for visitors. When she left that bathroom, she left her patient's Fentanyl syringe on a little shelf, near the waste basket, with some cabinets behind it. Typically, there were extra paper towels and extra toilet paper rolls on that shelf. The syringe was in plain sight.

---

[4] Howard testified that subsequent testing revealed the bogus syringe contained 3.4 micrograms per milliliter of Fentanyl. Simple math says that 3.4 of the 20 micrograms per milliliter of Fentanyl prescribed would be 17% of that prescribed Fentanyl, which is barely more than 1/6th of the prescribed dosage. Poepping admitted putting approximately 17% of the prescribed Fentanyl into the bogus syringe.

15. The syringe was discovered in the staff bathroom by Holly Jones, another R.N., who was the administrator on duty that day. Finding a syringe with liquid in it in the staff bathroom in a secure patient unit was an extraordinary event. NICU manager Dawn Howard, R.N., was not working on April 18, 2015. Jones called her and Howard decided to come to the NICU to investigate this extraordinary event.

16. Howard began at the Clinic in 1991 as a nurse extern, graduated in 1992, and began work as an R.N. in the Clinic's NICU, where she worked until 2000. She relocated to Wyoming and worked adult nursing. She returned to the Clinic's NICU in 2011. In addition to Montana, Howard has been licensed in New Mexico, Colorado, and Wyoming. She has a nurse practitioner certification, but is not presently active in that speciality. Most of her nursing work has been between NICU and the emergency room. She became a colleague of Poepping in NICU after she came back in 2011, after which Howard became the NICU manager and Poepping's supervisor.

17. Howard started her investigation of the mystery syringe in the staff bathroom at approximately 1:00 p.m. on April 18, 2015, on her cell phone. Poepping's patient was the only infant with any kind of an IV that day. Howard had concerns about the integrity of the syringe currently in the "Smart" infusion pump infusing Poepping's patient. Before she came to the hospital, Howard spoke with the pharmacist about arranging for a new syringe containing the Fentanyl prescribed for Poepping's patient.

18. Howard reached the hospital and stopped and talked to Dr. Blanco first. Dr. Blanco ordered a new syringe of Fentanyl for Poepping's patient at 1:21 p.m. on April 18, 2015. Poepping's patient had just started receiving the greatly reduced dose of Fentanyl at approximately 1:10 p.m. (three hours after Poepping restarted the patient's pump, with the bogus syringe attached). Leaving Dr. Blanco's office, Howard came to the unit and spoke with the nurses that had found the syringe or had been in the bathroom recently, including Jones. In her initial conversation with Poepping, Howard asked if Poepping had noticed a syringe in the bathroom, and Poepping said no. This was misleading and less than truthful.

19. When the newly prepared syringe arrived at the NICU, Poepping asked why a new syringe had been ordered. Poepping again was pretending not to know what had happened, and probably also fishing for information about what Howard knew or suspected. Poepping did not indicate to Howard in any way that her patient was receiving less than the prescribed amount of Fentanyl. Poepping did not indicate to Howard in any way that there was any problem with her patient.

20. At approximately 3:10 p.m., Howard and Poepping came to Poepping's patient's room. Poepping knew that her patient had now been receiving the greatly reduced dose of Fentanyl for approximately two hours. Poepping turned off the "Smart" infusion pump, disconnected the bogus syringe from the IV and from the

pump, and handed the bogus syringe to Howard. Howard gave the newly prepared syringe containing the amount of Fentanyl prescribed for Poepping's patient to Poepping, who then installed it and turned on the pump. Howard testified that the IV tubing was neither flushed nor replaced when the bogus syringe was replaced. At the time of the replacement of the bogus syringe, nobody but Poepping knew that her patient was receiving a greatly reduced Fentanyl dose, and would continue to receive the greatly reduced Fentanyl dose until all of the solution in the IV tubing, from the bogus syringe, had been delivered to the patient. It was going to take at least another three more hours after replacement of the syringe before the patient began to receive the prescribed dose of Fentanyl.

21. Poepping, the last witness in her case in chief, testified at hearing that she really had flushed the IV tubing after replacing the bogus syringe, to reduce the time before the patient received the full dose of Fentanyl prescribed to one hour. According to Poepping, the umbilical catheter, the connection into the patient, could not be flushed, and so even after flushing the IV tubing, the greatly reduced dose of Fentanyl that was in the umbilical catheter would be delivered to the patient for about another hour. Poepping, Tr., Vol. I, p. 200, ln. 14 – p. 202, ln. 10:

> Q. And when, after the order came in at 1:21, did the patient ultimately receive the new unaltered dose of Fentanyl?
> A. 3 p.m.
> Q. And explain to me how you removed the altered Fentanyl syringe and replaced it with the new one, the procedure you went through in doing that.
> A. Yes. Dawn was with me, you know. I took the altered Fentanyl syringe, gave it to her, obviously to take it -- for it to be studied, and then put the new syringe, hooked it up to the tubing. I knew what I had done and I knew, you know -- I knew it had three hours to go through the tubing. I know you never push, manually push Fentanyl through a baby.
> Q. Why not?
> A. Chest wall rigidity. That's, I guess, Fentanyl 101 with babies.
> Q. So that's a danger to the baby to push Fentanyl through?
> A. Absolutely, yeah.
> Q. So knowing that, what did you do?
> A. I disconnected the line from the baby, flushed the line with one cc. to flush the altered Fentanyl out of the line and hooked that up to the baby.
> Q. And as a result of flushing the line, what result, if any, did that have on the administering of the new unaltered Fentanyl?
> A. That new Fentanyl got to the baby three hours faster.

Q. So you heard testimony earlier from Dawn that the IV was not flushed and that it took an additional three to four hours to get to the baby as a result. Do you recall that?
A. I do.
Q. And do you agree with her testimony?
A. I do not. I will add, the umbilical catheter is the point three so there is that one extra hour; that obviously, I did not flush the umbilical catheter.
Q. So your testimony, if I understand it right, is that within one hour of the new unaltered dose of Fentanyl being changed in the pump, that baby was receiving the full effect of that?
A. Absolutely.
Q. And that would be in or around 4 p.m. –
A. Yes.
Q. – April 18th?
A. Yes.

22. In response to Howard's earlier testimony that she was in the room when Poepping changed out the bogus syringe and the IV tubing had not been flushed, Poepping testified that she waited and flushed the line after Howard, who was watching Poepping replace the bogus syringe, left the patient's room. Poepping, Tr., Vol. I, p. 249, lns. 1-9:

Q. And you agree that Dawn Howard watched you hang the new syringe?
A. Hang it, yes. She didn't watch me put it in, no.
Q. So you waited until she had departed before you did that?
A. Um-hum. She saw me twist it on and -- yes.
Q. Can you explain why you flushed the tube.
A. I wanted the medicine to get to the baby earlier than three hours.

23. Flushing the IV tubing was standard operating procedure in starting a new dose of medicine by IV. Thus, Poepping's testimony on the first day of hearing about waiting until Howard left the room to flush the IV tubing seemed, without any explanation, out of the ordinary (see, "Discussion," infra, pp. 14-15 on this point).

24. On the second day of the hearing, after Poepping's "I flushed the IV tubing after Howard left the room" testimony at the end of the first day of hearing, Lucille Byrd, recalled for rebuttal testimony, stated that she had met with Poepping on May 19, 2015 in an initial investigative interview with her. Byrd testified that Poepping had said nothing about flushing the IV during that interview. Byrd also testified that the next day, May 20, 2015, during the final interview with Poepping, Byrd was pointing out to Poepping how long the greatly reduced Fentanyl dose was

delivered to Poepping's patient on April 18. Byrd testified, and Howard (also at the May 20 meeting) corroborated that testimony, when she testified in rebuttal after Byrd, that Poepping immediately asserted that Howard was responsible for the failure to flush the IV tubing.

25. During cross-examination, Byrd repeated and summarized her testimony on direct examination. Her cross-examination is first quoted here because it was complete and succinct. Tr., Vol. II, p. 287, ln. 7 – p. 289, ln. 20:

> Q. Okay. Just to be clear, initially this morning you testified that you didn't recall having an exchange with Amanda regarding flushing the IV, but instead you had a conversation with her regarding the fact that the IVs weren't switched out, which is when she implicated Dawn; is that correct?
> A. No. I don't believe that's what I said. Could I have my, the beginning of my response read back to me? I don't believe that is what I said.
> Q. Okay. Can you just clarify for me? You came up with two different answers regarding flushing the IV just now and I just want to be clear for the record.
> A. Okay. So I think – and I believe this is what I said. I had really two conversations with her about changing out the IV, one was on the 19th when we were going over the findings that the Billings Clinic had and she talked about changing out the pump. There was no discussion at that point about talking about IV tubing.
> Q. Okay.
> A. And on May the 20th, which was the day that the termination occurred, there is a piece when I'm discussing my decision to terminate and why when I shared with Amanda that we also had a concern and in the notes it says .77 ccs to get tubing flushed, .4 ccs to get umbilical catheter flushed, almost four more hours not getting the narcotic dose. That was when I was talking to Amanda about the concern that it was longer than 10:00 to 3:30 and I shared with her the concerns about the tubing.
>
> At that point she said it was Dawn Howard's fault the tubing was not changed.
> Q. Perfect. So if I understand correctly, the 19th there was no discussion regarding the flushing of the tube or whatnot, but the 20th there was a discussion about the tubing?
> A. That's correct. On the 19th there was a discussion about changing out the syringe and the IV pump. She did not mention

anything about the tubing on the 19th, nor did she mention the tubing on the 20th.

Q. And you didn't bring up the tubing on the 19th either, correct?

A. That is correct.

26. In redirect, Byrd again avowed that Poepping had not asserted during either the May 19 interview or the May 20 interview that she changed or flushed her patient's IV tubing during or after switching out the bogus syringe on April 18, 2015. Tr., Vol. II, p. 297, lns. 13-20:

Q. (By Mr. Maki) Ms. Byrd, during your May 20th meeting with Ms. Poepping, did she ever tell you that she changed the patient's IV tubing on April 18th?

A. She did not.

Q. Did Ms. Poepping ever tell you that she flushed the patient's IV tubing on April 18th?

A. She did not.

27. Dawn Howard also described the May 20, 2015 discussion about flushing Poepping's patient's IV tubing when switching out the bogus syringe. Tr., Vol. II, p. 298, ln. 25 – p. 301, ln. 2 [<u>emphasis added</u>]:

Q. Ms. Howard, were you present at the Billings Clinic on May 20th during a meeting that was held with Amanda Poepping and Lu Byrd?

A. Yes, sir.

Q. And do you recall if Amanda Poepping made statements during that meeting?

A. I do.

Q. Did Ms. Poepping ever indicate during that meeting that she flushed the patient's IV tubing on April 18th?

A. No, sir.

Q. Did she ever indicate that she changed out the tubing, the patient's tubing on April 18th?

A. No, sir.

Q. Did she say anything at all about the patient's IV tubing during your May 20th meeting?

A. Yes. We had talked about how by not changing the tubing there was probably greater delay in the infant getting the medication. And at that point she tried to blame me for that and said, "Oh, I told Dawn we should." And I said, "Absolutely you did not." And Lu said, "This isn't about Dawn. This is about Amanda diluting out the syringe."

Q. So to clarify, Ms. Poepping acknowledged that the IV tubing wasn't changed, correct?
A. Correct.
Q. And she indicated that it was your fault that it was not changed?
A. Correct.
Q. And she never indicated that the IV was ever flushed by her?
A. No, sir.
Q. Ms. Howard, would you acknowledge then that the patient's IV tubing was not changed on April 18th?
A. I would agree.
Q. Did you direct Ms. Poepping not to change or flush the IV?
A. No. And it's one of those things that I kick myself every day that we didn't change that tubing.
Q. Did you affirmatively tell Ms. Poepping that she couldn't flush the IV tubing?
A. Absolutely not. That would have been the appropriate thing to do.
Q. Did you talk – when you were meeting with her at approximately 3:00 p.m. or so on April 18th, did you talk to her about the possibility of changing out the IV tubing with the pump and Fentanyl syringe?
A. No. It didn't even cross my mind. You know, at that point I didn't realize that the medication wasn't what we had initially prescribed.

28. Only Amanda Poepping knew on April 18, 2015 that the bogus syringe was bogus and did not contain enough Fentanyl to provide the sedation and pain relief Dr. Blanco intended the infant to receive. Perhaps Poepping did want to ameliorate the effects upon her patient of getting only a small fraction of the prescribed medication. What is very clear is that on April 18, 2015, Poepping was not willing to do anything to ameliorate those effects if it jeopardized her career by revealing that she had diverted the medication. Her inconsistent statements in May versus October about whether she flushed the tube persuaded this Hearing Officer that her testimony at hearing that she did flush the IV tubing was just one more dishonest statement (this one under oath) to try to minimize her behavior and minimize her responsibility for that behavior.

29. Another factor in the above finding was Poepping's testimony that she convinced herself that the infant really wasn't getting an appreciably smaller dose of Fentanyl for sedation and pain relief because Poepping put the portion of saline and

Fentanyl from the actual original Fentanyl syringe into the bogus syringe last, so that original mixture of Fentanyl and saline (presumably at the original strength) would go first into the IV, maintaining an effective dosage for a longer time. Tr., Vol. I, p. 203, lns. 1-23. Only in the very last response of that sequence of testimony did Poepping even acknowledge this maintenance of the prescribed dosage at the top of the bogus syringe would only last "until it went through that 15 mils [sic.]" Obviously, after that, Poepping's patient would have experienced the lack of adequate sedation and pain relief for many hours, until the bogus syringe was nearly empty and a new syringe with the proper medication replaced it.

30. Poepping engaged in unprofessional conduct when she diverted Fentanyl from her patient. Fentanyl is a powerful synthetic opiod analgesic similar to but more potent than morphine. It is a Schedule II prescription drug.

31. The safety of the public and her patients requires that Poepping not be allowed to practice nursing until competent professionals relied upon by the Board (such as NAP and licensed addiction and counseling professionals) have stated their professional opinions that Poepping is in recovery and can be trusted to provide full care to patients, including safely handling pain relief and sedation medication delivery to her patients. These requirements can include, at the Board's informed discretion, some or all of the following conditions:

(a) maintaining the suspension of her license until such a time as her recovery is verifiably advanced to the point at which she can safely practice nursing;
(b) imposing a set time in defined supported and documented recovery before she can practice nursing in a patient care capacity;
(c) requiring continued random drug and alcohol screening to verify abstention from drug abuse/alcohol use;
(d) probationary supervision to monitor and verify her continued clean and sober status as she progresses into recovery and then back into practice;
(e) documented participation in treatment modalities such as:
    (i) community based peer-support sobriety groups (12-step or other such programs);
    (ii) counseling and/or therapy through approved and licensed practitioners;
    (iii) periodic evaluations by a Board-approved professional to verify maintenance of her recovery, together
(f) any other requirements the Board deems necessary to protect the public safety while providing Poepping with a clearly defined reasonable and safe opportunity to return to nursing practice.

32. Poepping had been a very good – perhaps even a gifted – R.N. for almost two decades. In determining what sanctions against her license are necessary to ensure patient and public safety, the Board should fully consider how at the same time to offer Poepping rehabilitation and with it an eventual return to nursing. This may be a vital factor in Poepping's recovery. The devastating effect of having her license suspended is clear. Offering her a realistic path back to nursing practice is essential to motivate her to take the difficult and rigorous steps she must take to achieve and to maintain her clean and sober status.

33. During her initial suspension period, Poepping arranged and attended an extended course of treatment at a prominent treatment facility in Oregon. She has demonstrated her commitment to her recovery, probably at a cost of a significant financial burden. On the other hand, even at the hearing Poepping was still trying to minimize the egregious nature of her misconduct. The Hearing Officer finds it probable that Poepping will be dedicated and motivated to work at her recovery, and can reasonably be expected to seek reinstatement. The initial period of her suspension, from the Board's final decision to the point at which she can, if she has progressed sufficiently, petition the Board for reinstatement should be set at one year.

IV. DISCUSSION

A – Flushing the IV Tubing

At the end of the first day of testimony, the Hearing Officer was not sure what to make of Poepping's testimony that she flushed the solution containing the greatly reduced Fentanyl dose out of her patient's IV tubing after replacing the bogus syringe.

It was not physically impossible that Poepping did wait until Howard thought the installation process was completed and left the room, after which Poepping revisited some of the installation process to flush the IV. Doing this could have been to avoid making Howard suspicious about how much Poepping knew about what was in the bogus syringe. That would have been consistent with both of Poepping's apparent and inconsistent motives at that time.

Probably Poepping, once the original syringe was found, did not want her patient to continue to receive the greatly reduced Fentanyl dose any longer than necessary. On the other hand, after she had completed her diversion of the Fentanyl, her shame-filled realization of what she had just done left her terrified that she was going to get caught. See, Poepping, Tr., Vol. I, p. 202, ln. 17 – p. 203, ln. 19. She credibly testified about both her terror and her shame. Her behavior during the entire time she was at the hospital on April 18, 2015, and after that through her May 19, 2015 investigative interview, was fraught with her ongoing subterfuges to avoid being found out as the person who had created the bogus syringe and stolen

the patient's original Fentanyl syringe. Flushing the tubing in front of Howard or taking the risk of Howard returning to the room and catching her flushing the tubing – both options were just too frightening for Poepping to take on April 18, 2015.

After her first interview with Byrd on May 19, 2015, she finally decided it was time to confess to creating the bogus syringe. If she had indeed flushed the IV tubing on April 18, 2015, why then did she still not report flushing the IV tubing when she confessed on May 20? It was to her advantage to do so, yet she did not.

Poepping essentially agreed that the IV tubing had not been flushed by saying that it was Howard's fault that it had not been flushed. It is wildly unlikely that Poepping would have said this if she had surreptiously flushed the tubing after Howard left the room. Instead, she would have declared that she had flushed the tubing. Poepping did not say that during the May 20, 2015 interview because she had not yet come up with this "improvement" upon the truth. The substantial and credible evidence supported the finding that she was still not telling the truth when she testified at hearing that she had flushed the IV tubing on April 18.

B – Reasons for the Diversion Itself

Poepping had a fairly good idea how much Fentanyl was left in the original syringe after she removed part of it and put in the bogus syringe. She did know, once she thought about it, that the Fentanyl left in either of the syringes would be less than the amount prescribed for her patient. As an experienced nurse, she certainly knew when she thought about it that an entire infant's dose of Fentanyl would not be nearly enough to feed her addiction. Her expert witness testified that she knew it. Dr. Malters, Tr., Vol. 1, p. 23, ln. 5 - p. 24, ln. 2.

On the other hand, it would be absurd to find that she was consciously thinking that the Fentanyl was too little to feed her addiction at the time when she made the diversion. Given her justifiable fear of discharge if it became known that she had diverted the original syringe, she diverted the syringe anyway because she did not think she would be caught. Even Dr. Malters did not agree that Poepping "left the syringe on the counter because work was unbearable and she no longer wanted to work there." See, Dr. Malters, Tr., Vol. I, p. 22, ln. 8 – p. 23, l. 22.

Poepping gave the answer to why she diverted the medication. On April 18, 2015, Poepping had spent six months of "struggling with her own issues of addiction and depression and anxiety." Dr. Malters, Tr., Vol. I, p. 21, ln. 25 – p. 22, l. 4. On that date, according to her testimony, "my addiction took me that far." Poepping, Tr., Vol. I, p. 202, lns. 23-25. In other words, Poepping's need for controlled substance pain relief medications had so skewed her judgment that although she was not at the time under the influence of such medications, she consciously and voluntarily diverted her patient's medication, even though the amount she diverted would not feed her dependence. Poepping's behavior violated one of the most

fundamental standards in nursing, namely, to care for her patient (administer prescribed sedation and pain relief medication) first and foremost. Instead, she short-changed her patient by stealing most of her patient's sedation and pain relief medication. Under these circumstances, Poepping must be required to undergo such treatment and monitoring as can equip her to maintain her recovery and avoid abuse or misuse of prescription drugs as well as use of alcohol (a "gateway drug" to most abuse or misuse of prescription drugs) before she can return to nursing.

C – Term of Suspension Before First Petition for Reinstatement

The Hearing Officer recommends that the license of Amanda Poepping, Registered Nurse, License No. 23598, be suspended for a term of one year (from the date of the Board's final decision), subject to probationary reinstatement at that time, or such other time when she presents a satisfactory petition for a probationary reinstatement of her nursing license under Mont. Code Ann. § 37-1-314, with the advocacy and approval of the Nurses Assistance Program and with full compliance with recommended evaluation(s) and resultant aftercare contracts. Unless Poepping is in full compliance with all requirements and conditions stated herein, her suspension should be maintained for such an additional term as the Board deems necessary to protect the public welfare and safety and provide enough time so she can perfect a subsequent petition for reinstatement.

V. CONCLUSIONS OF LAW

1. The Board of Nursing has and exercises jurisdiction over this proceeding. Mont. Code Ann. §§ 37-1-131, 37-1-136, 37-1-307, 37-1-309, 37-8-202(1)(f), (g).

2. This matter was properly referred to the Office of Administrative Hearings for a contested case hearing. Mont. Code Ann. §§ 37-1-131(1)(b); 37-1-121(1). It is a licensing disciplinary case subject to the Montana Administrative Procedure Act, which has been properly and regularly employed. Mont. Code Ann. § 37-1-136(2) and § 37-1-310.

3. BSD, for the Board, bears the burden of proof to show by a preponderance of the evidence that licensee Amanda Poepping committed an act of unprofessional conduct. Mont. Code Ann. § 37-3-311; Ulrich v. St. ex rel. Bd. of Funeral Serv., 1998 MT 196, 289 Mont. 407, 961 P.2d 126. The department must also show any sanction it seeks is appropriate under the circumstances of the case. The department has sustained those burdens.

4. The Board of Nursing is charged with the responsibility to "safeguard life and health" of Montanans by assuring that those practicing nursing are properly qualified. Mont. Code Ann. § 37-8-101.

5. The "practice of professional nursing" is a sophisticated profession that requires extensive training in physical sciences and social sciences and also requires

the ability to undertake and engage in "assessment, nursing analysis, planning, nursing intervention, and evaluation in the promotion and maintenance of health, the prevention, case finding, and management of illness, injury, or infirmity, and the restoration of optimum function." Mont. Code Ann. § 37-8-102(9).

6. Pursuant to Admin. R. Mont. 24.159.2301(2):

> Unprofessional conduct, for purposes of defining 37-1-307, MCA, in addition to unprofessional conduct listed at 37-1-316, MCA, the following being unique, is determined by the board to mean behavior (acts, omissions, knowledge, and practices) which fails to conform to the accepted standards of the nursing profession and which could jeopardize the health and welfare of the people and shall include, but not be limited to, the following:
>
> . . . .
>
> (i) diversion of a medication for any purpose;
>
> (k) intentionally committing any act that adversely affects the physical or psychosocial welfare of the patient;
>
> . . . .

7. A practitioner whose judgment is radically impaired by dependence upon controlled substances cannot be allowed to practice professional nursing due to the unacceptable risk of harm to the public (the patients). Poepping's conduct in diverting medication from her tiny patient demonstrates such radical impairment.

8. A nurse (licensee) is subject to discipline for unprofessional conduct. Mont. Code. Ann. §§ 37-1-309, 312. Summary suspension of Poepping's license was appropriate to protect the public and should be continued through the Board's final decision herein. Mont. Code Ann. § 2-4-631.

9. Reinstatement of Poepping's license to practice as a registered nurse must be further sanctioned under Mont. Code. Ann. § 37-1-312(1) because she has committed unprofessional conduct and her ability to practice with reasonable skill and safety has not at this time been assured.

10. "To determine which sanctions are appropriate, the board shall first consider the sanctions that are necessary to protect or compensate the public. Only after the determination has been made may the board consider and include in the order any requirements designed to rehabilitate the licensee or license applicant." Mont. Code Ann. § 37-1-312(2). Based on the evidence, authority and arguments herein, the Hearing Officer recommends the following Proposed Board Order.

VI. PROPOSED BOARD ORDER

THE BOARD ENTERS THE FOLLOWING ORDER

1. Poepping's license to practice nursing in the State of Montana is suspended for one year from the date of this Order. Mont. Code Ann. § 37-1-312(1)(b). If not

already surrendered, she must surrender her license within 24 hours after notice of entry of this order (Mont. Code Ann. § 37-1-312(4)) to:

Board of Nursing c/o Business Standards Division, DLI
301 South Park Avenue
P.O. Box 200514
Helena, MT 59620-0514

2. At the end of the one year, or sooner if the Board chooses to reconsider in light of new developments, Poepping will be eligible to petition for a probationary reinstatement of her nursing license under Mont. Code Ann. § 37-1-314. To be eligible to petition for said reinstatement, she must first have the advocacy of the Nurses Assistance Program and be compliant with all recommended evaluation(s) and resultant aftercare contracts. Mont. Code Ann. §§ 37-1-312(1)(c), (d), and 37-3-203(2). The Board of Nursing, in its discretion, may impose such additional sanctions provided by Mont. Code Ann. § 37-1-312 as may be necessary for the protection of the public. Mont. Code Ann. §§ 37-1-312(1)(c).

3. Poepping shall scrupulously adhere to the terms of her Nurses Assistance Program as it may be amended from time-to-time in the professional judgment of the program including terms requiring further evaluation or treatment. Any violation of any of these terms shall be deemed a material breach of this Final Order and grounds for a new unprofessional conduct complaint under Mont. Code Ann. § 37-1-316(8), as well as provisions regarding compliance with the monitoring program including Admin. R. Mont. 24.159.2301(1)(r).

4. Any material violation of her Nurses Assistance Program Contract or any other unprofessional conduct may result in a complaint to the Board of Nursing with the Department of Labor moving for summary suspension of her probationary nursing license followed by an action to discipline or revoke that license.

NOTICE: Licensee is barred from practicing with a suspended license. Nonetheless, to petition for reinstatement, she must regularly renew her suspended license and comply with all continuing education requirements (if any) else her suspended license may terminate. She then would be ineligible for reinstatement and would have to apply for a license as a new applicant. Failure to receive a renewal form from the Board will not constitute an excuse for failure to renew the suspended license. It is Licensee's responsibility timely to renew her suspended license.

5. A regulatory board may impose any of the sanctions enumerated within Mont. Code Ann. Title 37, Chapter 1, upon a finding of unprofessional conduct. Mont. Code Ann. § 37-1-307(f). Among other things, Mont. Code Ann. § 37-1-312 provides that a regulatory board may suspend the license for an indefinite or fixed term.

6. Amanda Poepping has demonstrated, while practicing as a nurse, that she has the requisite skills, talents, and gifts to be an exemplary nurse. Now, her drug dependance has rendered her unsafe to practice until she has completed a course of treatment that equips her to maintain her recovery and avoid misuse of prescription drugs as well as use of alcohol. The Board intends the course of her suspension to last until she completes a course of treatment and recovery that convinces the Nurses Assistance Program that, with appropriate peer supervision and counseling, in whatever form deemed appropriate, she can return to the practice of nursing, whether it takes a year from the date of this order, or less time or more time, not only without jeopardizing the health and welfare of the people, but with the necessary means to practice nursing and enhance and contribute to the health and welfare of the people of Montana, to their mutual benefit and to hers.

DATED this 7th day of January, 2016.

DEPARTMENT OF LABOR & INDUSTRY
OFFICE OF ADMINISTRATIVE HEARINGS

By: /s/ TERRY SPEAR
TERRY SPEAR
Hearing Officer

NOTICE

Mont. Code Ann. § 2-4-621 provides that this proposed order, being adverse to licensee Amanda Poepping, may not be made final by the Board until this proposed order is served upon each of the parties and the party adversely affected by the proposed order is given an opportunity to file exceptions and present briefs and oral argument to the regulatory board.