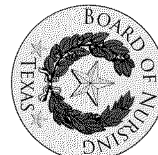
IN THE MATTER OF PERMANENT VOCATIONAL NURSE LICENSE NUMBER 177089 ISSUED TO AMANDA ANN ELLIOTT	§ § § § § § §	BEFORE THE TEXAS BOARD OF NURSING ELIGIBILITY AND DISCIPLINARY COMMITTEE



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.
Executive Director of the Board

ORDER OF THE BOARD

TO: AMANDA ANN ELLIOTT
421 SUTHERLAND DR.
TYLER, TX 75703

During open meeting held in Austin, Texas, on **December 9, 2014**, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by

reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN.CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Vocational Nurse License Number 177089, previously issued to AMANDA ANN ELLIOTT, to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

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.

Entered this **9th day of December, 2014**.

TEXAS BOARD OF NURSING

BY:

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charge filed January 31, 2014.

Re: Permanent Vocational Nurse License Number 177089
Issued to AMANDA ANN ELLIOTT
DEFAULT ORDER - REVOKE

CERTIFICATE OF SERVICE

I hereby certify that on the 10 day of December, 2014, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested
AMANDA ANN ELLIOTT
421 SUTHERLAND DR.
TYLER, TX 75703

BY: ______________________________
KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of	§	BEFORE THE TEXAS
Permanent Vocational Nurse	§	
License Number 177089	§	
Issued to AMANDA ANN ELLIOTT,	§	BOARD OF NURSING
Respondent	§	

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, AMANDA ANN ELLIOTT, is a Vocational Nurse holding License Number 177089, which is in delinquent status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about August 15, 2012, Respondent failed to comply with the Order of the Board issued to her on April 20, 2012, by the Texas Board of Nursing. Noncompliance is the result of Respondent's failure to comply with Stipulation Number Four (4) of the Agreed Order which states, in pertinent part:

> (4) RESPONDENT SHALL, pay an administrative reimbursement in the amount of one thousand six hundred thirty one dollars and twenty five cents ($1,631.25). RESPONDENT SHALL pay this administrative reimbursement within one hundred thirty five (135) days of entry of this Order....

A copy of the April 20, 2012, Order of the Board, Findings of Fact and Conclusions of Law, is attached and incorporated, by reference, as part of this pleading.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

CHARGE II.

On or about April 21, 2013, Respondent failed to comply with the Order of the Board issued to her on April 20, 2012, by the Texas Board of Nursing. Noncompliance is the result of Respondent's failure to comply with Stipulation Number One (1) of the Agreed Order which states, in pertinent part:

> (1) RESPONDENT SHALL, within one year (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

CHARGE III.

On or about April 21, 2013, Respondent failed to comply with the Order of the Board issued to her on April 20, 2012, by the Texas Board of Nursing. Noncompliance is the result of Respondent's failure to comply with Stipulation Number Two (2) of the Agreed Order which states, in pertinent part:

> (2) RESPONDENT SHALL, within one year (1) year of entry of this Order, successfully complete a course in Texas nursing documentation....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

CHARGE IV.

On or about April 21, 2013, Respondent failed to comply with the Order of the Board issued to her on April 20, 2012, by the Texas Board of Nursing. Noncompliance is the result of Respondent's failure to comply with Stipulation Number Three (3) of the Agreed Order which states, in pertinent part:

> (3) RESPONDENT SHALL, within one year (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills"....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for

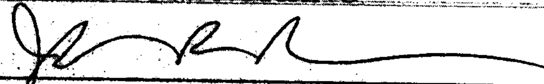
legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is/are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Order of the Board dated April 20, 2012.

Filed this 31 day of January, 2014.



TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
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333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6811
F: (512) 305-8101 or (512)305-7401

Attachments: Order of the Board dated April 20, 2012

D/2013.11.19

DOCKET NUMBER 507-11-3652

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 177089 ISSUED TO AMANDA ANN ELLIOTT	§ § § § §	BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

OPINION AND ORDER OF THE BOARD

TO: AMANDA ANN ELLIOTT
C/O DAN LYPE, ATTORNEY
1602 EAST 7th STREET
AUSTIN, TX 78702

STEPHEN J. PACEY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 19-20, 2012, 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 Findings of Fact and Conclusions of Law in the PFD regarding the vocational nursing license of Amanda Ann Elliott with changes; and (3) Respondent's response to Staff's recommendations and Respondent's proposed recommendations 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. Staff filed Exceptions to the PFD on January 4, 2012. Respondent filed Exceptions to the PFD on January 4, 2012. Respondent filed a Response to Staff's Exceptions to the PFD on January 18, 2012. Staff filed a Reply to Respondent's Response to Staff's Exceptions to the PFD on January 23, 2012. The ALJ issued a final letter ruling

on February 28, 2012, in which he declined to make any changes to the PFD other than two minor typographical corrections.

The Board, after review and due consideration of the PFD, Staff's Exceptions, Respondent's Exceptions, Staff's recommendations, and Respondent's presentation during the open meeting, if any, adopts Findings of Fact Numbers 1-35, including amended Finding of Fact Number 12 as set out in the ALJ's final letter ruling of February 28, 2012, and Conclusions of Law Numbers 1-3; 6-8; and 10 contained in the PFD as if fully set out and separately stated herein. The Board declines to adopt Conclusions of Law Numbers 4, 5, 9, 11, and 12 as proposed by the ALJ for the reasons stated herein.

Authority to Modify PFD

The Board has authority to review and modify the PFD in accordance with the Government Code §2001.058(e). Specifically, §2001.058(e)(1) authorizes the Board to change a finding of fact or conclusion of law made by the ALJ if the Board determines that the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions.

Conclusion of Law Number 4

The ALJ did not properly apply or interpret applicable law in this matter when he failed to find that there was a violation of the Occupations Code §301.452(b)(13) even though he found that the Respondent's conduct violated 22 Tex. Admin. Code §217.11(1)(N). The Occupations Code §301.452(b)(13) subjects a licensee to disciplinary action if the licensee fails to conform to the minimum standard of nursing practice that, *in the Board's opinion*, exposes a patient unnecessarily to a risk of harm. Pursuant to this statutory authority, the Board has established minimum standards of nursing practice for nurses in the State of Texas[1]. Failure to comply with these minimum standards of nursing

[1] See 22 Tex. Admin. Code §217.11.

practice subjects patients and the public to risk of harm. Pursuant to §217.11(1)(N), a nurse must clarify an order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the nurse makes the decision not to administer the medication or treatment. The ALJ clearly determined that the Respondent failed to meet this nursing standard of practice[2]. However, the ALJ fails to conclude that this same conduct also violated §301.452(b)(13). This conclusion is illogical and contradictory to the ALJ's own findings. If the Respondent violated the minimum standards of nursing practice set forth in §217.11(1)(N), as is clearly concluded by the ALJ, then the Respondent necessarily violated §301.452(b)(13), the statute from which the Board's rule (§217.11(1)(N)) is derived.

IT IS, THEREFORE, ORDERED THAT, under the authority of §2001.058(e)(1) for the reasons outlined herein, CONCLUSION OF LAW NUMBER 4 is AMENDED and ADOPTED as follows:

Amended Conclusion of Law Number 4

4. Based on the Findings of Fact, the Respondent's care to HB, including the decision to wait until the following morning to contact HB's treating podiatrist regarding her wound status and the use of Coban did not violate §301.452(b)(10) of the Act or 22 Tex. Admin. Code (TAC) §217.11(1)(P) or §217.12(1)(A), (B), (C) & (4), but did violate §301.452(b)(13) of the Act and 22 TAC §217.11(1)(N).

Conclusion of Law Number 5

The ALJ did not properly apply or interpret applicable law in this matter when he found that the Respondent's conduct did not violate §301.452(13) and 22 Tex. Admin. Code §217.11(1)(D). In Finding of Fact Number 30, the ALJ found that the Respondent's

[2] See PFD, Findings of Fact Numbers 19-21 and Conclusion of Law Number 8.

nursing note for the care she provided to HB was accurate and complete *except for* the Respondent's omission that she had substituted a wound dressing for the dressing ordered by the patient's treating podiatrist. The minimum standards of nursing practice set forth in §217.11(1)(D) require a nurse to accurately and completely document a client's status, including signs and symptoms; nursing care rendered; physician, dentist, or podiatrist orders; administration of medications and treatments; client responses; and contacts with other healthcare team members concerning significant events regarding client's status. The ALJ's finding indicates that the Respondent's documentation was incomplete, as it omitted mention of the wound dressing administered by the Respondent, but not ordered by the podiatrist. The minimum standards of nursing care require nursing documentation to be accurate and complete and to include information regarding nursing care rendered and administration of medications and treatments. Based upon the ALJ's findings, the Respondent's conduct violated the minimum standards of nursing practice set forth in §217.11(1)(D), as she failed to document the nursing care and treatments she provided and administered to HB[3]. Further, because Respondent's conduct violated §217.11(1)(D), the Respondent's conduct also necessarily violates §301.452(b)(13), the statute from which the Board's rule (§217.11(1)(D)) is derived.

IT IS, THEREFORE, ORDERED THAT, under the authority of §2001.058(e)(1) for the reasons outlined herein, CONCLUSION OF LAW NUMBER 5 is AMENDED and ADOPTED as follows:

Amended Conclusion of Law Number 5

5. Based on the Findings of Fact, the Respondent's accidental omission of her use

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[3] Neither §301.452(b)(13) nor 22 Tex. Admin. Code §217.11(1)(D) require a nurse's omission to be intentional in order to constitute a violation of the minimum standards of nursing practice. The ALJ's findings in this regard are, therefore, immaterial in determining whether a violation of the minimum standards of nursing practice occurred.

of Coban from her nursing note did not violate §301.452(b)(10) or 22 TAC §217.12(1)(A), (B), (C),& (4) & (6)(A) & (H), but did violate §301.452(b)(13) and 22 TAC §217.12(1)(D).

Conclusion of Law Number 9

The ALJ did not properly apply or interpret applicable law in this matter when he concluded that the Respondent did not violate any statutory provision. As has been discussed in detail in the preceding paragraphs of this Order, the Respondent's conduct, as found by the ALJ, violated the minimum standards of nursing practice enumerated in 22 Tex. Admin. Code §217.11. As such, as has also been discussed in detail in the preceding paragraphs of this Order, the Respondent's violations of the minium standards of nursing practice enumerated in 22 Tex. Admin. Code §217.11 necessarily constitute a violation of the Occupations Code 301.452(b)(13), the statute from which the Board's rule regarding minimum standards of nursing practice (§217.11) is derived. Therefore, the Board finds that the ALJ erred in making Conclusion of Law Number 9 and, therefore, declines to adopt it.

Conclusion of Law Number 11

The ALJ did not properly apply or interpret applicable law in this matter when he concluded that the Respondent only violated 22 Tex. Admin. Code §217.11(1)(N). The ALJ found that the Respondent did not accurately and completely document the nursing care and treatments she administered and provided to HB[4]. As has been discussed in detail in the preceding paragraphs of this Order, such conduct constitutes a violation of 22 Tex. Admin. Code §217.11(1)(D).

IT IS, THEREFORE, ORDERED THAT, under the authority of §2001.058(e)(1) for the reasons outlined herein, CONCLUSION OF LAW NUMBER 11 is AMENDED and ADOPTED as follows:

[4] See Finding of Fact Number 30 in PFD.

Amended Conclusion of Law Number 11

5. Based on the Findings of Fact and Conclusions of Law, Respondent violated the Board's rule 22 TAC §217.12(1)(D) and (1)(N).

Conclusion of Law Number 12

The Board declines to adopt Conclusion of Law Number 12 because it is a recommended sanction and not a proper conclusion of law. The Government Code §2001.058(e) authorizes the Board to change a finding of fact or conclusion of law made by the ALJ, or to vacate or modify an order issued by the ALJ if the Board determines that the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions. The ALJ did not properly apply or interpret applicable law in this matter when he included his recommended sanction as a conclusion of law.

A recommendation for a sanction is not a proper conclusion of law. While it may be appropriate for the ALJ to recommend a sanction, it is ultimately up to the Board to determine what the appropriate sanction should be. Further, the mere labeling of a recommended sanction as a conclusion of law or as a finding of fact does not change the effect of the ALJ's recommendation. Thus, the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact and conclusions of law. The Board, not the ALJ, is the final decision maker concerning sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. The choice of penalty is vested in the agency, not in the courts. Further, an agency has broad discretion in determining which sanction best serves the statutory policies committed to the agency's oversight. The propriety of a particular disciplinary measure is a matter of internal administration with which the courts should not interfere. *See 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); *Fay-Ray Corp. vs. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App. - Austin 1998, no pet.).

Further, the ALJ erred in applying and interpreting the applicable law in reaching his recommended sanction. The ALJ recommends that the Board treat the Respondent's conduct as a "minor violation" under 22 Tex. Admin. Code §217.16 and take no further action against the Respondent. The Board, however, finds that the ALJ has misconstrued the applicability of the Board's "minor incident" rule, §217.16, and, therefore, declines to adopt the ALJ's analysis and interpretation of §217.16. When construing administrative rules, "[a]n administrative agency's interpretation of its own rules is entitled to great weight and deference; it controls unless plainly erroneous or inconsistent with the agency's enabling statute." *Ackerson vs. Clarendon Nat'l Ins. Co.*, 168 S.W.3d 273, 275 (Tex.App.– Austin 2005, pet. denied).

Pursuant to §217.16, if a nurse's conduct qualifies as a "minor incident", the Board may forego imposing disciplinary action against the nurse. However, in order to qualify as a "minor incident" under 217.16, the nurse's continued practice cannot pose a risk of harm to a patient or another person. Further, a nurse's conduct cannot be considered a "minor incident" if: the nurse ignored a substantial risk that exposed a patient or other person to significant physical, emotional, or financial harm, or the potential for such harm; the nurse lacked a conscientious approach to or accountability for his/her practice; the nurse lacked the knowledge and competencies to make appropriate clinical judgment and such knowledge and competencies cannot be easily remediated; or the nurse has engaged in a pattern of multiple minor incidents that demonstrate the nurse's continued practice would

pose a risk of harm to patients or others[5]. If a nurse's conduct encompasses any one of the four situations identified in §217.16(c), it cannot be considered a "minor incident".

The ALJ found that the Respondent made an independent nursing decision to contravene a physician's written order by substituting a wound dressing for the dressing ordered by the physician. This decision was outside of the Respondent's authorized scope of practice. Further, the ALJ found that the Respondent did not call her supervisor nor the ordering physician to report the patient's change in condition or to discuss or clarify the physician's order for the wound dressing[6]. HB was a particularly vulnerable patient. As found by the ALJ, she was being treated for an ischemic ulceration on her foot, which was further complicated by her diabetes, poor circulation, and boney prominences that caused abrasion between her toes[7]. The Respondent was not authorized or qualified to make independent nursing decisions or to change the patient's plan of care without consultation with her supervisor and/or the patient's podiatrist. To pretend that such conduct[8] did not create a substantial risk of harm to HB, including the potential for additional and unforseen complications in the wound healing process, is illogical and disingenuous. Based upon the adopted Findings of Fact, the Board finds that the Respondent's conduct ignored a substantial risk of harm, and/or the potential for such harm, to HB. As such, it is inappropriate to qualify the Respondent's conduct as a "minor incident" under §217.16 and the Board declines to do so.

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[5] 22 Tex. Admin. Code §217.16(c).

[6] See Findings of Fact Numbers 19-21 in PFD.

[7] See Finding of Fact Number 5 in PFD.

[8] As summarized in the PFD.... "Respondent decided to use Coban to fixate the wound rather than Mefix. Coban had not been ordered by Dr. Overbeek. Respondent called neither the two RNs nor Dr. Overbeek's on-call answering service to report H.B.'s change in condition or to discuss or clarify the order for Mefix tape. Respondent made an independent nursing decision to contravene Dr. Overbeek's written order by substituting Coban for the Mefix tape. This decision was outside of Respondent's authorized scope of practice." See Findings of Fact Numbers 19-21 in PFD.

Based upon the adopted Findings of Fact and Conclusions of Law and the Board's opinion that the violations may not be considered "minor incidents" under the Board's rules, the Board finds that the Respondent's license should be disciplined. The Board has adopted rules that specifically address the factors that must be considered when determining the appropriate sanction in a disciplinary matter[9]. Based upon a review of the factors listed in §213.33(c), including risk of patient harm, the seriousness of the Respondent's conduct, the threat to the public safety, the vulnerability of the patient, the absence of any prior disciplinary history, and Respondent's prior practice history, the Board finds that the Respondent's conduct warrants a first tier, sanction level I sanction for her violation of §301.452(b)(13)[10], as outlined in the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(b), (c), (e), and (f).

IT IS THEREFORE ORDERED that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION, 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, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

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.

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[9] 22 Tex. Admin. Code §213.33.

[10] See the Board's Disciplinary Matrix, located at 22 Tex. Admin. Code §213.33(b), for a violation of §301.452(b)(13).

IT IS FURTHER ORDERED that while Respondent's license(s) is/are 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 State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER ORDERED that:

(1) 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.texas.gov/disciplinaryaction/stipscourses.html.

(2) 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.texas.gov/disciplinaryaction/stipscourses.html.

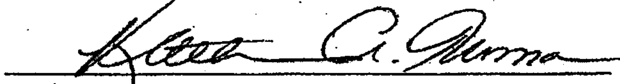
(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.

(4) RESPONDENT SHALL pay an administrative reimbursement in the amount of one thousand six hundred thirty one dollars and twenty five cents ($1,631.25). RESPONDENT SHALL pay this administrative reimbursement within one hundred thirty

five (135) 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.

Entered this 20th day of April, 2012.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; Docket No. 507-11-3652 (December 16, 2011).

Upload Date: 20111216024813 Account Number: 31 Upload Description: 507-11-3652 PFD

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

December 16, 2011

VIA INTER-AGENCY

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

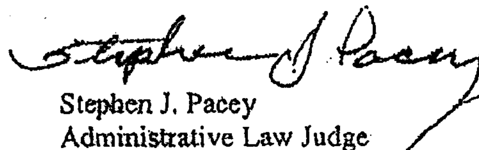
RE: Docket No. 507-11-3652; In the Matter of Permanent Certificate Number 177089 Issued to Amanda Ann Elliott

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,



Stephen J. Pacey
Administrative Law Judge

SJP/Ls
Enclosures
CC: Jena Abel, Assistant General Counsel, TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA INTER-AGENCY
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DOCKET NO. 507-11-3652

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 177089 ISSUED TO AMANDA ANN ELLIOT, Respondent	§ § § § §	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 Amanda Ann Elliot (Respondent). Staff alleged that Respondent failed to initiate appropriate interventions; failed to follow the physician's orders; and failed to honestly, accurately, and timely report and document all nursing and treatment care rendered. Staff alleged that Respondent's actions failed to meet the minimum standards in the Nursing Practice Act (Act)[1] and Board rules.[2] The Administrative Law Judge (ALJ) finds that Respondent has violated § 217.11(1)(N) of the Board Rules.

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 August 22, 2011, ALJ Stephen J. Pacey convened the hearing on the merits at the Austin office of the State Office of Administrative Hearings (SOAH). Counsel for Staff was Jena Abel, and counsel for Respondent was Dan Lype. The hearing adjourned August 23, 2011, and after allowing time for transcription and briefing, the record closed October 17, 2011.

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[1] TEX. OCC. CODE ANN. CH. 301.

[2] The Board rules are found at 22 Tex. Admin. Code (TAC) ch.217

II. DISCUSSION.

A. Background

Although many of the facts are disputed, there are enough undisputed facts to frame the issues. Respondent has been licensed as a vocational nurse (LVN) since 2000. In April of 2008, Respondent was employed as a Patient Services Coordinator (PCS) at Encompass Home Health (Encompass), a home health company. The duties of a PSC at Encompass involved scheduling patient visits. The job duties of a PSC did not normally involve rendering skilled nursing visits, although a PSC nurse could make such visits for extra pay if the originally scheduled nurse was unable to make a visit. On the weekend of April 5-6, 2008, the Respondent was assigned as the administrator-on-call. The administrator-on-call is responsible for rescheduling existing visits and scheduling new visits when an appropriate visit order was issued.[3]

The controversies involve the care of a patient, HB, who had dementia. Because of HB's disability, there is no evidence that Encompass communicated directly with HB, but rather through her daughter or caregiver. Patient HB was being treated by Troy Overbeek, DPM, for an ischemic ulceration on her foot and was receiving regular skilled nursing visits from Encompass.[4] HB's care was complicated by diabetes, poor circulation in her foot, and boney prominences which caused abrasion between the first and second toes. Patient HB lived in her own home. Her care was being overseen by her daughter, Virginia Sloan, RN, and Courtney Calhoun, a paid caregiver.

On April 4, 2008, Dr. Overbeek held meeting at his office with Ms. Sloan, Ms. Calhoun, and several members of Encompass staff including Mishalene Nash, RN. The meeting was held to review the care being provided to HB and Dr. Overbeek's concern that Ms. Sloan, Ms. Calhoun, and members of Encompass Staff were misinterpreting or misapplying his orders.[5] Respondent was not present at this meeting. After the meeting, Dr. Overbeek prepared a specific wound care order for the weekend of April 5-6, 2008. The order required: (1) the application of

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[3] Transcript at pages 62-64.

[4] Transcript at page 156ob lines 12-15

[5] Transcript at pages 156-164.

Fibracol as a primary dressing, to HB's ulceration, and (2) the use of Mefix tape used as a secondary dressing to hold the Fibracol in place. The order also required the placement of a piece of cast roll between the tips of HB's toes to hold the toes apart, and Sunday April 6, 2008, was the next scheduled day to check the wound.[6]

In the afternoon of Saturday April 5, 2008, the RN on-call, Tammy Parmer, received a phone call from Ms. Sloan stating that her mother was in pain and requested a skilled nursing visit be performed on that same day. In response, Ms. Parmer contacted the Respondent to inquire as to HB's next regularly scheduled visit. The Respondent informed Ms. Parmer that HB was scheduled for a visit the next day. As the RN on-call, Ms. Parmer held the authority to initiate an order for an unscheduled visit for HB. Respondent did not have the authority to make an unscheduled visit because it is beyond the LVN's authority level to initiate such an order. Despite Ms. Sloan's request, no nurse visited HB on Saturday.[7]

On Sunday morning, Ms. Sloan was angry that no one had attended to her mother on Saturday. Ms. Sloan called Ms. Parmer who called Respondent and told her to talk to Ms. Sloan about the scheduled visit. Before calling Ms. Sloan, Respondent called Ms. Nash because Ms. Nash was in the Friday meeting with Dr. Overbeek and might have wanted to tend to the wound herself.[8] Ms. Nash did not answer that call. Then, at 10:19 a.m., Respondent called Ms. Sloan and told her that Respondent would make the visit if she could not find someone. At 1:37 p.m., Ms. Nash returned Respondent's call. Respondent indicated to Ms. Nash that everything was fine. At 2:05 p.m., Respondent talked to Ms. Sloan and told her that she would make the visit.[9] Respondent arrived at HB's residence at about 4:00 and Ms. Sloan arrived when Respondent was removing HB's sock. This was the first time that Ms. Sloan was at HB's residence that weekend. Respondent apologized to Ms. Sloan because no one visited on Saturday.

[6] Exhibit 33 at page 157.

[7] Respondent testified that she attempted to call Ms. Sloan on Saturday, but sheas not successful. Staff disputes this testimony.

[8] Transcript at pages 604-608.

[9] Exhibit 38 at page 10 and Transcript at page 606.

Respondent examined HB's foot and identified two new red spots with an ulcer in the middle. There was Mefix tape stuck to the wound on the grand toe. The wound did not bleed until Respondent removed the Mefix tape from the wound bed. It bled a little upon removal of the tape.[10] Respondent took photographs showing the new damage to the toes.[11] Respondent believed that the two new ulcers were caused by the misplacement of the cast roll during Friday's wound dressing. Respondent found the cast roll abutting against the ulcers on bony prominences. The cast roll was between the HB's toes and on top of the ulcers causing pressure against both toes.[12] According to Dr. Overbeek's order, the cast roll should have been between the tips of the toes separating the toes.

Dr. Overbeek's order states to affix the Fibracol dressing with Mefix tape. Respondent used Coban tape instead. Her rational was that Coban will not stick to the wound like the Mefix. Before using the Coban tape, Respondent called Dr. Overbeek's office, but Dr. Murff was on-call.[13] Respondent did not talk to Dr. Murff because he had never treated HB's mother. Respondent waited until the next morning when HB could see Dr. Overbeek.

Early the next morning, Ms. Sloan and HB were in Dr. Overbeek's office. Dr. Overbeek was angry because the wound had been treated with Coban instead of Mefix. Dr. Overbeek knew that HB had trouble in the past with Coban, and he attributed all the new damage to the toes to the use of Coban, which is a compression tape. He maintains that HB has a problem with blood flow to the wound and when you put compression or pressure to the area you exacerbate the wound. Respondent admitted that she used the Coban. The doctor, Ms. Sloan, Ms. Nash, and Encompass management staff knew that Respondent used the Coban.

As a result of these events, Ms. Sloan filed with the Board a complaint against Respondent. Dr. Overbeek threatened to discontinue service to Encompass clients. In response to the complaints, Ms. Nash terminated Respondent's employment at 4:45 p.m. on Monday,

[10] Transcript at pages 610-612.

[11] Respondent's Exhibit 11.

[12] Transcript at page 623 on lines 7-25 and page 624 on lines 1-8.

[13] Respondent indicated that Ms. Sloan assisted her in applying the Coban tape, and it was Ms. Sloan's idea to wait until the next day when Dr. Overbeek could see HB. Ms. Sloan disputed both of these assertions.

April 7, 2011,[14] and filed an incident report with Adult Protective Services (APS).[15] During Respondent's termination, Ms. Nash requested that she turn in her visit note and documentation. The next day Ms. Nash, called Respondent and told her that: (1) she needed the required documentation, and (2) instead of termination, Respondent would be suspended pending further investigation and peer review. Respondent agreed to give Ms. Nash the documents, but she did deliver them until Wednesday, April 19, 2008. When Respondent met with Encompass management the next, day she was terminated again. Respondent was told she was terminated because of her actions during the weekend and her lateness in delivering her documentation.

In her note, Respondent did not mention using Coban. Ms. Nash and other Encompass staff investigating the incident felt that she intentionally omitted any reference to her use of Coban. They believed that the note was fraudulent by omission. Sharon Hobson RN, who did not testify at the hearing, reported that she asked Respondent why the reference was omitted. Respondent purportedly said "Why would I do that to incriminate myself?"[16]

B. Formal Charges

The following three charges were developed by the facts outlined above:

1. Formal Charge I. On or about April 5, 2008, through April 6, 2008, while employed at Rehab at Home-Encompass, Tyler, Texas, Respondent failed to timely respond, schedule, and/or perform a skilled nursing visit in order to assess Patient HB, as repeatedly requested by the daughter of Patient HB, after being notified by the daughter of Patient HB of a change in Patient HB's condition. Respondent's conduct caused the patient to suffer pain unnecessarily and deprived the patient of timely medical intervention.[17]

2. Formal Charge II. The Respondent failed to conform to nursing standards by not contacting her supervisor or the on-call physician when she discovered that Mefix tape was directly affixed to the wound and by not contacting the physician prior to

[14] Transcript at page 91 at line 25.

[15] Transcript at page 130 at lines 33-34.

[16] Petitioner's Exhibit 11. Respondent disputes this and at 637 and 638 of the transcript Respondent testified that she said: "Why did I incriminate myself" as if to say "did I do something wrong."

[17] Petitioner's Exhibit 5.

substituting Coban for the non-efficacious Mefix tape. That the Respondent's use of the Coban instead of Mefix tape may have contributed to the worsening of the patient's wound.[18]

3. Formal Charge III. On or about April 6, 2008, while employed at Encompass, Respondent falsely documented that she dressed the wound of Patient HB the same as it had been, instead of accurately documenting that she used Coban, which was not ordered for the patient, to fixate the wound filler. Respondent's conduct created an inaccurate medical record and deprived the physician and other caregivers of essential information, which was required to provide on-going medical care.[19]

III. DECISION AND ANALYSIS

A. Formal Charge I: Failure to Timely respond and Causation of Pain

To prove Formal Charge I, Staff had to demonstrate that Respondent failed to timely respond, schedule, and/or perform a skilled nursing visit. First, Staff failed to prove that the information that Respondent had about HB's condition on Saturday warranted her pursuing an extra visit. Second, Staff failed to provide any evidence that Respondent was ordered or otherwise instructed to schedule an extra visit on Saturday. Third, Petitioner failed to prove that Respondent had the authority to schedule an extra visit on Saturday. In fact, ordering an unscheduled visit would have been beyond her scope as an LVN. Ultimately, Respondent, having been unable to find a replacement nurse, made the scheduled visit on Sunday, according to physician's orders.

1. Respondent's information on Saturday, April 5, 2008

The proof of Formal Charge I hinges on the credibility of Ms. Parmer's testimony. She was the on-call nurse for the weekend, and she was the nurse with whom Ms. Sloan spoke on August 5, 2008. The key issue is whether Ms. Parmer told Respondent about Ms. Sloan's concerns about her mother's condition (as Ms. Parmer told the investigators), or whether

[18] *Id.*

[19] *Id.*

Ms. Parmer merely asked Respondent for the date of HB's next scheduled visit for the changing of her dressing (as Respondent contended).

In balancing the weight of the evidence, the ALJ must be able to evaluate the credibility of the witness and her testimony. For Ms. Parmer, she had a clear recollection of the events when she gave her statements to Staff investigators. But, at the hearing on the merits, she had no recollection of the events of that weekend. Her lack of recollection diminishes the credibility of her testimony at the hearing on the merits and in her statements to the investigators.

In addition to these concerns about Ms. Parmer's testimony, the ALJ is also concerned about other details. For example, Ms. Parmer made a note that she told Respondent that Ms. Sloan had described the details about the appearance of a red spot on her mother's wound and problems with her bandages. This seems highly unlikely since Ms. Sloan had not seen her mother when she called Ms. Parmer, and she had no opportunity to examine the wound or the bandages. Ms. Parmer did not see the bandage until late Sunday, April 6, 2008. That Ms. Parmer made a notation about matters that she could not have seen at the time that she made the note calls into question the accuracy of her statements. These matters might have been resolved if Ms. Parmer had been able to give meaningful testimony at the hearing. But, in the absence of her memory of any of these events, Ms. Parmer's testimony was of no evidentiary value to Staff in their presentation or to the ALJ in evaluating the allegations against Respondent.

Staff also argued that Respondent had a duty to HB to assess the condition of her wound when Respondent agreed to contact Ms. Sloan to obtain more information. Staff argued that Respondent could have assessed the patient's condition by phone. The argument cannot withstand scrutiny of the facts. Respondent could not have made an assessment by phone since neither HB's caregiver nor Ms. Sloan was at HB's residence. HB was unable to assist Respondent since HB had dementia. There was no one for Respondent to call who could have given Respondent more information. Although Respondent tried calling all upon whom she reasonably thought she could rely, she was unsuccessful in gaining more information.

2. Order to Respondent to schedule an extra visit

There was no evidence that Respondent was ordered by anyone to schedule an extra visit.

3. Respondent's authority to schedule an extra visit

Respondent had no authority to make an unscheduled visit to assess HB in person unless Respondent had a scheduling change order—which she did not have.

Instead, the focus of this inquiry returns to the issue of Ms. Parmer's direct contact with Ms. Sloan. Ms. Parmer either knew or should have known that Respondent could make no visit without a scheduling change order. Ms. Parmer was the nurse who was dealing directly with Ms. Sloan, not Respondent. Respondent did not know the extent of HB's medical problems and she lacked the means to obtain that information. Ms. Parmer was the only one who talked to Ms. Sloan, who could order a more complete and early assessment of the extent of HB's wound problems, and who failed to exercise her sole authority to issue a scheduling change order.

4. Delays that harmed the patient

On Sunday morning, Ms. Sloan called Ms. Parmer and told her that no one had visited HB on Saturday and that she was still in pain. Ms. Parmer called Respondent who in turn called Ms. Nash then Ms. Sloan. Ms. Nash did not answer, but at 10:19 a.m. Respondent talked to Ms. Sloan for 17 minutes.[20] Even though Ms. Parmer made it appear in the investigative reports that there was no communication between Ms. Sloan and Respondent, nothing could be further from the truth. Respondent called Ms. Nash once and talked to her again at 1:37 a.m. She called Ms. Sloan twice, once in the morning to tell Ms Stone that she was scheduling a nurse to visit and the second at 2:05 p.m. to tell Ms. Sloan that Respondent would make the visit Ms. Parmer's representations to Ms. Bowman and contained in Ms. Bowman's report are at best suspect and sometimes simply wrong. To make matters worse the misrepresentations tainted other testimony. After looking at her investigatory documentation, Lecia Bowman RN testified

[20] Petitioner's Exhibit 38 at page 10.

that the Respondent turned off her phone, which is an assumption taken from a statement by Ms. Parmer.[21] This statement is factually inaccurate. Respondent testified that she did not turn her phone, and the phone records[22] indicate sixteen calls between 10:00 a.m. and 4:00 p.m. with numerous calls each hour. And Ms. Parmer cannot be questioned on this because she does not remember.

The actions taken by Respondent on Sunday were not dilatory. After Ms. Parmer called Respondent and requested Respondent to call Ms. Sloan about the scheduled visit, Respondent immediately called Ms. Nash because Respondent thought that Ms. Nash might want to take the visit because she was in the Friday meeting with Dr. Overbeek. Ms. Nash did not answer. Respondent then immediately called Ms. Sloan. After talking to Ms. Nash that afternoon, Respondent called Ms. Sloan again. There is no proof that Respondent's actions on Sunday caused the patient to suffer pain or deprived the patient of timely intervention. The ALJ concludes that Respondent's actions were proper.

B. **Formal Charge II: Failing to Obtain Physician Approval**

While the Nursing Practice Act permits a nurse to decline to administer a treatment or a medication that the nurse believes to be contraindicated or non-efficacious, the nurse must contact the ordering physician to notify him/her at the time the nurse decides not to administer the treatment or medication.[23] Nurses are not authorized to alter a physician's order without notifying the physician to clarify the order. Although a licensed vocational nurse (LVN) has a duty to identify treatments that may be non-efficacious or contraindicated, the LVN may not make a medical diagnosis or prescribe therapeutic or corrective measures. Also, a LVN may not make independent nursing judgments or alter a patient's nursing plan of care.

In this situation, the Respondent assessed HB's wound dressing and determined that the Mefix tape was sticking to the wound bed. When the Respondent removed the Mefix tape from the wound

[21] Petitioner's Exhibit 11 at page 2.

[22] Petitioner's Exhibit 38 at page 10.

[23] 22 Tex. Admin. Code § 217.11(1)(N).

bed, the wound began to bleed. The Respondent also noted that there were new ulcers on the Respondent's second toe. The Respondent determined that using the Mefix tape to re-dress the wound might cause further injury to the wound. When the Respondent discovered the change in condition of the patient,[24] the Respondent should have either (i) contacted Dr. Overbeek's office to report the change in the patient's condition and clarify the orders for the wound dressing or (ii) contact Ms. Parmer or Ms. Nash so they could contact Dr. Overbeek's office and report the change in the patient's condition and clarify the orders for wound dressing. Dr. Overbeek's office had an on-call answering service available on that Sunday. Further, Dr. Overbeek's partner, Dr. Murff, was on-call that weekend and could have directed the care of HB.

It appears that the Respondent made an attempt to contact Dr. Overbeek's office because that was the only way she could have known that Dr. Murff was on-call. Respondent left no message for either Dr. Overbeek or Dr. Murff. She relayed no information to his office about HB's change in condition; and she relayed no information about altering Dr. Overbeek's existing order. The Respondent also did not contact Ms. Parmer, who was still on-call and available, or Ms. Nash. Rather, the Respondent made an independent nursing judgment to use Coban to fixate the wound dressing.

Respondent substituted Coban for the Mefix tape ordered by Dr. Overbeek. She failed to report the changes in HB's condition and to seek clarification of Dr. Overbeek's order to use Mefix tape. She also failed to contact either RN. These omissions are a violation of the Nursing Practice Act and the Board's rules.

The Respondent asserted that she felt she was acting in the best interest of the patient. However, on cross examination, she admitted that she had not followed the Board's guidelines for determining a nurse's appropriate scope of practice. Respondent's substitution of Coban for Mefix was not authorized by valid physician order or protocol. Her use of Coban in contravention of Dr. Overbeek's written order was inappropriate.

[24] The change in condition was new ulcers on HB's second toe and the Mefix tape that was stuck directly to the wound bed, causing the wound to bleed when removed.

The ALJ is not persuaded by Respondent's argument that Respondent she was not required to wait an indeterminable amount of time for someone to call back. The ALJ is also not persuaded that a better interpretation by the Board would take into account the individual circumstances confronting the nurse, the practice environment, the severity of the issue, the invasiveness of the nursing intervention performed, and other relevant circumstances prior to deciding whether a given intervention is within the scope of a trained nurse and when it is required to contact the on-call podiatrist.

The ALJ is persuaded that Respondent's unapproved substitution of Coban for Mefix neither caused nor contributed to the worsening of HB's wounds. The Staff failed to carry their burden of proof with respect to the harm issue. There was no credible evidence demonstrating that the Respondent's use of Coban caused harm to Patient HB or would be likely to cause harm. The evidence produced by the Respondent and testimony elicited from both her and the Staff's witnesses demonstrate the opposite: No harm was caused by the Respondent's use of Coban. Such an injury would not be expected from its use, and, in fact, the use of Coban likely mitigated the harm that was already present when the Respondent made her skilled nursing visit on April 6, 2008. The Staff's case for harm or potential harm rests entirely on the testimony of HB's treating podiatrist, Troy Overbeek, DPM. Dr. Overbeek's statements on this issue were highly speculative, and were based on assumptions which are factually incorrect as shown through the rest of the evidence and testimony produced at hearing.

Dr. Overbeek testified that his concern that the Respondent's use of Coban may have caused harm was based on his observation of two new ulcers and a small enlargement of the original ulcer during his assessment of HB on April 7, 2008, and his understanding that Coban was used as a compressive dressing, which may have compromised HB's circulation. The evidence shows that the two new ulcers were already present during the Respondent's skilled nursing visit, and that the original ulcer was likewise already worse at the time of her visit. It was further exacerbated by the Mefix tape being directly affixed to the wound. The Respondent did not use Coban as a compressive dressing. She tightened the Coban only tight enough to hold the primary dressing in place. Dr. Overbeek's testimony indicated that he held an incorrect understanding as to how the Coban had been applied by the Respondent, and this belief directly

bore on his misplaced fears that the Coban, as applied by Respondent, may have caused excess pressure and worsened HB's wound.

There are several problems with Dr. Overbeek's testimony and medical opinions as the relate to Staff's allegations that the Respondent's use of Coban may have caused harm to HB. First, the evidence establishes that the two new ulcerations identified by Dr. Overbeek during his April 7, 2008 assessment were already present when Respondent made her skilled nursing visit the prior evening. Dr. Overbeek acknowledged that the only first-hand knowledge he had regarding the new ulcerations where that they were not present when he saw the patient on April 4, 2008, but were present on April 7, 2008.[25] Dr. Overbeek had no personal knowledge as to when the new ulcerations appeared or whether their appearance preceded or postdated the Respondent's use of Coban.

In contrast, the Respondent testified that the two new ulcerations were already present when she made her nursing visit on April 6, 2008.[26] These observations were made prior to any Coban use. The new ulcerations were also documented in the Respondent's nursing note.[27] Most revealingly, the Respondent took multiple photographs of the patient's wound as it appeared during her visit.[28] These photographs demonstrate the presence of the two new ulcerations on HB's second toe as noted by Dr. Overbeek the following morning on April 7, 2008. The only three witnesses[29] who saw HB's feet at the time of the Respondent's only contact with the patient were in agreement that the two new ulcerations were already present and the original lesion was worse than it had been on Friday. This is further verified by the wound photographs which were taken on Sunday by the Respondent.[30] Taken together, the uncontroverted evidence and testimony establishes the Respondent's use of Coban did not cause the new ulcerations or the existing lesion to become larger. These all occurred prior to Respondent's visit.

[25] Transcript at page 175at lines: 1-21.

[26] Transcript at page 611at lines 11-17.

[27] Petitioner's Exhibit No 10 at 15.

[28] Respondent's Exhibit No 11.

[29] Ms. Sloan, Respondent, and Ms. Calhoun.

[30] Respondent's Exhibit No. 11.

Respondent's expert witness, Eddie Davis, DPM, disagreed with Dr. Overbeek's testimony. Dr. Davis said that it was unlikely that the use of Coban on a patient like HB would cause harm. Dr. Davis testified he frequently uses Coban in his practice to treat wounds in patients with similar presentations as HB, including patients with diabetes, poor circulation, and ischemic ulcerations.[31]

Dr. Davis' expert testimony that the Coban was unlikely to have harmed HB is further bolstered by the APS investigation which examined the same issue. After interviewing all of the same witnesses with first-hand knowledge who testified at the hearing including Dr. Overbeek, Respondent, Ms. Sloan, and Ms. Calhoun, the APS determined there was insufficient evidence to find that the Respondent's actions caused harm to HB.[32]

In summary, there is no credible or probative evidence that the Respondent's substitution of Coban for Mefix tape caused harm or was likely to cause harm to HB. The record demonstrates the original lesion was worse and the two new ulcers were already present when Respondent rendered her visit on April 6, 2008.

C. Formal Charge III: False Documentation

Staff''s argument is two fold: 1. In the note, Respondent's references and statement concerning Ms. Sloan's statements and behavior are false, and. 2.1. In her note documenting the visit, Respondent did not include the fact that she used Coban to dress the wound, and

In considering Staff's first allegation, Staff argued that the *credible* evidence suggests that the remainder of the Respondent's note was false. Staff alleged the following facts establish this assertion. Ms. Sloan specifically denied that she took part in dressing her mother's wound. She also specifically denied that she agreed to wait until Monday to notify Dr. Overbeek of the change in the wound dressing. On the contrary, Ms. Sloan testified that she told the Respondent several times to contact Dr. Overbeek's office to get an order for the Coban. Further, she

[31] Transcript at 317-318 at lines 17-9.

[32] Respondent's Exhibit No. 4.

testified several times that she did not participate in the dressing changes for her mother's wound, including the dressing change on that Sunday. It is undisputed that Encompass staff was notified on the following Monday of the Respondent's deviation from Dr. Overbeek's order.

The problem with Staff's argument is that Ms. Sloan is far from credible. Except for Tammy Parmer, Virginia Sloan was the least credible person at the hearing. The ALJ does not view her statements as true. The record is replete with references as to how difficult she was to deal with. She is an RN and an attorney. She was invited to the April 4, 2008 meeting because Dr. Overbeek was suspicious that either she and/or her caretaker were changing HB's bandages. When explaining how the wound got worse, Dr. Overbeek said Ms. Sloan may have changed the bandage.[33] Alicia Morris, Area Manager for Encompass reported[34] that Dr. Overbeek said: "He understood that Virginia Sloan was looking for something to complain about because she knowingly assisted Amanda in applying the Coban to her mother's foot, not providing information to Amanda that the Coban had caused problems with the wounds in the past, baiting her " There is no reason for Ms. Morris to lie, but at the hearing and after consulting with his private attorney, he denied that he said entire statement verbatim. Dr. Overbeek said he would never use the words "bailing her".[35] But in other conversations, Dr. Overbeek described Respondent's action as not malicious and under extenuating circumstances.

As to Staff's point number two, it fails because Ms. Sloan's statements are not credible, and they should not have been categorized as such. At best, they are disputed.

Staff's number one and main point was that the Respondent fraudulently omitted from her documentary note the fact that she used Coban on the wound. The ALJ concludes that Respondent did not intentionally omit the word because the note on its face states that Respondent observed HB's wound, finding that the Mefix had become affixed to the wound bed; she decided to dress the wound without the use of Mefix.

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[33] Transcript at page 182.

[34] Petitioner's Exhibit 10 at page 13

[35] Transcript at page 203.

Respondent's note for Sunday, April 6, 2008, states explicitly, "Mefix tape was not fixated to the Fibracol at this time due to it tearing out the wound bed just before changing the dressing."[36] This statement leaves no question as to Respondent's choice to depart from the previously used Mefix dressing. Respondent's note included a clear description of the problem caused by the Mefix tape, which had become dried out and affixed to the wound. Respondent's note indicates no falseness as to her choice not to use Mefix in redressing the wound, and certainly does not state that she dressed the wound the same as it had been, as Staff alleges.

Respondent's use of Coban as the secondary dressing to affix the Fibracol to HB's wound was not explicitly stated in the note. But Respondent testified that this was an oversight, and that she did not realize that she had not stated the particular alternate dressing she had used until it was pointed out by Sharon Hobson at a meeting on Thursday, April 10, 2008. However, as Respondent testified, Fibracol cannot be affixed to a wound without some type of secondary dressing. Despite Respondent's mistake in not specifying the alternate dressing, subsequent healthcare providers would understand that if Mefix was not used, an alternate dressing would have to be used. Even though Respondent left out the name of the alternate dressing, the note is still clear on the fact that she did not use Mefix, which is contrary to the Staff's allegations. It is difficult to understand Staff's argument in charge number 3. The term "as it is til then" has an entirely different meaning than the Staff asserts when read in context within the four corners of the note. The note actual states: "Virgiania Sloan agreed that wound changes, along with orders would be discussed with Dr. Overbeek in the morning and dressing as it is til then." The plain meaning is Respondent redressed the wound and did not use Mefix. Until HB sees the doctor Respondent is not going to redress the wound with Mefix. She will leave it as it is.

Staff's investigative records reflect that when confronted with the omission she responded "Why would I do that to incriminate myself." Respondent testified about this interchange, clarifying as follows:

> Sharon had asked me why I left out the word "Coban" and I didn't understand what she was asking. And she showed me my note and she said, you left out the word "Coban." And that's whenever I came to even notice that I had accidentally left it out.

[36] Petitioner's Exhibit No. 11 at page 16.

> When I asked her, Why, did I incriminate myself, is because Sharon had offered earlier in the week to help me with my note if I had any questions. And when I asked her that, I was asking, why? Did I do something wrong? I didn't understand. Did that hurt me in some way because I accidentally left that out?[37]

Respondent's reaction to being confronted about leaving out the word "Coban" was misunderstood by Encompass administrators as being the reaction of someone being caught in an attempt to falsify a record. But according to her testimony, it appears to be the reaction of a scared nurse that had just realized that she left that particular piece of information out of her note.

IV. RECOMMENDATION

In summary, the ALJ finds that Respondent violated the Board's rule at 22 TEX. ADMIN. CODE (TAC) § 217.11(1)(N) which states that all vocational nurses shall:

> Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the nurse makes the decision not to administer the medication or treatment

TLJ determines that the other alleged violations were not proved; consequently this qualifies as a minor incident under the Act and Board's rules and does not warrant disciplinary action.

Section 301.401(2) of the Occupations Code creates a category of violations which are deemed "minor incidents" and which do not warrant disciplinary action. TEX. OCC. CODE §301.402(2). Specifically, this statute defines a minor incident as:

> Conduct by a nurse that does not indicate that the nurse's continued practice poses a risk of harm to a patient or another person. This term is synonymous with "minor error" or "minor violation" of this chapter or board rule.

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[37] Transcript at page 637 at lines 7-24.

By rule the Board has determined that minor incidents do not need to be reported and do not warrant disciplinary action. 22 TAC § 217.16(a)-(c). A minor incident only needs to be reported to the Board if five or more occur within a twelve month period.

It is recommended that the Board treat Respondent's only incident in eight years as a minor incident and impose no sanctions. The board is entitled to the costs of the proceeding as set forth in Staff's affidavit.[38]

V. FINDINGS OF FACT

1. Amanda Elliott (Respondent), is a Licensed Vocational Nurse duly licensed in the State of Texas under Permanent Certificate Number 177089 since 2000.

2. In April of 2008, the Respondent was employed as a Patient Services Coordinator (PSC) at Encompass Home Health (Encompass), a home health company.

3. The duties of a PSC at Encompass involved scheduling patient visits. The job duties of a PSC did not normally involve rendering skilled nursing visits although a PSC nurse could make such visits for extra pay if the nurse originally scheduled to make a visit were unable to do so.

4. On the weekend of April 5-6, 2008, the Respondent was assigned as the administrator-on-call. The administrator-on-call was responsible for rescheduling existing visits and scheduling new visits when an appropriate visit order was issued.

5. Patient HB was being treated by Troy Overbeek, DPM, for an ischemic ulceration on her foot and was receiving regular skilled nursing visits from Encompass. HB's care was further complicated by her diabetes, poor circulation in her foot, and boney prominences which would cause abrasion between the first and second toes.

6. Patient HB had dementia and her care was being overseen by her daughter, Virginia Sloan, RN, and Courtney Calhoun, a paid caregiver.

7. On April 4, 2008, a meeting was held at Dr. Overbeek's office between himself, Ms. Sloan, Ms. Calhoun, and several members of Encompass Home Health Staff including Mishalene Nash, RN. The meeting was held to go over the care being provided to HB and Dr. Overbeek's concern that Ms. Sloan, Ms. Calhoun, and members of Encompass Staff were misinterpreting or misapplying his orders. The Respondent was not present at this meeting.

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[38] Staff's affidavit is somewhat confusing. Each party agreed to pay one-half the cost of the transcript. I assume that is the intent of the affidavit.

8. On the weekend of April 5-6, 2008, Dr. Overbeek's wound care orders called for the application of Fibracol as a primary dressing to HB's ulceration with Mefix tape used as a secondary dressing to hold the Fibracol in place. Dr. Overbeek's order also called for the placement of a piece of cast roll between the tips of HB's toes to hold the toes apart.

9. On April 5, 2008, the RN on-call, Tammy Parmer, received a phone call from Ms. Sloan stating her mother was in pain and that she wanted a skilled nursing visit performed on that same day.

10. In response to Ms. Sloan's phone call, Ms. Parmer contacted the Respondent to inquire as to HB's next regularly scheduled visit. The Respondent informed Ms. Parmer that HB was scheduled for a visit the next day on April 6, 2008.

11. As the RN on-call, Ms. Parmer held the authority to initiate an order for an unscheduled visit for Patient HB. There is no evidence that Ms. Parmer ever initiated such an order to have a skilled nursing visit performed for Patient HB on April 5, 2008.

12. The statements in the investigative reports attributable to Ms. Parham lack credibility because Ms. Parmer testified that she had no memory of that weekend and could not corroborate her statements.

13. The Respondent attempted to contact Ms. Sloan on April 5, 2008, to let her know HB was scheduled for a visit on the following day but was unable to reach her by phone.

14. In the morning of Sunday, April 6, 2008, the Respondent telephoned Ms. Sloan. During that phone call, the Respondent informed Ms. Sloan that the original nurse scheduled to visit her mother on Sunday, Celeste Ralda, RN, had canceled and that she would either find another nurse to render the visit or would make the visit herself later that afternoon.

15. About 2:00, Respondent talked to Ms. Sloan and told her that she would make the visit.

16. At approximately 4:00 p.m. on April 6, 2008, the Respondent arrived at HB's home to perform a skilled nursing visit.

17. When Respondent assessed HB.'s wound on April 6, 2008, she discovered that the Mefix tape was stuck directly to the wound bed. Also, she discovered that HB had two new ulcers on her second toe.

18. Respondent removed the Mefix tape from the wound bed and caused the wound to bleed a little.

19. Respondent decided to use Coban to fixate the wound rather than Mefix. Coban had not been ordered by Dr. Overbeek.

20. Respondent called neither the two RNs nor Dr. Overbeek's on-call answering service to report H.B.'s change in condition or to discuss or clarify the order for Mefix tape.

21. Respondent made an independent nursing decision to contravene Dr. Overbeek's written order by substituting Coban for the Mefix tape. This decision was outside of Respondent's authorized scope of practice.

22. At approximately 8:15 a.m. on April 7, 2008, the Respondent informed her supervisors Lecia Bowman, RN, and Mishalene Nash, RN, of HB's condition, the new ulcerations on her foot, and her use of Coban instead of the Mefix tape.

23. With the Respondent's involvement, Dr. Overbeek's office was then called and this information was relayed. When Dr. Overbeek's office was called, Ms. Sloan and HB were already there meeting with Dr. Overbeek.

24. Based on the phone call from Encompass and information provided by Ms. Sloan, Dr. Overbeek was made aware of the events of the weekend including the Respondent's substitution of Coban for Mefix tape.

25. Dr. Overbeek testified that when compared to his last visit with the patient on April 4, 2008, he noted two new ulcers and a slight enlarging of the original ulcer when he saw HB again on April 7, 2008.

26. Dr. Overbeek was uncertain about the conditions or factors that caused HB's wound to deteriorate.

27. Eddie Davis, DPM, Respondent's expert frequently uses Coban as a secondary dressing in his practice for patients with identical medical presentations as HB. The amount of compression applied with Coban is selectable by the nurse and a low level of compression would be highly unlikely to cause HB's wounds to worsen.

28. The Respondent's substitution of Coban for Mefix tape did not cause HB's wound to deteriorate.

29. The Respondent was terminated from Encompass on April 7, 2008, with instructions to finish and turn in her nursing notes regarding the visit with HB.

30. On April 9, 2008, the Respondent turned in her nursing note to Encompass. The note was accurate and complete except for the Respondent's accidental and unintentional omission that she had used Coban.

31. The Respondent has no prior disciplinary history with the Texas Board of Nursing. ✓

32. Staff of the Petitioner, Texas Board of Nursing, filed Formal Charges against the Respondent's nursing license on August 31, 2010.

33. On March 7, 2011, Board Staff mailed a copy of its Notice of Hearing to the Respondent by certified mail, return receipt requested.

34. On May 20, 2011, Staff of the Petitioner filed Second Amended Formal Charges and a Second Notice of Hearing and mailed the same to the Respondent, care of her attorney, Dan Lype, by certified mail, return receipt requested.

35. On August 22, 2011, ALJ Stephen J. Pacey convened the hearing on the merits at the Austin office of the State Office of Administrative Hearings (SOAH). Counsel for Staff was Jena Abel, and counsel for Respondent was Dan Lype. The hearing adjourned August 23, 2011, and after allowing time for transcription and briefing, the record closed October 17, 2011.

IV. CONCLUSIONS OF LAW

1. The Texas Board of Nurse Examiners (Board) has jurisdiction over the discipline of licensed nurses in Texas. TEX. OCC. CODE ANN. ch. 301.

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 ANN. 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, the Respondent's care to HB including the decision to wait until the following morning to contact HB's treating podiatrist regarding her wound status and the use of Coban did not violate § 301.452(b)(10) & (13) of the Act or 22 TEX. ADMIN. CODE (TAC) § 217.11(1)(P) or § 217.12(1)(A), (B), (C) & (4), but did violate 22 TAC § 217.11(1)(N).

5. Based on the Findings of Fact, the Respondent's accidental omission of her use of Coban from her nursing note did not violate § 301.452(b)(10) & (13) or 22 TAC § 217.11(1)(D) or § 217.12(1)(A), (B), (C) & (4) & (6)(A) & (H).

6. The Respondent did not fail to timely respond to, schedule, and/or perform a skilled nursing visit to Patient HB.

7. The Respondent's deviation from the podiatrist's wound care orders by substituting Coban for Mefix tape did not cause Patient HB's wound to worsen.

8. By substituting Coban tape for the medically ordered Mefix tape without first contacting the treating physician, Respondent violated 22 TAC § 217.11(1)(N).

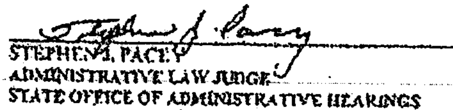
9. Based on Findings of Fact and Conclusions of Law, Respondent did not violate any statutory provision.

10. Administrative costs of this proceeding should be imposed on Respondent in the amounts noted on the affidavit, but in no event shall Respondent be required to pay more than one half the cost of the transcript.

11. Based on the above Findings of Fact and Conclusions of Law, Respondent violated the Board rule22 TAC § 217.11(1)(N).

12. Based on the above Findings of Fact and Conclusions of Law, and based upon the factors referenced in TEX. OCC. CODE ANN. §. 301.401(2), this violation should be considered a minor incident, and does not warrant further disciplinary action. .

SIGNED DECEMBER 16, 2011.



STEPHEN J. PACEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

SOAH DOCKET NUMBER 507-11-3652

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER 177089	§	OF
ISSUED TO	§	
AMANDA ANN ELLIOTT	§	ADMINISTRATIVE HEARINGS

STAFF'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

COMES NOW, Staff of the Texas Board of Nursing, and files exceptions to the Proposal for Decision issued in this matter on December 16, 2011, and would state as follows:

Finding of Fact Number 13

Staff excepts to Finding of Fact Number 13. The credible evidence in the record does not support this finding. State's Exhibit Number 38 shows that no phone call was initiated from Respondent's phone to Ms. Sloan on April 5, 2008. Further, Ms. Sloan testified that she did not receive a message or a phone call from the Respondent on April 5, 2008. Ms. Sloan had four contact numbers on file with Encompass. However, the Respondent did not leave a message on any of these numbers. Further, when cross-examined, the Respondent admitted that she had no evidence showing that she attempted to contact Ms. Sloan on April 5, 2008. Respondent's testimony is not credible. If she had actually attempted to contact Ms. Sloan, it seems reasonable to expect that she would have left a message on one of Ms. Sloan's contact numbers. However, this was not the case. See pages 231-232 and 652-654 of transcript. Staff respectfully requests that Finding of Fact 13 be removed from the PFD.

Finding of Fact Number 26

Staff excepts to Finding of Fact Number 26 because the record does not support this finding as written. Dr. Overbeek testified that several factors could have caused the harm to H.B.'s wound, including the use of Coban by the Respondent. Although Dr. Overbeek could not state with 100% certainty that the use of Coban by the Respondent *did* cause H.B.'s wound to deteriorate, Dr. Overbeek was adamant that the use of Coban *could* cause harm to an ischemic wound like H.B.'s wound and that he would never order a compressive dressing, such as Coban, to be used on such a wound for this reason. As H.B.'s treating podiatrist, Dr. Overbeek's opinion should be given significant weight. See pages 166-171 and 176 -178 of transcript. Staff respectfully requests that Finding of Fact Number 26 be reworded to state: "Although Dr. Overbeek could not be certain about the conditions or factors that caused H.B.'s wound to deteriorate, Dr. Overbeek was firm that the use of a compressive dressing like Coban on H.B.'s wound could cause harm to the wound and that he did not order the use of Coban for this reason."

Finding of Fact Number 27

Staff excepts to Finding of Fact Number 27 because it is not supported by the credible evidence in the record. Although Dr. Davis testified that he uses Coban as a secondary dressing in his practice, the evidence in the record does not support a finding that the amount of compression of Coban may be selectable by the nurse and that a low level of compression would be highly unlikely to cause H.B.'s wounds to worsen. Dr. Overbeek was H.B.'s treating podiatrist. Dr. Davis never examined H.B. On cross-examination, Dr. Davis admitted that wound treatment is an individualized process and that a treating podiatrist has to take into account what the podiatrist is seeing and how the patient is responding to the treatment. The medical records admitted into evidence from Dr. Overbeek's office show that Dr. Overbeek never ordered the use of Coban for H.B.'s wound dressing (which is consistent with Finding of Fact Number 19) because of its compressive nature. Further, Dr. Overbeek specifically stated that Coban could not be used as a low level compressive dressing or the dressing would not stay in place. He further testified that loosely wrapping Coban around a wound would not undo the compressive nature of the dressing. Further, neither Dr. Overbeek nor Dr. Davis personally observed the dressing applied by the Respondent. Therefore, Dr. Davis' testimony is speculative at best as to how the Respondent applied the dressing. Further, Dr. Davis' opinion that Coban could be used in a non-compressive manner is only speculative. No evidence was presented by Dr. Davis to corroborate his opinion. The evidence may support a finding that Dr. Davis uses Coban as a secondary dressing in his practice, but such finding is irrelevant to the issue in this matter. This matter hinges on what Dr. Overbeek's medical judgment is and why he wrote the orders the way he did. Dr. Overbeek was unequivocal in his statement that Coban would be problematic on an ischemic wound in all situations and could cause harm to an ischemic wound because of its very nature. Dr. Overbeek's testimony should be given its appropriate weight. See pages170-171 and 350-354 of transcript. As such, Staff respectfully requests that Finding of Fact Number 27 be eliminated from the PFD.

Finding of Fact Number 28

Staff excepts to Finding of Fact Number 28 as written. The evidence in the record supports a finding that the use of Coban *could* cause harm to H.B.'s wound. Dr. Overbeek repeatedly testified that a compressive dressing was contraindicated in treating an ischemic wound, such as H.B.'s wound. Further, Dr. Overbeek testified that Coban is a compressive dressing. Further, on cross-examination, Dr. Davis admitted that Coban could cause harm if it was applied incorrectly. However, Dr. Davis never personally saw how the Respondent applied the Coban to the wound. Thus, he has no knowledge if she applied the Coban correctly or incorrectly to H.B.'s wound. The credible evidence in the record establishes that the use of Coban *could* cause harm to H.B.'s wound. See pages 170-171; 176-178; 207-211; and 216-217 of transcript. Staff respectfully requests that Finding of Fact Number 28 be reworded to state, "Although the evidence does not establish that the Respondent's substitution of Coban for Mefix tape caused H.B.'s wound to deteriorate, the evidence in the record supports a finding that Respondent's substitution of Coban for Mefix tape could have caused H.B.'s wound to deteriorate".

Conclusion of Law Number 4

Staff excepts to Conclusion of Law Number 4. The Occupations Code §301.452(b)(13) provides that a licensee is subject to disciplinary action if the licensee fails to conform to the minimum standard of nursing practice that, *in the Board's opinion*, exposes a patient unnecessarily to a risk of harm. Pursuant to this statutory section, the Board enumerated specific standards of minimum nursing practice that all nurses must conform to in Board Rule 217.11. Thus, it is an error of law to state that the Respondent violated the Board's rule that specifically enumerates the minimum standards of nursing practice (§217.11(1)(N) that a nurse must meet, but not also find that she violated §301.452(b)(13), which requires compliance with the minimum standards of nursing practice set forth by the Board. As such, Staff respectfully requests that Conclusion of Law Number 4 be reworded to state: "Based on Findings of Fact, the Respondent's care to H.B., including the decision to wait until the following morning to contact H.B.'s treating podiatrist regarding her wound status and the use of Coban, did not violate §301.452(b)(10) of the Act or 22 Tex. Admin. Code §217.11(1)(P) or §217.12(1)(A), (B), (C), & (4) but did violate §301.452(b)(13) and 22 Tex. Admin. Code §217.11(1)(N).

Conclusion of Law Number 5

Staff excepts to Conclusion of Law Number 5. Findings of Fact Numbers 19 - 21 specifically state that the Respondent failed to report H.B.'s change in condition to Dr. Overbeek and her supervising RNs. Further, as summarized in Finding of Fact Number 30, the Respondent failed to completely and accurately document the use of Coban in her nursing note. The Occupations Code §301.452(b)(13) provides that a licensee is subject to disciplinary action if the licensee fails to conform to the minimum standard of nursing practice that, *in the Board's opinion*, exposes a patient unnecessarily to a risk of harm. Pursuant to this statutory section, the Board enumerated specific standards of minimum nursing practice that all nurses must meet in Board Rule 217.11. Specifically, §217.11(1)(D) requires a nurse to accurately and completely report and document the client's status, including signs and symptoms; nursing care rendered; and administration of medications and treatments. Clearly, the Respondent failed to meet this standard. Thus, it is an error of law to state that the Respondent did not violate §301.452(b)(13), which requires compliance with the minimum standards of nursing practice, or the Board's rule (§217.11(1)(D)) that specifically addresses the minimum standards of nursing practice at issue in Findings of Fact 19-21 and 30. As such, Staff respectfully requests that Conclusion of Law Number 5 be reworded to state: "Based on the Findings of Fact, the Respondent's accidental omission of her use of Coban from her nursing note did not violate §301.452(b)(10) or 22 Tex. Admin. Code §217.12(1)(A), (B), (C), (4), (6)(A) & (H), but did violate §301.452(b)(13) and 22 Tex. Admin. Code §217.11 (1)(D).

Conclusion of Law Number 7

Staff excepts to Conclusion of Law Number 7 because the record does not support this finding as written. Dr. Overbeek testified that several factors could have caused the harm to patient H.B.'s wound, including the use of Coban by the Respondent. Although

Dr. Overbeek could not state with 100% certainty that the use of Coban by the Respondent caused H.B.'s wound to deteriorate, Dr. Overbeek was adamant that the use of Coban *could* cause harm to an ischemic wound like H.B.'s wound and that he would never order a compressive dressing, such as Coban, to be used on such a wound. Further, Dr. Overbeek did not testify that the use of Coban did not cause the harm to H.B.'s wound.. Rather, it was stated that the use of Coban, among other factors, could have caused the actual harm to H.B.'s wound, and that the use of Coban could, in general, cause harm to an ischemic wound. See pages 166-171 and 176 -178 of transcript. Staff respectfully requests that Conclusion of Law Number 7 be reworded to state: "The Respondent's deviation from the podiatrist's wound care orders by substituting Coban for Mefix tape could have caused Patient H.B.'s wound to worsen."

Conclusion of Law Number 9

Staff excepts to Conclusion of Law Number 9. Based upon the above discussions regarding Conclusions of Law Numbers 4 and 5, the evidence clearly establishes that the Respondent violated the statutory provisions of §301.452(b)(13). As such, Staff respectfully requests that Conclusion of Law Number 9 be removed from the PFD.

Conclusion of Law Number 11

Staff excepts to Conclusion of Law Number 11. Based upon the above discussions regarding Conclusion of Law Number 5, the evidence clearly establishes that the Respondent violated Board Rule 217.11(1)(D) in addition to 217.11(1)(N). As such, Staff respectfully requests that Conclusion of Law Number 11 be reworded to state as follows: "Based on the above Findings of Fact and Conclusions of Law, Respondent violated Board Rule 22 Tex. Admin. Code 217.11(1)(D) & (1)(N)".

Conclusion of Law Number 12

Staff excepts to Conclusion of Law Number 12 because, as a matter of law, a recommended sanction is not a proper "conclusion of law". *See 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); *Fay-Ray Corp. vs. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App. - Austin 1998, no pet.). Staff respectfully requests that Conclusion of Law Number 12 be removed from the PFD.

Recommended Sanction

Staff excepts to the ALJ's Recommended Sanction. Considering Respondent's conduct a "minor incident" incorrectly applies the Board's adopted rules and is an error of law. Board Rule 217.16(c) enumerates the criteria that must be considered when

determining if a violation is a minor incident. Pursuant to §217.16(c), if a nurse's conduct indicates _any_ one of the following, the incident cannot be considered a minor incident:

a. the nurse ignored a substantial risk that exposed a patient or other person to significant physical, emotional, or financial harm, or the *potential for such harm*;

b. the nurse lacked a conscientious approach to or accountability for his/her practice;

c. the nurse lacked the knowledge and competencies to make appropriate clinical judgment and such knowledge and competencies cannot be easily remediated; _or_

d. the nurse has engaged in a pattern of multiple minor incidents that demonstrate the nurse's continued practice would pose a risk of harm to patients or others.

Further, the definition of "minor incident" excludes any conduct by a nurse that poses a risk of harm to a patient or another person.

The record conclusively shows that the Respondent's conduct posed a potential risk of harm to H.B.; that she did not take responsibility for her conduct; and that she lacked the knowledge to make appropriate clinical judgments. As such, as a matter of law, the Respondent's conduct cannot be considered a "minor incident".

The Respondent did not take any responsibility for her conduct, even throughout the hearing. Only upon cross-examination, after hearing a full day of testimony from multiple nurses explaining how the Respondent's conduct violated the Nursing Practice Act and Board rules, did the Respondent admit that she had violated the Nursing Practice Act. The Respondent never displayed a conscientious approach to or accountability for her conduct. Further, even though she admitted on the stand that she failed to follow the Board's guidelines and rules regarding the minimum standards of nursing practice, the Respondent couldn't articulate exactly where she erred in her practice. Clearly, the Respondent lacked an understanding of her scope of practice and as such, was unable to make appropriate clinical judgments in her practice. Further, because she refuses to take responsibility for her conduct, her practice cannot be easily remediated. A nurse who does not understand the limits of her scope of practice is at risk to repeat the same mistakes again. This is of primary concern to Board Staff. Nurses are not authorized to make independent medical decisions or contravene or change a nursing plan of care without collaborating with a physician. If a nurse does so, the nurse is operating outside her scope of practice and places her patient in harm's way. Thankfully, in this case, the Respondent's conduct did not create an emergent situation for patient H.B. However, the errors in her judgment and the lack of insight into her behavior could place future patients at a risk of serious harm. The Respondent's conduct is not a "minor incident" as defined by the NPA or Board rules. To hold otherwise misapplies the Board's adopted rules and written policies, which the

Board is entitled to rely upon. Further, such error justifies a modification of the PFD under the Government Code §2001.058(e).

Further, while it may be appropriate for the ALJ to recommend a sanction, it is ultimately up to the Board to determine what the appropriate sanction should be. The Board is the final decision maker concerning sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. The choice of penalty is vested in the agency, not in the courts. Further, an agency has broad discretion in determining which sanction best serves the statutory policies committed to the agency's oversight. The propriety of a particular disciplinary measure is a matter of internal administration with which the courts should not interfere. *See 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); *Fay-Ray Corp. vs. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App. - Austin 1998, no pet.).

The Board has adopted a disciplinary matrix, in rule, to address the appropriate sanction in its disciplinary cases. Staff introduced extensive evidence to support its request for the sanction of "Warning with Stipulations". Staff's expert testified at length regarding the factors that should be considered when utilizing the matrix to determine the appropriate sanction in this matter. Staff's expert also opined on the necessity of Board monitoring and the specific stipulations that would be necessary to ensure the safety of Respondent's continued practice. Further, Staff provided a previous administrative decision in which a similar issue was considered by SOAH and finally decided by the Board. Staff has proved that the Respondent violated the NPA and Board rules, as evidenced in part by Findings of Fact Numbers 19-21 and 30. Staff has further supported its requested sanction with credible evidence. As such, Staff respectfully requests that the ALJ re-consider his recommendation in light of the evidence in the record related to the appropriate sanction in this matter and recommend that the Respondent receive a Warning with Stipulations for her violations of the Nursing Practice Act and Board rules. See pages 479 - 524 of transcript.

Respectfully submitted,

TEXAS BOARD OF NURSING

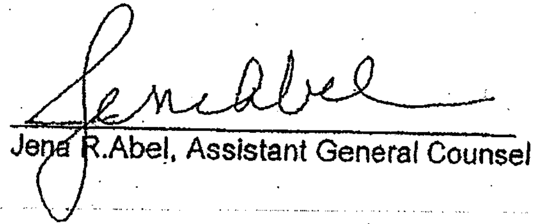
Jena Abel, Assistant General Counsel
State Bar No. 24036103
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6822
F: (512) 305-8101 or (512)305-7401

CERTIFICATE OF SERVICE

I hereby certify that a true copy of *Staff's Exceptions* was sent on this, the 4th day of January, 2012, to:

Amanda Ann Elliott
c/o Dan Lype, Attorney
1602 East 7th St.
Austin, TX 78702

Facsimile (512) 482-0164



Jena R.Abel, Assistant General Counsel

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 507-11-3652

IN THE MATTER OF THE PERMANENT CERTIFICATE	BEFORE THE
NUMBER 177089	
AMANDA ANN ELLIOTT *Respondent*	TEXAS BOARD OF NURSING

RESPONDENT'S EXCEPTIONS TO PROPOSAL FOR DECISION

TO THE HONORABLE ADMINSTRATIVE LAW JUDGE:

COMES NOW, AMANDA ANN ELLIOTT, Respondent, and files the following Exceptions to the Proposal for Decision previously issued in the above referenced cause. The Exceptions concern only the two following instances where the incorrect name was used, and are only for the purpose of clarification for the record:

I.

EXCEPTION TO DECISION AND ANALYSIS A. 4.

The Respondent excepts to Section A. 4. of the Decision and Analysis section of the Proposal for Decision (PFD) which states:

> "She called Ms. Sloan twice, once in the morning to tell *Ms. Stone* that she was scheduling a nurse to visit..."

The Respondent respectfully suggests that the Administrative Law Judge meant to reference Ms. Sloan in that sentence, rather than Ms. Stone.

II.

EXCEPTION TO FINDINGS OF FACT 12

The Respondent excepts to Findings of Fact 12 of the Proposal for Decision (PFD) which states:

> "The statements in the investigative reports attributable to *Ms. Parham* lack credibility because Ms. Parmer testified that she had no memory of that weekend and could not corroborate her statements."

The Respondent respectfully suggests that the Administrative Law Judge meant to reference Ms. Parmer in that sentence, rather than Ms. Parham.

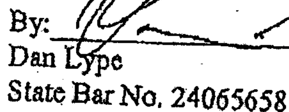
III.

PRAYER

WHEREFORE PREMISES CONSIDERED, the Respondent respectfully prays that the Honorable Administrative Law Judge issue a revised Proposal for Decision consistent with the above exceptions.

Respectfully submitted,

LAW OFFICE OF LOUIS LEICHTER
1602 East 7th Street
Austin, Texas 78702
Tel. (512) 495-9995
Fax (512) 482-0164



By:
Dan Lype
State Bar No. 24065658

ATTORNEY FOR RESPONDENT
Amanda Ann Elliott

CERTIFICATE OF SERVICE

This is to certify that a true and correct copy of the foregoing instrument (Respondent's Exceptions to Proposal for Decision) has been forwarded to the following individuals on January Jan 4, 2012:

Jena Abel –Assistant General Counsel
Texas Board of Nursing
333 Guadalupe Street
Austin, TX 78701

VIA CERTIFIED MAIL/ FACSIMILE 512-305-8101

Docket Clerk
State Office of Administrative Hearing
William P. Clements Building
300 W. 15th, Suite 504
Austin, TX 78701-1649

VIA CERTIFIED MAIL/ VIA FACSIMILE 512-322-2061

1602 East 7th Street
Austin, Texas 78702
Tel. (512) 495-9995
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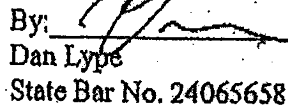
By: 
Dan Lype
State Bar No. 24065658

ATTORNEY FOR RESPONDENT
Amanda Ann Elliott

SOAH DOCKET NO. 507-11-3652

IN THE MATTER OF PERMANENT CERTIFICATE	§	BEFORE THE
	§	
	§	STATE OFFICE OF
NUMBER 177089 ISSUED TO	§	
	§	
AMANDA ANN ELLIOTT	§	ADMINISTRATIVE HEARINGS

RESPONDENT'S REPLY TO STAFF'S EXCEPTIONS TO PFD

COMES NOW, Amanda Ann Elliott, LVN, (Respondent) and hereby files her reply to Staff's Exceptions to the ALJ's Proposal for Decision and in support thereof, would submit the following:

I.

REPLY TO STAFF'S EXCEPTIONS

The Respondent respectfully submits that Board's Staff's exceptions be denied. The Respondent believes that the ALJ's Proposal for Decision correctly reflects the evidence and testimony in regards to the issues raised by Board Staff in their exceptions. For ease of organization, the Respondent will reply to Staff's exceptions in the same order they are raised in their submission.

a) Finding of Fact No. 13:

Board Staff are requesting that Finding of Fact No. 13 be removed from the PFD. Finding of Fact No. 13 memorializes the Respondent's unsuccessful attempt to contact Ms. Sloan on April 5, 2008, to let her know her mother was scheduled for a home health visit the following day. As testified by the Respondent at hearing, Ms. Elliott was unable to reach Ms. Sloan. Hrg. Transcr. 653:6-7. She also testified that she did not use her cell phone to contact Ms. Sloan on Saturday. Hrg. Transcr. 653:10-11.

Board Staff contend Ms. Elliott's testimony was not credible because she would be expected to leave a voice mail message with Ms. Sloan. The Respondent submits that the lack of a voice mail message does not render her testimony non-credible. First, there is no evidence of a requirement at Encompass Home Health that a nurse leave a voice mail message when contacting a patient family member. Additionally, leaving a voice mail message on a phone number and with a person the Respondent had never contacted before could raise potential privacy and HIPPA concerns regarding HB. Third, given the passage of three years it is uncertain which one of Ms. Sloan's phone numbers was called by the Respondent and whether this phone line even had a messaging option.

Regardless, as recognized by the Court, Ms. Sloan was not a credible witness. She was clearly angry at the perceived ill treatment of her mother by Encompass and Ms. Elliott and this colored her testimony against the Respondent. Moreover, even laying aside her bias against Ms. Elliott, it is not unreasonable to expect Ms. Sloan not to remember an unsuccessful phone call from three years prior, particularly when no voice message was left by the Respondent. In contrast Ms Elliott was a credible witness. For example, Ms. Elliott acknowledged not having talked to the on-call podiatrist or leaving him a message and also admitted that it was wrong for her not to have spoken with the podiatrist prior to applying the Coban.

The Respondent submits Finding of Fact No. 13 is supported by the credible evidence and should stand.

b) **Findings of Fact No. 26:**

Finding of Fact No. 26 states:

> Dr. Overbeek was uncertain about the conditions or factors that caused HB's wound to deteriorate.

PFD at pg. 19. The Respondent believes this Finding of Fact accurately reflects the evidence and testimony and should not be modified as proposed by Board Staff.

As recognized in the ALJ's PFD, Dr. Overbeek's statements on the issue of harm were extremely speculative, in conflict with the observations of the only three witness to see HB's wound over the weekend, and based on inaccurate assumptions as to how the Coban had been wrapped and affixed by the Respondent. First, the testimony of Ms. Calhoun, Ms. Sloan, and the Respondent, all agreed that the new ulceration identified by Dr. Overbeek when he saw HB on his Monday, April 7, 2009 assessment was already present when the Respondent first saw the patient on Sunday. Hrg. Transcr. 276:18-23; 237:11-19; 611:11-17. This is also confirmed by the wound photographs taken by the Respondent on Sunday. Respondent's Exhibit No. 11. In contrast, Dr. Overbeek had no opportunity to view HB's foot over the course of the weekend.

Additionally, Dr. Overbeek's opinion was based on his inaccurate belief that the Respondent had wrapped a single piece of Coban around HB's first and second toes thus compressing them together. Hrg. Transcr. 189-190-7-18. As argued in the Respondent's Closing Brief, it is understandable how Dr. Overbeek would believe this could have caused damage to HB's wound as the wrapping of the Coban in this manner would be expected to press the inner aspects of the first and second toes together. This would be adverse to HB's wound as it would go directly against the goal of off-loading the two toes. By itself, this renders any opinion of Dr. Overbeek as to potential harm caused by the Respondent's use of Coban not probative or credible.

Finally, even laying aside this fatal flaw in his testimony, Dr. Overbeek readily acknowledged Coban was only one of several possible etiologies. Hrg. Transcr. 176-

177:20-4. These included the incorrect application of the wound care order by Celeste Ralda on April 4, 2008, the removal of the Fibracol and cast roll by someone prior to the Respondent's visit on Sunday, or the imbedding of the Mefix tape into the primary ulceration with the inappropriate placement of a piece of cast roll directly on top. Hrg. Transcr. 181-182:22-6; 184-186:25-24.

The current Finding of Fact No. 26 accurately reflects the uncertainty of his testimony regarding the conditions or factors which caused the change in condition of HB's wound. More to the point, the modified finding advocated by Staff (that a compressive dressing like Coban could cause harm to HB) was not borne out through his testimony or other evidence. It bears stressing that even with his inaccurate assumption that the Coban had been wrapped around both the first and second toes, Dr. Overbeek still openly acknowledged he could not be certain that the Coban had caused any harm to HB. The Finding of Fact should remain as written.

If the ALJ was to change Finding of Fact No. 26 as suggested by Board Staff, the Respondent believes that the Board will likely use this highly speculative finding as a basis to flip the ALJ's decision on this portion of Formal Charge II and sanction the Respondent. Staff clearly holds a highly elastic interpretation of Tex. Occ. Code §301.452(b)(13) and what must be proven in order to find a violation under this statute. Staff appears to believe that the Respondent has violated this statute if her use of Coban could have caused harm to HB, even if such potential harm is only in a theoretical or counterfactual sense. For this reason, the Respondent strongly urges the Court to leave Finding of Fact No. 26 as written.

If the Court is inclined to alter Finding of Fact No. 26 as suggested by Board

Staff, the Respondent respectfully submits the following language as better reflecting the evidence and testimony:

> Although Dr. Overbeek testified he could not be certain about the conditions or factors that caused H.B.'s wound to deteriorate, Dr. Overbeek was firm that the use of a compressive dressing like Coban on H.B.'s wound could cause harm to the wound. Dr. Overbeek's testimony that the Respondent's use of Coban on HB could have caused harm to the patient's wound was neither credible nor probative given his incorrect assumption as to how the Coban had been applied by the Respondent, the fact that he had no personal knowledge as to how HB's wound had progressed over the weekend, and the acknowledged highly speculative nature of his opinion as to what had caused HB's wound to deteriorate.

c) **Finding of Fact No. 27:**

Finding of Fact No. 27 states:

> Eddie Davis, DPM, Respondent's expert frequently uses Coban as a secondary dressing in his practice for patients with identical medical presentations as HB. The amount of compression applied with Coban is selectable by the nurse and a low level of compression would be highly unlikely to cause HB's wounds to worsen.

PFD at pg. 19. In their exceptions Staff advocates for the complete elimination of Finding of Fact No. 17.

The first sentence of Finding of Fact No. 27 is clearly factually correct and reflective of Dr. Davis's testimony which was credible and probative on the uses of Coban, whether it would be medically appropriate to use in HB's case, and whether the Respondent's use of Coban could have caused harm to HB. The second sentence of this finding reflects both Dr. Davis' testimony and that of the Respondent. Both agreed that the amount of compression applied with Coban is selectable by the user and that a low level of compression would be highly unlikely to be deleterious to HB. Hrg. Transcr. 320:6-19; 356:7-23; 626:4-16; 318-320:25-18; 325:13-21; 328:3-20; 357:4-24; 399-400:12-1.

Dr. Davis has been a practicing Podiatrist since 1983 and is a Fellow of both the American Professional Wound Care Association and American College of Foot and Ankle Surgeons. Respondent's Exhibit No. 13. Per his testimony, he regularly uses Coban in his practice and this includes patients such as HB who present with diabetes, poor circulation, and ischemic ulcerations. Hrg. Transcr. 317-318:17-9. He testified that the use of Coban on HB was safe and unlikely to cause any harm as long as it was not applied with excessive compression. 318-320:25-18; 325:13-21; 328:3-20; 357:4-24; 399-400:12-1.

Finding of Fact No. 27 accurately reflects the credible evidence and testimony and should remain as written.

d) Finding of Fact No. 28:

Finding of Fact No. 28 states:

> The Respondent's substitution of Coban for Mefix tape did not cause HB's wound to deteriorate.

PFD at 19. Staff are asking the ALJ to change this Finding to state that the Respondent's use of Coban could have caused HB's wounds to deteriorate.

Again, Staff's exception on this issue is counterfactual and does not reflect the credible evidence and testimony. Staff's exception is again predicated on Dr. Overbeek's testimony that the Respondent's use of Coban could have caused to HB. As argued above and in her Closing Brief, Dr. Overbeek's opinion was highly speculative, founded on an incorrect belief on how the Coban had been applied by the Respondent, and in conflict with the first hand observations of Ms. Elliot, Ms. Calhoun, and Ms. Sloan. In contrast, the credible testimony of the Respondent and Dr. Davis, as corroborated by the parallel evidence showing the Respondent's use of Coban actually arrested any further

deterioration in HB's wound, established that the Coban did not cause harm to HB. This is correctly represented in Finding of Fact No. 28.

This exception also indicates Staff intends to sanction the Respondent based on their belief that even a theoretical and counterfactual existence of a risk of harm constitutes a violation of the Act. As the credible evidence and testimony did not establish the Respondent's use of Coban carried such a risk, the Respondent strongly urges the Court to leave Finding of Fact No. 28 intact.

e) **Conclusion of Law No. 4:**

Board Staff argue it is an error of law to state that the Respondent violated §217.11(1)(N) of the Board's rules, but did not violate Tex. Occ. Code §301.452(b)(13). The Respondent contends that this is incorrect.

Board Staff correctly state that a violation of Tex. Occ. Code §301.452(b)(13) requires both a failure to adhere to minimum standards of nursing practice and that such a failure expose a patient or other person to an unnecessary risk of harm. Staff's Exceptions at 3. Conclusion of Law No. 4 finds that the Respondent has violated §217.11(1)(N) of the Board's rules by failing to clarify with the on-call podiatrist the potentially non-efficacious wound care order for HB. PFD at 20. The PFD also found, correctly, that the decision of Ms. Elliott to use Coban on patient HB and the application of the same did not, and would be highly unlikely, to cause harm. Findings of Fact Nos. 27-28. This absence of harm or a risk of harm to HB precludes any violation of Tex. Occ. Code §301.452(b)(13) which requires an unnecessary risk of harm.

It is also incorrect to state a violation of 22 TAC §217.11(1)(N) establishes a violation of Tex. Occ. Code §301.452(b)(13) as a matter of law. Section 301.452(b)

contains another section, not pled by the Petitioner, covering the situation contemplated by Board Staff: where a nurse has violated 22 TAC §217.11(1)(N) but such actions did not create an unnecessary risk of harm. Tex. Occ. Code §301.452(b)(1) permits the Board to discipline a nurse for:

> a violation of this chapter, a rule or regulation not inconsistent with this chapter, or an order issued under this chapter;

Id. This section permits the Board to discipline the Respondent for a violation of a Board rule without also needing to show an unnecessary risk of harm attributable to the rule violation as is required under Tex. Occ. Code §301.452(b)(13).

The Respondent submits that Conclusion of Law No. 4 should stand as written.

f) Conclusion of Law No. 5:

Board Staff are asking that the Court modify Conclusion of Law No. 5 to state that the Respondent's accidental and unintentional omission in her note that she had used Coban is a violation of Tex. Occ. Code §301.452(b)(13) and 22 TAC §217.11(1)(D). The Respondent believes that this Conclusion of Law should not be modified.

In Formal Charge III, the Petitioner pled that the Respondent "falsely documented that she dressed the wound of Patient HB the same as it had been, instead of accurately documenting that she used Coban." Petitioner's Second Amended Formal Charges. The evidence and testimony at trial showed that the Respondent did not intentionally leave out the word "Coban" from her note. PFD at 14. As reflected in the PFD, the Respondent's "note on its face states that Respondent observed HB's wound, finding that the Mefix had become affixed to the wound bed, she decided to dress the wound without the use of Mefix." *Id.* Ms. Eliott's note also states "Mefix tape was not fixated to the Fibracol at this time due to it tearing out the wound bed just before changing the

dressing." *Id.* at 15. As recognized in the PFD anyone reading this note would recognize that Mefix tape had not been reused and that a different secondary was holding the Fibracol in place. *Id.* at 15. Additionally, both Dr. Overbeek and other nursing staff at Encompass were made aware of the Coban by the Respondent the morning following its application. *Id* at 19.

Moreover, even excepting for the sake of argument that the Respondent's note was inaccurate or incomplete, Board Staff's own expert, Skylar Caddell, RN, acknowledged that a one-time unintentional omission of a material fact from a nursing note was not cause for public discipline by the Board. Hrg. Transcr. 542:20-25. As admitted by Mr. Caddell, every experienced nurse has made similar errors throughout their career and the same does not warrant official action by the Board. Hrg. Transcr. 541-543:24-3.

Finally, the testimony showed Encompass did not offer to allow Respondent to amend her note to include the word "Coban," and Respondent did not have the opportunity to otherwise amend the note because she was subsequently terminated, and locked out of the medical recordkeeping system. Hrg. Transcr. at 640:12-23. Respondent testified that in her current position as a quality assurance specialist for a different home health agency, it is not uncommon for nurses to be allowed to amend their notes to add things that have been inadvertently left out. *Id.* at 642:8-16. Likewise, none of the remaining Encompass nursing staff felt the need to amend or supplement the Respondent's note to more clearly reflect that Coban had been used as a substitute secondary dressing.

Accordingly, Staff failed prove a violation under either Tex. Occ. Code

§301.452(b)(13) or 22 TAC §217.11(1)(D). The Respondent respectfully submits that the Petitioner's exception on this Conclusion of Law be denied.

g) Conclusion of Law No. 7:

Conclusion of Law No. 7 reads:

> The Respondent's deviation from the podiatrist's wound care order by substituting Coban for Mefix tape did not cause Patient HB's wound to worsen.

PFD at 20. Staff's exception to this Conclusion of Law is again based on their belief in the weight to be accorded to Dr. Overbeek.

Board Staff put forth the same arguments for this exception as those raised in relation to Findings of Fact Nos. 26-28. The Respondent submits the same response raised in her Closing Brief and in Reply to Staff's exceptions to Findings of Fact Nos. 26-28. The Respondent submits this Conclusion of Law should remain as written.

h) Conclusion of Law No. 9:

Conclusion of Law No. 9 concluded the Respondent had not violated any statutory provision. PFD at 20. Pursuant to the arguments raised elsewhere in this Reply and in her Closing Brief, the Respondent contends this Conclusion of Law should remain intact.

i) Conclusion of Law No. 11:

Conclusion of Law No. 11 concluded that the Respondent had violated 22 TAC §217.11(1)(N) based on her failure to talk to the on-call podiatrist when substituting Coban for the Mefix tape ordered for HB. PFD at 21. Pursuant to the arguments raised in relation to Conclusion of Law No. 5, Board Staff advocate for the modification of this

finding. For the same reasons raised in this Reply as well as her Closing Brief, the Respondent urges that the Petitioner's exception be denied.

j) **Conclusion of Law No. 12 & Recommended Sanction:**

Finally, the Petitioner urges the deletion of Conclusion of Law No. 12 which found that the Respondent's violation of 22 TAC §217.11(1)(N) was a minor incident under Tex. Occ. Code §301.401(2) and recommended that no disciplinary action be taken against Ms. Elliott's license. Board Staff claim the Respondent's violation of 22 TAC §217.11(1)(N) is not a minor incident under the Board's rules.

As initial matter, the Petitioner claims the Respondent's conduct was not a minor violation as the definition of minor incident "excludes conduct by a nurse that poses a risk of harm to a patient or another person." Staff's Exceptions at 5. This is an incomplete reading of the Board's rule regarding minor incidents. Specifically, this rule states conduct cannot be considered to be a minor incident if the nurse:

> ignored a **substantial** risk that exposed a patient or other person to **significant physical, emotional, or financial harm, or the potential for such harm.**

22 TAC §217.16(c); (emphasis added). Thus the nurse must ignore a "substantial" risk and thereby expose a patient to actual or potential "significant physical, emotional, or financial harm." *Id.*

Staff argue, again based on Dr. Overbeek's testimony, that the Respondent's use of Coban could have caused harm to HB and therefore her conduct cannot be a minor incident. This argument is flawed as the PFD correctly finds that Dr. Overbeek's testimony on the issue of harm was not credible or probative for the numerous reasons outlined above and in earlier briefing. PFD at 11-13; Findings of Fact Nos. 26-28;

Conclusion of Law No. 7. Secondly, even if accepting *en arguendo* that the Respondent's conduct posed some risk to patient HB, there is no evidence that this was a "substantial risk" of "significant physical, emotional, or financial harm." In fact, the evidence showed the Respondent's actions stopped any further deterioration in HB's wound.

Staff also argue that the Respondent has not taken responsibility for her conduct or understood what she did wrong. This is also incorrect. Ms. Elliott freely acknowledged under cross-examination that she violated the Board's rules by not speaking with the on-call podiatrist on Sunday when she substituted Coban for Mefix tape. Hrg. Transcr. 668:1-14. This exact exchanged reads:

> Q (Ms. Abel): I don't think, Ms. Elliott, anybody is saying that you should have. I think the testimony has been that everybody recognizes that up until that point, with regard to that specific incident, you were fine. You recognized that there was some nonefficacious treatment right? But the problem is, and this what I don't think you understand, so here is my question: Do you realize that it's not enough for a nurse to choose not to follow an order, there has to be more to that duty?
> A (Ms. Elliott): Yes. I understand now that waiting until the morning to contact Dr. Overbeek was apparently not sufficient.

Id. This is a clear articulation of how the Respondent believes she violated 22 TAC §217.11(1)(N): she erred by not calling and conferring with a podiatrist on Sunday after noting the issue with Dr. Overbeek's wound care order and prior to selecting Coban as a temporary alternative. Simply because the Respondent noted various mitigating circumstances, recounted her in-the-moment reasoning, and later became teary eyed and worn down by the experience of testifying does not mean that she doesn't understand where she erred. In truth, it is hard to fathom how the Respondent will not have learned from the experience of undergoing a grueling multi-day contested case hearing and spending thousands of dollars to defend herself against all the charges brought by the

Petitioner. The mere fact that the Respondent admitted while testifying that she had violated the Board's rules shows she is someone who can acknowledge and learn from her mistakes. Finally, there is no indication that the Respondent has ever repeated such an error or committed any other violations of the Board's rules.

Contrary to Board Staff's assertions, the Respondent's conduct does qualify as a minor incident and does not require Board discipline to remediate or prevent a reoccurrence. The Respondent respectfully submits that Conclusion of Law No. 12 and the ALJ's recommended sanction be left unaltered.

II.

PRAYER FOR RELIEF

WHEREFORE PREMISES CONSIDERED, the Respondent respectfully prays that the honorable Administrative Law Judge enter an Order denying Board's Staff's Exceptions to the ALJ's Proposal for Decision.

Respectfully submitted,

LEICHTER LAW FIRM

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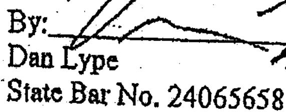
Tel (512) 495-9995
Fax (512) 482-0164



By:
Dan Lype
State Bar No. 24065658

ATTORNEY FOR RESPONDENT
AMANDA ELLIOTT

CERTIFICATE OF SERVICE

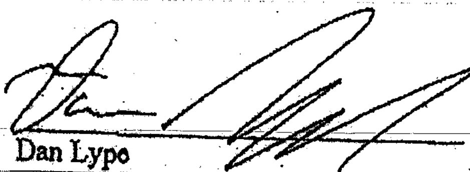
This is to certify that on January 16, 2012, a true and correct copy of the foregoing instrument (Respondent's Reply to Staff's Exceptions to PFD) was forwarded to the following individuals in the manner indicated below:

Jena Abel
Assistant General Counsel
Texas Board of Nursing
333 Guadalupe Street, Suite 3-460
Austin, TX 78701

Via Facsimile (512) 305-8101

Rommell Corro, Deputy Clerk
State Office of Administrative Hearings
300 West 15th Street, Suite 504
Austin, TX 78701-1649

Via Facsimile (512) 322-2061



Dan Lypo
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SBN 24065658

SOAH DOCKET NUMBER 507-11-3652

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER 177089	§	OF
ISSUED TO	§	
AMANDA ANN ELLIOTT	§	ADMINISTRATIVE HEARINGS

STAFF'S REPLY TO RESPONDENT'S RESPONSE TO STAFF'S EXCEPTIONS TO THE PFD

COMES NOW, Staff of the Texas Board of Nursing, and responds to Respondent's Response to Staff's Exceptions to the PFD as follows:

When construing administrative rules, "[a]n administrative agency's interpretation of its own rules is entitled to great weight and deference; it controls unless plainly erroneous or inconsistent with the agency's enabling statute." *Ackerson vs. Clarendon Nat'l Ins. Co.*, 168 S.W.3d 273, 275 (Tex.App.--Austin 2005, pet. denied).

Board Rule 217.16(c) is clear, concise, and designed to support the Board's mission of protecting the public health and safety. Further, the definition in 217.16(b) clearly states that an incident cannot be considered minor if it poses a risk of harm to a patient. Risk of harm inherently means the *potential for* harm. Actual harm need not be shown. Further, if an incident indicates any one of the four situations identified in 217.16(c), it cannot be considered a minor incident. It is an error of law to construe the Respondent's conduct as a minor incident under this rule.

Board Rule 217.11 clearly states, "Failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted". Further, Board Rule 213.33(c) requires SOAH and the Board to consider the threat to public safety, the seriousness of the violation, and evidence of actual or potential harm to patients, clients, or the public. Further, Board Rule 213.33(b), with regard to a violation of the Occupations Code §301.452(b)(13) specifically includes an analysis of risk of patient harm. To pretend that the Respondent's conduct[1] did not create a *risk* of harm to Patient H.B., regardless of whether actual harm occurred or not, is illogical and disingenuous.

Finally, it is an error of law to find that the Respondent violated the Board's rules for

[1] As summarized in the PFD.... "Respondent decided to use Coban to fixate the wound rather than Mefix. Coban had not been ordered by Dr. Overbeek. Respondent called neither the two RNs nor Dr. Overbeek's on-call answering service to report H.B.'s change in condition or to discuss or clarify the order for Mefix tape. Respondent made an independent nursing decision to contravene Dr. Overbeek's written order by substituting Coban for the Mefix tape. This decision was outside of Respondent's authorized scope of practice."

the minimum standards of nursing practice, but to find that she did not violate the statute that gives the Board the authority to prescribe the minimum standards of nursing practice. The Occupations Code §301.452(b)(13) specifically states: "...failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm." The same conduct that the ALJ found to be a violation of Board Rule 217.11 is the same conduct that also constitutes a violation of §301.452(b)(13).

Staff re-iterates its objections and exceptions stated in its filed Exceptions to the PFD.

Respectfully submitted,

TEXAS BOARD OF NURSING

Jena Abel, Assistant General Counsel
State Bar No. 24036103
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6822
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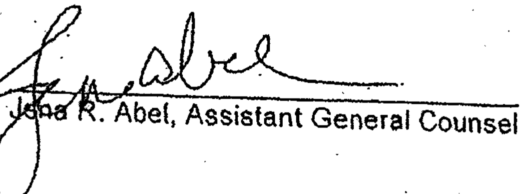
CERTIFICATE OF SERVICE

I hereby certify that a true copy of *STAFF'S REPLY TO RESPONDENT'S RESPONSE TO STAFF'S EXCEPTIONS TO THE PFD* was sent on this, the 23rd day of January, 2012, to:

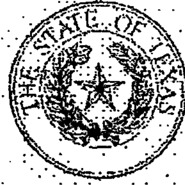
Amanda Ann Elliott
c/o Dan Lype, Attorney
1602 East 7th St.
Austin, TX 78702

Facsimile (512) 482-0164



Jena R. Abel, Assistant General Counsel

State Office of Administrative Hearings



Cathleen Parsley
Chief Administrative Law Judge

February 28, 2012

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

VIA FACSIMILE: 305-8101

RE: Docket No. 507-11-3652; In the Matter of Permanent Certificate Number 177089 Issued to Amanda Ann Elliott

Dear Ms. Thomas:

I am in receipt of Staff's exceptions, Respondent's exceptions, Respondent's response to Staff's exceptions, and Staff's sur-reply to Respondent's response. I also allowed time for Respondent to respond to Staff's sur-reply, but Respondent declined to file a response.

The Administrative Law Judge (ALJ) makes two non-substantive changes to the Proposal for Decision (PFD): 1. The word Stone was inadvertently substituted for Sloan in Section A.4 of the Analysis on page 8. The sentence is changed to read: "She called Ms. Sloan twice, once in the morning to tell Ms Sloan that she was scheduling a nurse to visit and the second at 2:05 p.m. to tell Ms. Sloan that Respondent would make the visit." 2. The word Parham was inadvertently substituted for Parmer in Finding of Fact 12. The Finding is changed to read: "The statements in the investigative reports attributable to Ms. Parmer lack credibility because Ms. Parmer testified that she had no memory of that weekend and could not corroborate her statements."

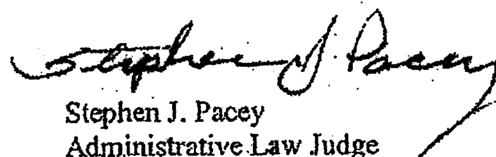
The ALJ has reviewed the exceptions and responses and concludes that Staff's exceptions do not contain anything that was not considered when the PFD was written. Consequently, no changes will be made to the PFD except for the non-substantive changes noted above. Therefore, I will not address each exception, but rather, generally address various evidentiary issues that reflect my decision, and address one or more of Staff's exceptions.

Most of Staff's exceptions (including but not limited to Findings of Fact Nos. 26, 27, 28, and Conclusions of Law Nos. 4 and 7) rest on the credibility of the testimony of Troy Overbeek, DPM. The ALJ found some of Dr. Overbeek's testimony less than forthright. In Staff's arguments supporting the exceptions, Staff paraphrases Dr. Overbeek who said that he could not state with 100% certainty that the use of Coban by the Respondent caused H.B's wound to deteriorate. This answer was in response to a question from the ALJ who noted that before the Coban was used, H.B was in pain on Saturday and in pain on Sunday. The Doctor's answer was unresponsive as to the question what caused the pain on Saturday and Sunday. The obvious conclusion was that the Coban did not cause the deterioration because the pain occurred prior to the time the Coban was applied. Dr. Overbeek's answer, at the very least, continued to insinuate that the Coban caused the deterioration.

Even though Dr. Overbeek testified that Coban could have caused the deterioration, the ALJ did not make such a finding, as Staff requested, because the great weight of the evidence indicates that his statement is incorrect. The following evidence indicates that the Coban did not deteriorate the wound: as noted above the pain occurred before the Coban was applied; when Respondent removed the Mefix tape that was stuck to the wound Ms. Calhoun, Ms. Sloan, and Respondent all testified that they observed the new ulcerations; Respondent took photographs (Exhbit11) that depicted the acerbation of the wound (the photographs were not fuzzy as Dr. Overbeek stated); Respondent testified that she applied the Coban loosely; and Eddie Davis, DPM testified that he frequently uses Coban as a secondary dressing in his practice for patients with identical medical presentations as HB. Additionally, he asserted that the amount of compression applied with Coban is selectable by the user and that a low level of compression would be highly unlikely to be deleterious to HB.

The evidence clearly indicates that the wound was aggravated before the Coban was administered.

Sincerely,



Stephen J. Pacey
Administrative Law Judge

SJP/Ls
Enclosures
CC: Jena Abel, Assistant General Counsel, TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA FACSIMILE: 305-8101
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA FACSIMILE: 305-8101
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