

DOCKET NUMBER 507-10-1758

IN THE MATTER OF
PERMANENT CERTIFICATE
NUMBER 620119
ISSUED TO
JOLINE REESE

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BEFORE THE STATE OFFICE
OF
ADMINISTRATIVE HEARING



Patricia P. Thomas
Executive Director of the Board

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

OPINION AND ORDER OF THE BOARD

TO: JOLINE REESE
C/O ANTHONY GRIFFIN
1115 MOODY
GALVESTON, TX 77550

HUNTER BURKHALTER
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 21-22, 2010, the Texas Board of Nursing (Board) considered the following items: (1) The Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD regarding the registered nursing license of Joline Reese with changes; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. No exceptions were filed by any party.

The Board, after review and due consideration of the PFD, Staff's recommendations, and Respondent's presentation during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD as if fully set out and separately stated herein, with the exception that Conclusion of Law Number 7 is re-designated as a recommendation*. All proposed findings of fact and conclusions

of law filed by any party not specifically adopted herein are hereby denied.

IT IS, THEREFORE, ORDERED THAT RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS AND A FINE, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER ORDERED that while Respondent's license is encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER ORDERED that:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to JOLINE REESE, to the office of the Texas Board of Nursing within ten (10) days from the date of this Order.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary

Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:* <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL

successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

(5) RESPONDENT SHALL pay a monetary fine in the amount of two hundred and fifty dollars (\$250). RESPONDENT SHALL pay this fine within forty five (45)

days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

(6) RESPONDENT SHALL pay an administrative reimbursement in the amount of one thousand two hundred and thirteen dollars (\$1,213). RESPONDENT SHALL pay this fine within ninety (90) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(7) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of

employment.

(8) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(9) RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(10) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year of employment as a nurse.

IT IS FURTHER ORDERED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license to practice nursing

in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.



Entered this 22nd day of October, 2010.

TEXAS BOARD OF NURSING

Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; Docket No. 507-10-1758 (July 8, 2010).

*This re-designation is authorized under the Government Code §2001.058(e). Authority is also found in *Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed); *Sears vs. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex.App.-Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n vs. Brinkmeyer*, 662 S.W. 2d 953, 956 (Tex. 1984); *Granek vs. Tex. State Bd. of Med. Exam'rs*, 172 S.W. 3d 761, 781 (Tex.App.-Austin 2005, pet. denied).

State Office of Administrative Hearings



Cathleen Parsley
Chief Administrative Law Judge

July 8, 2010

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA INTER-AGENCY

RE: Docket No. 507-10-1758, Texas Board of Nursing v. Joline Reese

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 TEX. ADMIN. CODE § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,

A handwritten signature in black ink, appearing to read "HBK", written over a circular stamp.

Hunter Burkhalter
Administrative Law Judge

HB/slc

Enclosures

XC: John Legris, TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTER-AGENCY**
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – (with 1 CD;
Certified Evidentiary Record) – **VIA INTER-AGENCY**
Anthony Griffin, 1115 Moody, Galveston, TX 77550-**VIA REGULAR MAIL**

DOCKET NO. 507-10-1758

TEXAS BOARD OF NURSING

V.

JOLINE REESE

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BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing (Staff, Board) brought this action seeking to impose disciplinary sanctions against Joline Reese (Respondent) based on allegations that she failed to meet the minimum standards in the Nursing Practice Act (Act)¹ and Board rules. The Administrative Law Judge (ALJ) finds that Staff proved the allegations against Respondent and recommends that the sanctions sought by Staff be imposed.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The parties did not challenge the issues of jurisdiction or notice. Those matters will be addressed in the findings of fact and conclusions of law.

On May 25, 2010, ALJ Hunter Burkhalter convened the hearing on the merits at the Austin office of the State Office of Administrative Hearings (SOAH). Counsel for Staff was John F. Legris, and counsel for Respondent was Anthony Griffin. The hearing adjourned the same day, and the administrative record was closed that day.

II. DISCUSSION

A. Background

Since 1995, Respondent has been licensed by the Board as a Registered Nurse (RN), holding license number 620119.² At the time of the events at issue in this case, Respondent was

¹ TEX. OCC. CODE ANN. CH. 301.

² Staff Ex. 1.

employed by the University of Texas Medical Branch Hospital in Galveston, Texas (UTMB) as an RN. On the date in question, February 7, 2008, Respondent provided care to CB, a patient who had undergone surgery the previous day.

B. Staff's Evidence and Argument

Staff levels the following three charges against Respondent arising from her treatment of CB:

Charge 1: Respondent failed to assess and intervene when CB's IV site became infiltrated, remained in place, and continued to be used by Respondent for approximately four hours after Respondent had discovered it was infiltrated, constituting a violation of TEX. OCC. CODE § 301.452(b)(10) and (b)(13), 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (1)(B), and (1)(M), and 217.12(1)(B) and (4);

Charge 2: Respondent failed to document the route used to administer pain medication when she administered 25 milligrams of Fentanyl to CB via intramuscular injection at around 12:45 p.m., constituting a violation of TEX. OCC. CODE § 301.452(b)(10) and (b)(13), 22 TEX. ADMIN. CODE §§ 217.11(1)(A) and (1)(D), and 217.12(1)(B) and (4); and

Charge 3: Respondent failed to document a verbal order given to her by Dr. Spogmai Komak to administer 25 milligrams of Fentanyl to CB via intramuscular injection, constituting a violation of TEX. OCC. CODE § 301.452(b)(10) and (b)(13), 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (1)(C), and (1)(D), and 217.12(1)(B) and (4).

In the Board's Second Amended Notice of Hearing, Staff recommended that Respondent's license be revoked. At the hearing, however, Staff recommended only that Respondent receive a warning, be indirectly supervised for one year and be required to complete additional training. In addition, Staff sought recovery of its administrative costs of the proceeding pursuant to TEX. OCC. CODE § 301.461.

In support of their case, Staff called four witnesses, plus Respondent, and produced 18 exhibits.

Pamela Brown

Pamela Brown, CB's mother, testified at the hearing. Ms. Brown described CB's many chronic health problems. CB has had roughly 80 surgeries over the course of her life, suffers from spina bifida and arthritis, was born with a club foot, is paralyzed from the waist down, and has a shunt for hydrocephalus. CB is a high school graduate and has completed two years of college. She is able to communicate and express her wishes intelligently and verbally. A significant portion of CB's life has been spent as a patient of UTMB.

CB was a patient at UTMB on February 6, 2008, when she had surgery to repair a hernia and reduce the size of her colostomy pouch. This was CB's 71st surgery. The surgery began around noon and CB was returned to her room around 8:30 p.m. Ms. Brown spent the night in the hospital room with her daughter and observed that CB was in pain all night.

According to Ms. Brown, around 8:30 the next morning, Respondent came into CB's room to check on her. Ms. Brown told Respondent that CB had been in pain all night and she asked Respondent to check CB's IV. When Respondent did so, she stated that the IV, which was located on CB's wrist, was "blown" and, therefore, CB was not getting her pain medication.³ According to Ms. Brown, Respondent said she had heard that CB was a "hard stick," meaning that it was difficult to find a vein and insert an IV into her. Ms. Brown confirmed that CB has had so many surgeries that her veins have become very faint and difficult to find. So, rather than inserting a new IV herself, Respondent announced that she would call the "infusion therapy" department and have someone from that department come down and insert an IV in CB.⁴ Respondent then left the room.

³ Throughout the hearing, the IV in question was variously referred to as "blown" or "infiltrated." This means, essentially, that the IV has become clogged or is otherwise no longer delivering fluids and medications as intended.

⁴ An RN such as respondent is trained and capable of inserting an IV line. However, "infusion therapy" is a department within the hospital that may be called to insert IV lines in more difficult cases.

At 10:00 a.m., Respondent wrote in CB's medical records: "IV site infiltrated."⁵ She also wrote that the volume of the contents in the IV bag was "15.7."⁶ At 4:45 that afternoon, Respondent again wrote that there was "15.7" in the IV bag. This suggests that CB received none of the contents of the IV bag between 10 a.m. and 4:45 p.m., which would confirm the premise that the IV was infiltrated. Elsewhere in the medical records, on an "IV Site Assessment" form for CB, Respondent made three entries, at 8:00 a.m., 10 a.m. and 12 noon, all stating that the IV was "NFP."⁷ Respondent explained that NFP stands for "normal finding, patent," meaning that the IV is in good working order. At the hearing, Respondent conceded that these medical record entries are contradictory – by definition, an IV site cannot simultaneously be both "infiltrated" and "NFP."

The medical records also include a number of entries by Respondent that would appear to be inconsistent with an infiltrated IV site. For example, at 9:00 a.m., Respondent administered 1,000 milligrams of a medication to CB via "IV piggyback," meaning that the medication is routed through the IV.⁸ Similarly, the records show that at 10:07 a.m. Respondent administered 4 milligrams of Zofran to CB via "slow IV push."⁹ This occurred roughly an hour and a half after she had told CB that the IV was "blown," and just seven minutes after she had entered into CB's medical records that the IV site was "infiltrated."

Ms. Brown testified that, after Respondent's first visit to CB's room, several hours passed when nothing happened. CB had had nothing to eat or drink since before her surgery and she continued to be in considerable pain. She was crying and scared. During that time, Ms. Brown repeatedly called Respondent back into the room, but a new IV was not put in. Infusion therapy never showed up that day to insert a new IV.

⁵ State's Ex. 6, p. 86.

⁶ The unit of measurement is unknown.

⁷ State's Ex. 6, p. 93.

⁸ State's Ex. 6, p. 125.

⁹ State's Ex. 9, 31.

Ms. Brown testified that, around 12:40 pm, Respondent reentered the room, removed CB's IV, and gave her a shot of pain medication. A significant part of the dispute concerns how this dose of pain medication was administered to CB by Respondent. The medical records indicate that, at 12:41 p.m. on February 7, 2008, Respondent administered to 25 milligrams of the pain killer Fentanyl PF via "Slow IV Push."¹⁰ However, Ms. Brown was adamant that Respondent gave CB a shot of the pain medication, rather than administering it through the IV.

At roughly 1:30 p.m., the attending physician, Dr. Esham, entered the room and told CB and Ms. Brown that they were not going to wait any longer for the infusion therapy team to insert a new IV. Instead, the doctor ordered that CB be taken to another department at the hospital so that a "PIC" line could be inserted into her.¹¹

Dr. Spogmai Komak

Dr. Komak is a resident in the Department of Surgery at UTMB. On February 7, 2008, at around 10:00 a.m., while she was "scrubbed in" and in surgery, Dr. Komak was phoned by Respondent who reported that CB's IV had become infiltrated. Because she was in surgery, Dr. Komak did not speak directly with Respondent. Rather, an intermediary in the operating room spoke with Respondent on the phone and relayed what was being said between the doctor and Respondent. Over the phone, Dr. Komak ordered Respondent to (1) contact Infusion Therapy to have a new IV inserted; and (2) give CB an intramuscular injection of Fentanyl pain medication.¹² Dr. Komak testified that she ordered an intramuscular (or "IM") injection because the IV was no longer usable.

¹⁰ Staff Ex. 9, p. 12.

¹¹ See also State's Ex. 6, p. 160. According to Ms. Brown, a PIC line is an alternative to an IV line that is inserted into a larger artery or vein in the patient's shoulder. Ms. Brown opined that a PIC line is superior to an IV. She testified that, when CB has surgeries, she is typically fitted with a PIC line rather than an IV, because of the problems with her veins.

¹² An intramuscular injection is a normal injection, much like those given for flu shots. It is contrasted with medication that is delivered by injecting through a pre-existing IV.

Much later, when Dr. Komak reviewed the medical records, she saw that the medical records indicated that the pain medication had been administered by Respondent through the IV rather than via IM injection as she had ordered. Dr. Komak stated that Respondent failed to comply with her order because she failed to administer the medication via an IM injection. Moreover, because Dr. Komak ordered the medication at around 10 a.m. and the medical records indicate that Respondent gave the medication at 12:41, Dr. Komak offered the opinion that Respondent took much too long to give the medication. According to the doctor, Respondent should have administered the drug "immediately or as soon as possible" after the doctor ordered it.

Dr. Komak also testified that Respondent never documented the doctor's verbal order in CB's medical records. According to Dr. Komak, verbal doctor's orders should always be documented by the nurse receiving the order.

On February 22, 2008, Dr. Komak prepared the first of two written statements about the incident. This first statement, which is addressed to "To whom it may concern," begins: "This letter is in support of Joline Reese, RN for her care of [CB]." In this first statement, Dr. Komak lauds Respondent:

[Respondent] worked hard on trying to have [CB] seen by Special Procedures¹³ to secure IV access for pain medications. She did everything to the best of her ability & went beyond her responsibility to help [CB] and management of a difficult situation & family members.¹⁴

At the hearing, the doctor explained that she wrote this first statement at the request of Respondent. When she wrote it, she was relying on the description of events given her by Respondent, and she believed that her order had been properly carried out. She had not yet reviewed the medical records when she wrote the first statement.

¹³ "Special Procedures" is apparently a reference to the infusion team.

¹⁴ State's Ex. 7, p. 105.

Roughly two weeks later, on March 10, 2008, Dr. Komak wrote a second statement, which was addressed to Respondent's nurse manager, Suzanne Couture. In this second statement, Dr. Komak explained that she had assumed her orders were properly carried out by Respondent, "based on the information provided to me by" Respondent. As to her first statement, Dr. Komak explained:

I thought that Ms. Reese was working towards trying to facilitate care of the patient, and so I wrote a letter of support towards her actions. I did not at this point verify Ms. Reese's statements regarding her administration of the IM medication . . . The letter I wrote was based on the information I was told by Ms. Reese. . . . I have subsequently learned that [CB] and her family had difficulty with communication and interaction with Ms. Reese on other circumstances on this same day, and . . . that Ms. Reese did not document the verbal order for pain medication that I ordered, and charted that she administered the medication through the infiltrated IV site rather than through the IM route. . . . I would not have written the initial letter of support had I been better informed of the actual events as they occurred.¹⁵

Dr. Komak offered the opinion that once an IV site is suspected of being infiltrated, it should not be used again. Instead, a new IV should promptly be put in place.

Nancy Krause

Nancy Krause testified on behalf of the Board. She is a licensed Registered Nurse employed as an investigator for the Board. She has extensive professional experience working as an RN.

On behalf of the Board, Ms. Krause conducted the investigation of the complaint against Respondent. She met with Respondent on March 17, 2009. At that meeting, Respondent told her she had administered the pain medication to CB via IM injection as ordered by Dr. Komak. However, Ms. Krause pointed out that this contradicts the medical records which, as explained

¹⁵ State's Ex. 7, pp. 106-07.

above, indicate that the medication was delivered by "Slow IV push."¹⁶ Respondent also admitted to Ms. Krause that she had failed to document Dr. Komak's verbal order, and that she had failed to note that she had administered the medication via injection instead of via the IV.

Melinda Hester

Melinda Hester testified on behalf of the Board. She is a licensed Registered Nurse and works as a consultant for the Board. She has extensive professional experience working as an RN, including in a number of practice areas.¹⁷ She regularly testifies on behalf of the Board as an expert witness regarding nursing issues.

As to the first charge against Respondent (regarding the infiltrated IV) Ms. Hester expressed the opinion that Respondent failed to appropriately assess that that IV was infiltrated, and to adequately intervene when she determined that the IV was infiltrated. She explained that when an IV site becomes infiltrated, it increases the risk of patient infection because the IV fluids leak into the patient's tissue, but do not enter the blood stream as intended. Moreover, she opined that CB was harmed because the fluids and medication she vitally needed shortly after surgery were not being received.

There is nothing in the record to indicate that CB suffered any lingering adverse effects from the infiltrated IV or from delayed receipt of medication. Therefore, counsel for Respondent argued that CB was not "harmed" by the Respondent's actions. However, Ms. Hester stated the opinion that CB was harmed by the Respondent's actions, in that the patient was forced to endure extreme pain unnecessarily. For example, at 12:45 on February 7, 2008, CB rated her pain level at 10 of 10. This could have been avoided if Respondent had administered the pain medication immediately after Dr. Komak ordered it, rather than over two hours later. Moreover, according to Ms. Hester, when patients experience such extreme pain, it can delay the healing

¹⁶ State's Ex. 9, p. 12.

¹⁷ State's Ex. 10.

process. Ms. Hester also stated that infiltrated IV sites are one of the leading causes of hospital-acquired infections among patients. Ms. Hester expressed concern about the low quality of Respondent's record-keeping, noting that Respondent apparently made nearly simultaneous, but incompatible, record entries that the IV site was both "infiltrated" and "NFP."

Ms. Hester opined that, by failing to remove the IV immediately upon noticing that it was infiltrated, Respondent violated UTMB policies.¹⁸ Ms. Hester also expressed the opinion that Respondent's actions with respect to CB's IV violated TEX. OCC. CODE § 301.452(b)(10) and (13), 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (B), and (M), and 217.12(1)(B) and (4).

As to the second charge against Respondent (regarding failure to document the IM injection of Fentanyl) Ms. Hester expressed concern about the low quality of Respondent's record-keeping. She explained that it is critical that nurses accurately and carefully document their actions so that all involved in a patient's care can have a clear picture of when and how medicine has been given. Ms. Hester stated that failure to accurately document the route by which the pain medication increased the risk of harm to CB by creating potential confusion among subsequent care givers. Ms. Hester stated that Respondent's failure in this regard constituted a violation of TEX. OCC. CODE § 301.452(b)(10) and (13), 22 TEX. ADMIN. CODE §§ 217.11(1)(A) and (D), and 217.12(1)(B) and (4).

As to the third charge, Ms. Hester stated that if a nurse receives a verbal order from a doctor, it is the nurse's duty to document that order. By failing to document Dr. Komak's verbal order to administer Fentanyl via IM injection, Respondent violated of TEX. OCC. CODE § 301.452(b)(10) and (13), 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (C), and (D), and 217.12(1)(B) and (4).

¹⁸ State's Ex. 7, pp. 1-2, 9, 15.

Ms. Hester recommended that the following sanctions be imposed:

1. A formal warning with stipulations from the Board, which include requiring that Respondent take and pass courses (within a one-year period from the Board order) in: (a) nursing jurisprudence and ethics; (b) remedial education; (c) medication administration; and (d) documentation.
2. A requirement that Respondent, for a one-year period following the final order, notify any current or future employers of the Board's actions and existence of a final order.
3. A requirement that Respondent's current or future employers, for a one-year period following the final order, file quarterly reports to the Board.
4. A requirement that Respondent, for a one-year period following the final order, be indirectly supervised by another RN.
5. An administrative penalty of \$250.

Ms. Hester offered the opinion that these sanctions were justified pursuant to the Board's Disciplinary Matrix, found at 22 TEX. ADMIN. CODE §213.33(b). Specifically, Ms. Hester concluded that the sanctions for Respondent's violations were properly assessed under the portions of the Disciplinary Matrix addressing "Second Tier Offenses" at "Sanction Level 1" for violations of TEX. OCC. CODE §§ 301.452(b)(10) and (b)(13). However, neither Ms. Hester, in testimony, nor Staff, in argument, addressed the factors set out in 22 TEX. ADMIN. CODE § 213.33, which a SOAH ALJ is required to consider when recommending sanctions.¹⁹

Finally, the Board sought recovery of its administrative costs of the proceeding pursuant to TEX. OCC. CODE § 301.461, and provided evidence demonstrating that the Board had incurred administrative costs totaling \$1,213.

¹⁹ The ALJ notes that Ms. Hester did reference the potential harm to CB, which is only one factor listed in Rule 213.33.

C. Respondent's Evidence and Argument

Respondent attempted to explain the inconsistencies of her entries in CB's medical records. On October 6, 2008, during the investigation of this incident, Respondent wrote a letter to the Board's investigator, Ms. Krause. In that letter, Respondent stated:

My 10am documentation on the PCA flow sheet [*i.e.* Respondent's entry of "IV site infiltrated"] wasn't reflected of actual events and assessment in retrospect I omitted to document what I observed. The site appeared to be infiltrated but I was not certain. Patient did not complain of tenderness to site or pain, but refused to allow me to remove IV site. . . . Patient was a difficult stick . . . At no time was any pain medication given through the compromised IV site.²⁰

At the hearing, Respondent conceded that she first observed that CB's IV was infiltrated around 8:00 or 8:30 a.m. Contrary to her written statement quoted above, Respondent also conceded that CB was complaining of pain and said she had been in a lot of pain all night long. Respondent claims she noticed that CB had a 22 gauge catheter for her IV. Respondent believed this to be too small a catheter for a patient who had just undergone a serious surgery. Respondent thought it would not last long, given the types of medications CB was receiving, which can act as irritants at the IV site.

Respondent concedes that she told CB and Ms. Brown that the IV site was infiltrated and that she wrote "IV site infiltrated" in the medical records. However, during the hearing, she claimed that when she wrote the entry she was merely *assuming* that the site was infiltrated based upon the fact that the IV was of a small gauge. In other words, Respondent claims that when she told CB and her mother that the site was infiltrated, she was merely wondering aloud whether the site *might* be infiltrated. Respondent stated: "I jumped the gun" and assumed incorrectly that the IV was infiltrated.

²⁰ State's Ex. 5.

When she visited CB's room later that morning, she reassessed the IV site and observed that CB had good blood return and the site appeared normal. She also "flushed" the IV by injecting saline through it. Having done so, she continued to use the IV because she believed it to still be usable.

Respondent conceded that she called Dr. Komak at roughly 10:45 to report that the IV was infiltrated, and that Komak ordered her to: (1) consult infusion therapy to have a new IV installed; and (2) give CB a dose of pain medication. At the hearing, Respondent denied that Dr. Komak ordered her to deliver the pain medication via IM injection. On cross examination, however, she admitted that, at a settlement hearing before the Board, she had stated that Dr. Komak instructed her to deliver the medication via IM injection. Respondent testified that she administered the pain medication via the IV. "I gave the patient the narcotics slow IV push, through the catheter." She stated that the IV was not infiltrated at the time.

Respondent documented the portion of Dr. Komak's verbal order calling for a consult with the infusion team, but she failed to document the portion of the order calling for an IM shot of pain medication.

Respondent, who is black, alleged that the complaints against her stemmed from Ms. Brown's racial animosity towards black people, and/or from Ms. Brown's generally difficult personality, and/or from retaliation for a racial discrimination suit brought by Respondent against UTMB. According to Respondent, multiple nurses encountered difficulties in dealing with Ms. Brown during CB's hospital stay. Respondent stated that CB's mother told her to "shut up" on a couple of occasions. In reaction to this, Respondent asked her supervisor if she could be reassigned so as to not treat CB. Respondent described Ms. Brown as difficult. She claims that, around 2 p.m., she attempted to remove the infiltrated IV, but Ms. Brown barred her from doing so. Ms. Brown denied this.

At the hearing, a number of other incidents were discussed which Respondent alleges demonstrate Ms. Brown's animus to Respondent or to nurses generally. There was an incident during the morning in question when Respondent entered the room in order to remove CB's nasal gastric tube. Ms. Brown testified that, because of Respondent's inaction regarding the pain CB was in, "I was kind of scared of [Respondent]." Ms. Brown expressed concern about Respondent removing the tube, explaining that it is usually a doctor that removes the tube. According to Ms. Brown, Respondent left the room and promptly returned with a paper that she "shoved" in Ms. Brown's face, saying, "These are the [doctor's] orders, and I'm the nurse." Then Respondent "jerked" the line out of CB's mouth.

There was also an incident with another nurse, who Ms. Brown had barred from the room. According to Ms. Brown, the unnamed nurse grabbed CB by the mouth and said: "This is how I used to get my kids to take their medicine. You're gonna take this pill." Ms. Brown complained and that nurse had been "very rude" to CB and thereafter, the nurse was not allowed back into CB's room.

Ms. Brown also had complaints about nurses concerning laytex gloves. According to Ms. Brown, CB is allergic to laytex. This apparently means that caregivers must put on new gloves when dealing with her. Ms. Brown testified that there were signs posted in CB's room explaining this requirement. Nevertheless, Ms. Brown complained that nurses were not complying with this requirement.

In stark contrast to Ms. Brown, Respondent described CB as "very sweet." According to Respondent, at some point during her hospital stay, CB had another nurse relay to Respondent a message apologizing for her mother's behavior. After her hospital stay, CB wrote Respondent a note thanking her for her help. Respondent contended that CB liked Respondent and had no complaints about her. Ms. Brown explained the CB "likes everyone." However, according to Ms. Brown, as to Respondent, CB told her: "Mama, she's very mean."

Respondent explained that, at the time the allegations in the case were raised against her, she had a racial discrimination suit pending against UTMB. In his closing arguments, counsel for Respondent suggested that the allegations against her were raised simply in retaliation for that lawsuit.

D. The ALJ's Analysis and Recommendation

The primary purpose of the Board is to protect and promote the welfare of the people of Texas.²¹ A licensed nurse is subject to disciplinary action for violating the Act, or a Board rule or Order.²² Staff alleges that Respondent violated the following provisions:

- Act § 301.452(b)(10). It is grounds for disciplinary action if a nurse engages in unprofessional conduct that is likely to injure a patient.
- Act § 301.452(b)(13). It is grounds for disciplinary action if a nurse fails to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient unnecessarily to risk of harm.
- 22 TEX. ADMIN. CODE § 217.11. This rule establishes the "minimum acceptable" standards of practices for nurses, and provides that failure to meet the standards may result in disciplinary action, "even if no actual patient injury resulted."
 - Pursuant to subpart (1)(A), all nurses are required to know and conform to the Act, the Board's rules, and all applicable federal, state, or local laws, rules or regulations.
 - Pursuant to subpart (1)(B), all nurses are required to promote a safe environment for clients and others.
 - Pursuant to subpart (1)(C), all nurses are required to "know the rationale for and the effects of medications and treatments and shall correctly administer the same."
 - Pursuant to subpart (1)(D), all nurses are required to "accurately and completely report and document," among other things, "the client's status

²¹ 22 TEX. ADMIN. CODE § 211.2(a).

²² TEX. OCC. CODE ANN. § 301.452(b)(1).

including signs and symptoms,” “nursing care rendered,” “physician . . . orders,” and “administration of medications and treatments.”

- Pursuant to subpart (1)(M), all nurses are required to take appropriate nursing interventions that may be required to stabilize a client’s condition and/or prevent complications.
- 22 TEX. ADMIN. CODE § 217.12. This rule identifies various “unprofessional or dishonorable behaviors of a nurse” which are likely to injure a patient, and explains that “actual injury to a client need not be established” in order to find unprofessional or dishonorable behavior.
 - Pursuant to subpart (1)(B), “carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings” constitutes an “unsafe practice.”
 - Pursuant to subpart (4), “careless or repetitive conduct that may endanger a client’s life, health, or safety” constitutes unprofessional conduct, even if actual injury to a client is not established.

Charge 1

The ALJ concludes that Staff proved Charge 1 – that Respondent failed to assess and intervene when the IV site for CB became infiltrated, remained in place, and continued to be used by Respondent for several hours after Respondent had discovered its compromised condition. Ms. Brown testified, credibly, that at around 8:00 or 8:30 a.m., Respondent checked CB’s IV and announced that it was “blown” and CB was not getting her pain medication. Moreover, according to Ms. Brown, Respondent said that CB was a “hard stick” and, therefore, she would call infusion therapy to install a new IV. There is no dispute that at 10:00 a.m., roughly one and a half to two hours after first discovering it to be infiltrated, Respondent wrote in CB’s chart: “IV site infiltrated.”

Thereafter, Respondent inexplicably continued to use the IV site – administering 1,000 milligrams of a medication via “IV piggyback” at 9:00 a.m., and 4 milligrams of Zofran via “slow IV push” at 10:07 a.m. The IV was not extracted and replaced with a PIC line until the

mid-afternoon.

The parties also agree that, between 10:00 and 10:45 a.m., Respondent called Dr. Komak and reported that the IV was infiltrated.²³ The parties agree that Dr. Komak ordered Respondent to have infusion therapy install a new IV and give CB a dose of pain medication. Although she denied it at the hearing, Respondent conceded to a Board investigator that Dr. Komak had ordered the pain medication to be delivered via IM injection. Respondent delivered the pain medicine to CB roughly two hours after Dr. Komak's order was given. According to Dr. Komak, this is an unacceptably long delay.

Respondent's testimony was not credible and was contradicted by previous statements she has made. For example, in her October 6, 2008 written statement, Respondent claimed that CB had not complained of pain. At the hearing, however, she conceded that when she first entered CB's room at around 8:30, CB complained of pain and said she had been in much pain all night long.

Respondent's explanation that she had initially, and wrongly, assumed the site was infiltrated and then later flushed the IV and found it to be working well was not credible. If, in fact, she had determined that the IV was working well after all, she surely would have called Dr. Komak back to report a "false alarm" and cancelled the call to infusion therapy. She also presumably would have made corrections to CB's medical records. It is clear she did none of this.

Respondent's 8:00 a.m., 10:00 a.m. and 12:00 p.m. notations that the IV site was "NFP" are obviously in conflict with her notation that the IV site was infiltrated, and with Respondent's other actions, such as calling Dr. Komak and her comments to CB and Ms. Brown. At best, the entries are simply instances of sloppy paperwork by Respondent. At worst, they may be an after-

²³ Again, the hour and half delay between when Respondent first observed the IV to be infiltrated and when she called Dr. Komak is troubling.

the-fact attempt by Respondent to justify the lengthy delay in getting CB's IV replaced. It appears indisputable that the IV became infiltrated sometime prior to 8:00 a.m. and remained so until a PIC line was installed mid-afternoon.

Ms. Hester testified, convincingly, that Respondent's actions created a risk of injury to CB because infiltrated IV sites increase the risk of infection and prevent the patient from receiving vitally needed medication. Moreover, the ALJ agrees with Ms. Hester's testimony that CB was harmed by Respondent's actions because she was forced to endure extreme pain unnecessarily.

Respondent's allegations that the complaints against her arise from racial animus or in retaliation for her suit against UTMB are unsupported by credible evidence. It is clear that Ms. Brown and Respondent had difficulties dealing with each other. However, Respondent failed to demonstrate animus or prejudice on Ms. Brown's part. Rather, the evidence showed that Ms. Brown is a concerned mother who has devoted a large part of her life to tending to her chronically ill adult daughter. Ms. Brown is more much experienced, and perhaps less passive, than the general public in dealing with hospital staff. It is impossible to determine from the record whether Ms. Brown was justified in her behavior in barring other nurses from CB's room and in reminding nurses to use new laytex gloves. However, in light of the evidence, Ms. Brown *was* justified in questioning Respondent's actions. As such, the ALJ cannot dismiss the complaints against Respondent as merely evidence of Ms. Brown's prejudices. Moreover, the Board's case is not based primarily on testimony from Ms. Brown, but on Respondent's own entries in the medical record.

For the same reasons, there is no credibility, and no evidence other than Respondent's minimal testimony on the point, to the assertion that this complaint is made in retaliation for Respondent's racial discrimination suit against UTMB.

The ALJ agrees with Staff's witness, Ms. Hester, that Respondent's actions with respect to the IV constituted violations of Act § 301.452(b)(10) and (b)(13), 22 TEX. ADMIN. CODE §§217.11(1)(A), (1)(B), and (1)(M), and 217.212(1)(B) and (4).

Charge 2

The ALJ concludes that Staff proved Charge 2 – that Respondent failed to document the route used to administer pain medication when she administered the Fentanyl to CB via IM injection. The parties agree that, between 10:00 and 10:45 a.m., Dr. Komak ordered Respondent to give CB a dose of pain medication. Dr. Komak is adamant that she ordered that the medication to be delivered via an IM injection. This is entirely believable because the doctor's order was given after she had just been informed that the IV was infiltrated. In other words, it would have been non-sensical for Dr. Komak to order the medication to be delivered through an IV that she had just been told was infiltrated.

At 12:41, Respondent administered the pain medicine to CB. Ms. Brown was adamant that Respondent gave CB a shot, rather than delivering it through the IV. During the investigation of this matter, Respondent told Ms. Krause, the Board investigator, that she had delivered the medication via IM injection. At the hearing, however, Respondent insisted that she had delivered the medication through the catheter. Again, on this point Respondent was not credible. Unlike the other witnesses, Respondent had a motive for lying on this point because, in CB's medical records, Respondent noted that the medication was given to CB at 12:41 p.m. by "slow IV push."

The ALJ agrees with Ms. Hester that Respondent's actions with respect to Charge 2 constituted violations of Act § 301.452(b)(10) and (b)(13), and 22 TEX. ADMIN. CODE §§ 217.11(1)(A), and (1)(D), and 217.212(1)(B) and (4).

Charge 3

The ALJ concludes that Staff proved Charge 3 – that Respondent failed to document a verbal order given to her by Dr. Spogmai Komak to administer the Fentanyl to CB via IM injection. The parties agree that, between 10:00 and 10:45 a.m., Dr. Komak ordered Respondent to give CB a dose of pain medication by IM injection. There is no entry of this order in CB's records. The ALJ agrees with Ms. Hester that Respondent's actions with respect to Charge 3 constituted violations of Act § 301.452(b)(10) and (b)(13), and 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (1)(C), and (1)(D), and 217.212(1)(B) and (4).

Appropriate Sanctions

As noted previously, Ms. Hester, on behalf of Staff, recommended various sanctions. Pursuant to 22 TAC § 213.33(c), the following factors must be considered when contemplating the imposition of sanctions:

- 1) evidence of actual or potential harm to patients, clients, or the public;
- 2) evidence of a lack of truthfulness or trustworthiness;
- 3) evidence of misrepresentation(s) of knowledge, education, experience, credentials, or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe;
- 4) evidence of practice history;
- 5) evidence of present fitness to practice;
- 6) evidence of previous violations or prior disciplinary history by the Board or any other health care licensing agency in Texas or another jurisdiction;
- 7) the length of time the licensee has practiced;
- 8) the actual damages, physical, economic, or otherwise, resulting from the violation;
- 9) the deterrent effect of the penalty imposed;
- 10) attempts by the licensee to correct or stop the violation;
- 11) any mitigating or aggravating circumstances;
- 12) the extent to which system dynamics in the practice setting contributed to the problem;
- 13) whether the person is being disciplined for multiple violations of the Act or its derivative rules and orders;

- 14) the seriousness of the violation;
- 15) the threat to public safety;
- 16) evidence of good professional character; and
- 17) any other matter that justice may require.

There is ample evidence that Respondent's actions caused harm, and had the potential to cause harm, to CB – such as by making her suffer pain, by increasing the risk of infection, by slowing the healing process, and by creating confusion in the medical records as to the care given. The ALJ believes that Respondent was untruthful and untrustworthy during the hearing. There is no evidence that Respondent has misrepresented her skills, or that the Board has taken previous disciplinary actions against her. The Respondent did make some attempts to ameliorate CB's suffering – she contacted infusion therapy to get a new IV installed. To some extent, the duration of CB's pain can be attributed to slowness on the part of infusion therapy to act. In this case, Respondent is guilty of multiple violations of the Act and its derivative rules. This appears to have been an isolated incident. On the other hand, the potential complications that could have arisen from Respondent's actions are quite serious.

Because the violations involve failure to comply with substantive Board rules regarding unprofessional conduct resulting in serious risk to a patient, the ALJ agrees that the penalty matrix used by Ms. Hester supports a warning with a \$250 fine, consistent with the Board Disciplinary Matrix, 22 TEX. ADMIN. CODE § 213.33(b), Attached Graphic. The ALJ, based on the above factors, recommends the following sanctions:

1. A formal warning with stipulations from the Board, which include requiring that Respondent take and pass courses (within a one-year period from the Board order) in: (a) nursing jurisprudence and ethics; (b) remedial education; (c) medication administration; and (d) documentation.
2. A requirement that Respondent, for a one-year period following the final order, notify any current or future employers of the Board's actions and existence of a final order.
3. A requirement that Respondent's current or future employers, for a one-year period following the final order, file quarterly reports to the Board.

4. A requirement that Respondent, for a one-year period following the final order, be indirectly supervised by another RN.
5. An administrative penalty of \$250.

Finally, the ALJ recommends that Respondent be required to pay the Board's administrative costs of \$1,213.

III. FINDINGS OF FACT

1. Joline Reese (Respondent) is a licensed registered nurse (RN), license number 620119, and has been licensed as an RN in Texas since 1995.
2. On February 6, 2008, CB underwent surgery at University of Texas Medical Branch Hospital in Galveston, Texas (UTMB). She spent the night at the hospital following the surgery.
3. CB is an adult who suffers from numerous, lifelong health problems and has endured roughly 80 surgeries during the course of her life.
4. Sometime during the night after her surgery, the IV site on CB's wrist became "infiltrated," meaning that it became clogged or otherwise ceased delivering fluids and medications into CB's blood stream.
5. Because the IV was infiltrated, CB did not receive the pain medications she had been prescribed and she was in considerable pain during the night.
6. At all times relevant to this proceeding, Respondent was employed by UTMB as an RN.
7. On February 7, 2008, the day after CB's surgery, Respondent was working at the hospital.
8. At roughly 8:30 that morning, Respondent entered CB's room, and was told that CB was in considerable pain.
9. Respondent inspected CB's IV site and announced to CB and her mother that the IV was "blown" (meaning infiltrated) and that CB was no longer receiving her medications.
10. At some point during that morning, Respondent informed CB and her mother that, because CB was a "hard stick" (meaning that it was difficult to find a vein and insert a

- new IV in CB), Respondent would arrange to have someone from the hospital's infusion therapy team install a new IV.
11. At 10:00 a.m., Respondent wrote in CB's medical records: "IV site infiltrated."
 12. At 8:00 a.m., 10:00 a.m., and 12:00 p.m., Respondent wrote in CB's medical records that the IV site was "NFP," meaning that the IV was in good working order.
 13. The entries described in Findings of Fact 11 and 12 are, by definition, contradictory. An IV site cannot simultaneously be both "infiltrated" and "NFP."
 14. Respondent continued to use CB's IV site to administer medications, despite knowing that the site was infiltrated and unusable. For example, she administered 1,000 milligrams of medication via "IV piggyback" at 9:00 a.m., and 4 milligrams of Zofran via "slow IV push" at 10:07 a.m.
 15. At roughly 10:00 a.m., Respondent called Dr. Spogmai Komak, who was in surgery, to report that CB's IV was infiltrated. Dr. Komak gave Respondent a verbal order to: (1) contact the hospital's infusion therapy team to have a new IV inserted; and (2) give CB an intramuscular (IM) injection of pain medication.
 16. Respondent failed to document Dr. Komak's verbal order to give CB an IM injection of pain medication.
 17. At 12:41 p.m., Respondent administered the pain medication to CB via IM injection as Dr. Komak had ordered. However, this was almost three hours after Dr. Komak had given the order, which is an unacceptably long delay.
 18. Moreover, in CB's medical records, Respondent erroneously wrote that she had administered the pain medication via "slow IV push."
 19. Respondent remained in considerable, and unnecessary, pain from roughly 8:30 a.m. to roughly 12:40 p.m., due to Respondent's slowness in assessing that the IV was infiltrated, and intervening once she knew it was infiltrated.
 20. By failing to appropriately assess that the IV was infiltrated, by failing to adequately intervene once she determined it was infiltrated, and by continuing to use the infiltrated IV, Respondent: (1) unnecessarily harmed CB by causing her to suffer considerable pain and by preventing her from obtaining the fluids and medications she vitally needed shortly after surgery; (2) increased the risk of infection to CB; and (3) potentially slowed CB's healing process.
 21. By making contradictory and incorrect entries in CB's medical records, and by failing to document Dr. Komak's verbal order in the medical records, Respondent increased the

risk of harm to CB by creating potential confusion among hospital workers about the course of CB's care.

22. There is no credible evidence in the record to indicate that the complaints against Respondent are motivated by racial animus or in retaliation for a suit brought by Respondent against UTMB.
23. During the hearing, Respondent was untruthful.
24. Staff offered no evidence that Respondent has misrepresented her skills, or that the Board had previously taken disciplinary actions against her.
25. Respondent did make some attempts to ameliorate CB's suffering, by contacting the infusion therapy team.
26. To some extent, the duration of CB's suffering can be attributed to the slowness on the part of the infusion therapy team to act.
27. Although this appears to be an isolated incident, the potential complications that could have arisen from Respondent's actions are quite serious.
28. In conducting this hearing, Staff incurred administrative costs of \$1,213.
29. On January 27, 2010, Staff served its Second Amended Formal Charges on Respondent.
30. Staff provided a timely notice of hearing to Respondent. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.
31. On May 25, 2010, Administrative Law Judge (ALJ) Hunter Burkhalter held a hearing on the merits at the SOAH Austin office. Counsel for Staff was John F. Legris, and counsel for Respondent was Anthony Griffin. The record closed on the same day.

IV. CONCLUSIONS OF LAW

1. The Texas Board of Nursing (Board) has jurisdiction over the discipline of licensed nurses in Texas. TEX. OCC. CODE ch. 301 (the Act).
2. The State Office of Administrative Hearings (SOAH) has jurisdiction to conduct hearings and issue a proposal for decision in this matter. TEX. GOV'T CODE ch. 2003.

3. Notice given by Staff of the Board (Staff) to Respondent was sufficient under law. TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.
4. Based on Findings of Fact Nos. 8-11, 14-15, 17, and 19-20, Respondent violated Act § 301.452(b)(10) and (b)(13), 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (1)(B), and (1)(M), and 217.212(1)(B) and (4).
5. Based on Findings of Fact Nos. 15, 17-18, and 21, Respondent violated Act § 301.452(b)(10) and (b)(13), and 22 TEX. ADMIN. CODE §§ 217.11(1)(A), and (1)(D), and 217.212(1)(B) and (4).
6. Based on Findings of Fact Nos. 15-16, and 21, Respondent violated Act § 301.452(b)(10) and (b)(13), and 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (1)(C), and (1)(D), and 217.212(1)(B) and (4).
7. Based on the above Findings of Fact and Conclusions of Law, and based upon the factors referenced in 22 TEX. ADMIN. CODE § 213.33, Respondent should:
 - receive a formal warning with stipulations from the Board, which include requiring that Respondent take and pass courses (within a one-year period from the Board order) in: (a) nursing jurisprudence and ethics; (b) remedial education; (c) medication administration; and (d) documentation;
 - be required, for a one-year period following the final order, to notify any current or future employers of the Board's actions and existence of a final order;
 - require Respondent's current or future employers, for a one-year period following the final order, file quarterly reports to the Board;
 - be indirectly supervised by another RN for a one-year period following the final order; and
 - be assessed an administrative penalty of \$250.
8. Respondent should be required to pay the Board's administrative costs of \$1,213.

SIGNED July 8, 2010.



HUNTER BERKHALTER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS