DOCKET NUMBER 507-14-2098

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBER 567816,	§	**OF**
ISSUED TO	§	
ROSEMARY HALL	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: ROSEMARY HALL
301 BINNEY LANE
WYLIE, TX 75098

D.A. BERGER and CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGES
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 22-23, 2015, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's exceptions to the PFD; (3) the ALJs' final letter ruling of July 10, 2015; (4) Staff's recommendation that the Board adopt the PFD with changes; and (5) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. Staff filed exceptions to the PFD on June 9, 2015. Respondent did not file a response to Staff's exceptions to the PFD or her own exceptions to the PFD. On July 10, 2015, the ALJs issued their final letter ruling, in which they declined to amend the PFD.

The Board, after review and due consideration of the PFD; Staff's exceptions to the PFD; the ALJs' final letter ruling of July 10, 2015; Staff's recommendations; and the presentation by the Respondent during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJs contained in the PFD as if fully set out and separately stated herein, except for proposed Finding of Fact 46 and Conclusion of Law 9[3], which are amended and adopted as set out herein. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Modification of PFD

The Board has authority to review and modify a PFD in accordance with the Government Code §2001.058(e). Specifically, §2001.058(e)(1) authorizes the Board to

[3] The PFD contains two conclusions of law, both numbered "9". The Board declines to adopt the second proposed conclusion of law numbered "9".

change a finding of fact or conclusion of law made by the ALJ or vacate or modify an order issued by the ALJ if the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions. Section 2001.058(e)(3) further authorizes the Board to change a finding of fact or conclusion of law to correct technical errors.

Proposed Finding of Fact 46 and Conclusion of Law 9[4]

The Board finds that the Respondent should be assessed administrative costs under the authority of the Occupations Code §301.461 in the amount of $5,360.64. The Occupations Code §301.461 provides that the Board may assess a person who is found to have violated the Nursing Practice Act (Chapter 301) the administrative costs of conducting the hearing to determine the violation. The ALJs' findings and conclusions regarding the assessment of administrative costs to be borne by the Respondent interject an analysis that is not contemplated by §301.461. As such, the Board specifically rejects the ALJs' analysis in this regard and declines to adopt proposed Finding of Fact 46 and Conclusion of Law 9 as irrelevant to the proper application of §301.461. Further, the Board does not consider any of the ALJs' discussion and analysis regarding the assessment of costs under §301.461 as precedent for any purpose. The assessment of administrative costs against the Respondent is properly authorized by statute and is supported by sufficient, uncontroverted evidence in the record[5]. As such, the Board chooses to follow the unambiguous language of §301.461 and its own administrative precedent in assessing costs against the Respondent[6].

For these reasons, and under the authority of §2001.058(e)(1), IT IS, THEREFORE ORDERED THAT FINDING OF FACT 46 is MODIFIED and ADOPTED as follows:

Finding of Fact 46

The Board incurred administrative costs in this matter in the amount of $5,360.64.

Additionally, the PFD contains two proposed Conclusions of Law 9. In addition to the reasons set out above, the Board modifies the second proposed Conclusion of Law 9 to correct this technical error.

Therefore, under the authority of §2001.058(e)(1) and (3), IT IS, THEREFORE ORDERED THAT CONCLUSION OF LAW 9[7] is MODIFIED and ADOPTED as follows:

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[4] The PFD contains two conclusions of law, both numbered "9". The Board declines to adopt the second conclusion of law numbered "9" as proposed.

[5] Staff's Ex. No. 15, cited in PFD, page 20.

[6] The Board has consistently required the reimbursement of administrative costs in the following matters, based upon recommendations from ALJs in other cases, without reference to, or use of, the factors or analysis utilized by the ALJs in this matter: See Docket Numbers 507-13-5433; 507-14-2093; 507-13-4349; 507-13-5439; 507-13-2752; and 507-13-2793. Further, the Board has modified PFDs where ALJs have suggested alternative analysis regarding the imposition of administrative costs, contrary to the provisions of §301.461. See Docket Numbers 507-13-0936 and 507-12-4027.

[7] The PFD contains two conclusions of law, both numbered "9". The Board declines to adopt the second conclusion of law numbered "9" as proposed..

Conclusion of Law 10

Respondent should be assessed administrative costs in the amount of $5,360.64. Tex. Occ. Code §301.461.

Recommendation for Sanction

The Board agrees with the ALJs that the Respondent's conduct constitutes violations of the Nursing Practice Act, for which discipline is warranted[8]. Further, the Board finds that the Respondent's conduct warrants a second tier, sanction level I sanction for her violations of the Occupations Code §301.452(b)(10) and (13)[9]. For a second tier, sanction level I sanction for a violation of §301.452(b)(10) and (13), the Board's Disciplinary Matrix authorizes either a Warning or Reprimand, with Stipulations. Although 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 or conclusions of law[10], the Board agrees with the ALJs that a Warning with Stipulations is the most appropriate sanction in this matter.

The Respondent's pattern of behavior is concerning to the Board. The Respondent's conduct involved four patients on three different dates[11]. Further, the Respondent's conduct unnecessarily posed a risk of harm to these patients[12]. Aside from not having prior discipline with the Board[13], the Respondent provided no evidence of mitigation.

Therefore, after carefully reviewing and considering the aggravating and mitigating factors in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix[14] and the Board's rules, including 22 Tex. Admin. Code §213.27 and §213.33(e), that a

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[8] See adopted Conclusions of Law 6 and 7.

[9] See pages 25 and 27 of the PFD.

[10] 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. 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. As such, 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 choice of penalty is vested in the agency, not in the courts. 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.).

[11] See Findings of Fact 15-42.

[12] See Findings of Fact 42-44 and Conclusion of Law 8.

[13] See Finding of Fact 45.

[14] 22 Tex. Admin. Code §213.33(b).

Warning with Stipulations is appropriate and warranted.

Regarding the particular stipulations that should be imposed against the Respondent's license, the Board finds that a remedial education course in critical thinking is necessary to encourage good professional judgment and critical thinking. A course in physical assessment is also warranted and is designed to remediate the Respondent's errors and prevent future violations of the Nursing Practice Act from occurring. The Board also finds that a nursing jurisprudence and ethics course is appropriate and consistent with the Board's rules[15]. Additionally, the Board finds that incident reporting is warranted for the duration of the Order. This is a minimal level of supervision and will ensure the Respondent's accountability for the duration of the Order. The Board further finds that employer notifications and quarterly employer reports are necessary to implement the other requirements of the Order. These provisions are consistent with the provisions of 22 Tex. Admin. Code §213.33(e)(3)[16].

IT IS THEREFORE ORDERED that RESPONDENT SHALL receive the sanction of **WARNING WITH STIPULATIONS** in accordance with the terms of this Order.

I. TERMS OF ORDER

A. This Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

B. This Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

C. Respondent may not work outside the State of Texas in another nurse licensure compact party state without first obtaining the written permission of the Texas Board of Nursing and the Board of Nursing in the nurse licensure compact party state where Respondent wishes to work.

II. COMPLIANCE WITH LAW

While under the terms of this Order, 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.

III. REMEDIAL EDUCATION COURSE(S)

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[15] See 22 Tex. Admin. Code §213.33(f).

[16] 22 Tex. Admin. Code §213.33(e)(3) provides that a Warning with Stipulations may include reasonable stipulations, such as the completion of remedial education courses, at least one year of supervised practice, and periodic Board review.

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A. **A Board-approved course in Texas nursing jurisprudence and ethics that 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. Home study courses and video programs will not be approved.

B. **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.

C. **A Board-approved course in physical assessment** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include physical assessment of all body systems. The clinical component SHALL include physical assessment of live patients in a clinical setting; Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.*

IV. ADMINISTRATIVE REIMBURSEMENT

RESPONDENT SHALL **pay an administrative reimbursement in the amount of $5,360.64. RESPONDENT SHALL pay this amount within 360 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.

V. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse, providing direct patient care in a licensed healthcare setting, for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) quarterly periods of employment as a nurse have elapsed. Any quarterly period without continuous employment with the same employer for all three (3) months will not count towards completion of this requirement. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

A. **Notifying Present and Future Employers**: RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Incident Reporting:** RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

D. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the nurse who supervises the RESPONDENT and these reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month quarterly period for four (4) quarters [one (1) year] of employment as a nurse.

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT may be eligible for nurse licensure compact privileges, if any.

Entered this 23rd day of October, 2015.

TEXAS BOARD OF NURSING

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

Attachment: Amended Proposal for Decision; Docket No. 507-14-2098 (May 22, 2015).

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

May 22, 2015

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

VIA INTERAGENCY

RE: **Docket No. 507-14-2098**; *Texas Board of Nursing v. Rosemary Hall, R.N.*

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains our 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,

Catherine C. Egan
Administrative Law Judge

and

D. A. BERGER
ADMINISTRATIVE LAW JUDGE

CCE:DAB:daa
Enclosures

c: John F. Legris, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA INTERAGENCY
Kathy A. Hoffman, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 2 CDs) – VIA INTERAGENCY
Rosemary Hall, 301 Binney Lane, Wylie, TX 75098 – VIA REGULAR MAIL

SOAH DOCKET NO. 507-14-2098

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
ROSEMARY HALL, RN, Respondent	§	ADMINISTRATIVE HEARINGS

TABLE OF CONTENTS

SOAH DOCKET NO. 507-14-2098

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
	§	
	§	
v.	§	**OF**
	§	
ROSEMARY HALL, RN,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) brought action against Rosemary Hall, RN (Respondent) seeking issuance of a written warning with certain stipulations for alleged violations of the Nursing Practice Act (the Act).[1] Staff met its burden of proof as to all of the allegations. Therefore, the Administrative Law Judges (ALJs) recommend that the Board issue a warning with stipulations to be determined by the Board, and further recommend that the Board assess a part of the administrative costs of this proceeding against Respondent.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no contested issues of notice or jurisdiction in this proceeding. Those matters are set out in the Findings of Fact and Conclusions of Law without further discussion here.

The hearing convened on October 6, 2014, before ALJs David A. Berger and Catherine C. Egan at the State Office of Administrative Hearings (SOAH) in Austin, Texas. Staff attorney John F. Legris represented Staff. Respondent appeared and represented herself. Although the parties had represented that the hearing only required 2 days, the parties had not concluded Staff's direct case at the close of the business day on October 7, 2014. The hearing reconvened on March 9-10, 2015, with both parties in attendance.[2] At the request of Staff, the record remained opened for Staff to submit an affidavit regarding its administrative costs and for Respondent to file objections to the affidavit. The affidavit was admitted into evidence as Staff

[1] Tex. Occ. Code ch. 301.

[2] On October 31, 2014, the ALJs entered Order No. 12 scheduling the hearing to reconvene on January 5, 2015. On January 5, 2015, the ALJs reconvened the hearing. Staff appeared, but Respondent did not. On January 15, 2015, the ALJs convened a telephonic conference during which Respondent represented that she had not received Order No. 12 and was unaware that the hearing had been reset. After a search of SOAH's electronic filing system, the ALJs found insufficient evidence to establish that Respondent received Order No. 12. Therefore, the ALJs found that fundamental fairness required that the evidence presented on January 5, 2015, be struck, and that the hearing be reset to convene on March 9-10, 2015.

Ex. 15, and in accordance with Order No. 17, the record closed on March 25, 2015. After the record closed, Respondent filed objections to Staff's affidavit that were not considered because they were untimely filed.[3]

II. BACKGROUND, DISPUTED ISSUES, AND APPLICABLE LAW

A. Background

The Board licensed Respondent as a registered nurse (RN) on March 18, 1991.[4] On April 14, 2008, Parkland Health and Hospital System (Parkland) in Dallas, Texas, hired Respondent as a triage call center nurse.[5] Parkland terminated Respondent's employment on May 31, 2011, for "unsatisfactory work performance."[6]

In 2011, Parkland's call center nurses did not treat the caller/patients or make nursing diagnoses. The call center nurses did evaluate symptoms to assess how quickly a caller/patient needed to seek medical treatment. Parkland's call center triage services provided:

> [C]omplex, clinical specialty care for patients through non-diagnostic telephone assessment using medically-approved nursing assessment guidelines, educational knowledge base and nursing experience to determine the level of urgency and timeframe for medical evaluation of patient symptoms and/or situation.[7]

After listening to the caller's/patient's medical concerns, asking open-ended questions, and utilizing the medically-approved assessment guidelines, the triage RN was to determine and document the caller's/patient's level of urgency to advise the patient on "when" and "where" to seek medical care, based on the triaged level of urgency.[8] When the call center received a call, Parkland required that the triage RN open the computer guideline applicable to the caller's/patient's most serious symptom first and then to rule out each question before

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[3] Respondent's objections were filed with SOAH on March 31, 2015.

[4] Respondent holds Certificate No. 567816.

[5] Staff Ex. 5d at 2.

[6] Staff Exs. 5d at 2 and 7 at 3.

[7] Staff Ex. 6 at 2.

[8] Staff Ex. 12 at 61.

proceeding to the next question.[9] The call center's triage procedures were designed to provide a consistent approach in determining when a caller/patient should seek medical care.[10]

B. Disputed Issues

Staff alleges that, on April 25, 28, and May 10, 2011, while working as a Parkland telephone triage nurse, Respondent failed to appropriately assess and follow the physician-approved triage guidelines when she triaged 4 callers/patients who had called into Parkland's call center. Staff contends that Respondent's conduct deprived these callers/patients of physician-approved information and may have delayed their receiving appropriate medical treatment. Specifically, Respondent received calls from:

- Patient 1, could not get out of bed because of severe hip pain;
- Patient 2, who had complaints of low blood pressure;
- Patient 3, who had complaints of breast pain and high blood pressure; and
- Patient 4, who had complaints of chest pain with hot flashes.[11]

Respondent denied that she failed to properly triage these callers/patients. She argues that Parkland terminated her employment in retaliation for questioning whether the computer triage system protected patients' rights and safety. Consequently, Respondent submits that the Board should not sanction her.

C. Applicable Law

The Board is responsible for establishing nursing practice standards and regulating the practice of professional and vocational nursing throughout the State of Texas.[12] The Board's responsibility includes investigating possible violations of the Act and, when warranted, taking

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[9] Parkland primarily used two computer-based information systems relevant to this case: (1) E-Centaurus, a community-based electronic medical record containing the physician-approved triage guidelines used by Parkland's triage call center nurses when assessing patients/callers; and (2) Epic, Parkland's internal electronic medical record system.

[10] Staff Ex. 6 at 2.

[11] 1 Tex. Admin. Code § 155.101(d) (requiring redaction of confidential personal identifiers).

[12] Tex. Occ. Code § 301.001 *et seq.*

disciplinary action against the violators.[13] Staff bore the burden of proving the charges in this case by a preponderance of the evidence.[14]

1. Law Regarding Alleged Violations

The Board may take disciplinary action against a licensee who engages in unprofessional or dishonorable conduct that is "likely to deceive, defraud, or injure a patient or the public";[15] fails to adequately care for a patient; or fails to conform to the minimum standards of acceptable nursing practices in a manner that exposes a patient unnecessarily to risk of harm.[16] Board Rule 217.12 identifies specific instances of unprofessional conduct that, regardless of actual injury or harm, are deemed likely to deceive, defraud, or injure a patient or the public. Unprofessional conduct includes, among other things, engaging in unsafe practices by "[c]arelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings," and engaging in "[c]areless or repetitive conduct that may endanger a client's life, health, or safety."[17]

Board Rule 217.11 sets out minimum standards of nursing practice that govern all nurses as well as those applicable only to RNs. The standards applicable to all nurses require all nurses to "[i]mplement measures to promote a safe environment for clients and others"; and to "[c]onsult with, utilize, and make referrals to appropriate community agencies and health care resources to provide continuity of care."[18] The Board standards applicable to RNs further require that an RN "assist in the determination of healthcare needs of clients" and utilize a systematic approach to provide individualized, goal-directed, nursing care by:

(i) performing comprehensive nursing assessments regarding the health status of the client;

(ii) making nursing diagnoses that serve as the basis for the strategy of care;

(iii) developing a plan of care based on the assessment and nursing diagnosis;

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[13] Tex. Occ. Code §§ 301.452-.453.

[14] 1 Tex. Admin. Code § 155.427.

[15] Tex. Occ. Code § 301.452(b)(10).

[16] Tex. Occ. Code § 301.452(b)(13).

[17] 22 Tex. Admin. Code § 217.12(4).

[18] 22 Tex. Admin. Code § 217.11(1)(B), (Q).

(iv) implementing nursing care; and

(v) evaluating the client's responses to nursing interventions.[19]

2. Sanctions and Assessment of Administrative Costs

When determining an appropriate penalty/sanction against a licensee, in addition to the Board's published Disciplinary Matrix,[20] the following factors must be considered:

1. evidence of actual or potential harm to patients, clients, or the public;
2. evidence of a lack of truthfulness or trustworthiness;
3. evidence of misrepresentation(s) of knowledge, education, experience, credentials, or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe;
4. evidence of practice history;
5. evidence of present fitness to practice;
6. whether the person has been subject to previous disciplinary action by the Board or any other health care licensing agency in Texas or another jurisdiction and, if so, the history of compliance with those actions;
7. the length of time the person has practiced;
8. the actual damages, physical, economic, or otherwise, resulting from the violation;
9. the deterrent effect of the penalty imposed;
10. attempts by the licensee to correct or stop the violation;
11. any mitigating or aggravating circumstances, including those specified in the Disciplinary Matrix;
12. the extent to which system dynamics in the practice setting contributed to the problem;
13. whether the person is being disciplined for multiple violations of the NPA or its derivative rules and orders;
14. the seriousness of the violation;
15. the threat to public safety;
16. evidence of good professional character as set forth and required by §213.27 of this chapter (relating to Good Professional Character);
17. participation in a continuing education course described in §216.3(f) of this title (relating to Requirements) completed not more than two years

[19] 22 Tex. Admin. Code § 217.11(1)(B), (Q), (3)(A).

[20] 22 Tex. Admin. Code § 213.33(b).

before the start of the Board's investigation, if the nurse is being investigated by the Board regarding the nurse's selection of clinical care for the treatment of tick-borne diseases; and,

18. any other matter that justice may require. The presence of mitigating factors does not constitute a requirement of dismissal of a violation of the NPA and/or Board rules.[21]

Additionally, the Act authorizes the Board to assess the administrative costs of conducting a hearing against a nurse who is found to have violated chapter 301 of the Act.[22]

III. DISCUSSION OF THE EVIDENCE

At the hearing, Staff offered 19 exhibits that were admitted into evidence.[23] Additionally, Staff called Sheila Oliver, RN;[24] Melinda Savage, RN; and Melinda G. Hester, RN, DPN, as witnesses. Respondent offered 5 exhibits that were admitted into evidence.[25] Respondent did not testify and did not call any witnesses to testify. Therefore, Respondent's positions regarding the issues discussed below are taken from her written responses to Parkland when she was terminated,[26] and her written responses to Staff's allegations.[27]

A. The Triage Center

Ms. Oliver has been employed in Parkland's call center since 1997, and was promoted to Director of Parkland's call center in February 2011. As Director, Ms. Oliver is responsible for the overall operation of the call center. She recalled that in 1997, Parkland created the call center to provide 24-hour medical triage advice to the public to comply with its Medicare/Medicaid contract. Parkland's call center only hires RNs to handle telephone triage calls, and utilizes computer software programs with physician-approved triage guidelines, called "E-Centaurus." Ms. Oliver explained that physician vendors review the computerized triage guidelines at least annually to update them based on recent medical advancements. According to Ms. Oliver, when

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[21] 22 Tex. Admin. Code § 213.33(c).

[22] Tex. Occ. Code § 301.461; *see also* 22 Tex. Admin. Code § 213.22(n)(2).

[23] Staff Exs. 1-4, 5, 5a, 5b, 5c, 5d, 5e, and 6-15.

[24] Ms. Oliver was formerly known as Sheila Cook-Dolciame.

[25] Res. Exs. 1-2, 8, 9, and 10. Res. Exs. 8 and 9 include several items.

[26] Staff Ex. 7 at 7-12.

[27] Staff Exs. 5c and 5d at 15-43.

a guideline is updated, the updated guideline overwrites the prior guideline. Consequently, it is essential that RNs open the triage guidelines each time a call is received.

Although the call center had no training manual on how to use the triage guidelines, Ms. Oliver testified that each new triage nurse received on-the-job training by being paired with an experienced call center RN until they demonstrated proficiency in using the computerized system. The call center's nurses also attended internal classes and receive emails on how to use the computerized triage guidelines. In addition, Ms. Oliver and Ms. Savage, Unit Manager and Respondent's direct supervisor, frequently reviewed the incoming triage calls to monitor whether the triage RNs are properly using the triage guidelines.

According to Ms. Oliver, the call center recorded all calls, synchronizing the oral communications with what is on the nurse's computer screen (the audio/video recording). Ms. Oliver conceded that Respondent was not required to ask callers each question on the triage guideline, but emphasized that Respondent was required to rule out certain conditions before moving on to less serious symptoms. She stressed that when the call center received a call, a call center nurse was required to open the appropriate guideline for the patient's most urgent and severe symptoms based on the nurse's clinical assessment of the patient's condition. By way of an example, Ms. Oliver testified that if a patient called the call center with symptoms of menopausal pain and chest pain, the nurse should first access the more urgent guideline for chest pain to rule out certain medical conditions such as a heart attack.

Ms. Savage confirmed that she prepared the call review summary of the 4 calls in issue and reviewed it with Ms. Oliver. Ms. Oliver confirmed that she listened to the 4 calls in issue and agreed with Ms. Savage's summary of the deficiencies in Respondent's performance.

B. The Triage Calls

The issues in the case center around 4 calls handled by Respondent on 3 different days during a 15-day period in April and May 2011. The documentary evidence included, among other things, the audio/video recording for each of the 4 clients/patients,[28] Ms. Savage's call review summary,[29] Respondent's hand-written responses to the allegations when her

[28] Staff Ex. 11.

[29] Staff Ex. 6 at 2-5.

employment was terminated,[30] and Respondent's responses to Staff's inquiries during the investigation.[31]

In addition, Staff's expert, Dr. Hester, attended the hearing, reviewed the admitted evidence, and addressed the allegations for each caller/patient in issue.[32] Dr. Hester clarified that Parkland's physician-approved triage guidelines constitute standing delegation orders, and that it was imperative that a triage nurse follow these computerized triage guidelines, and not simply rely on her generalized nursing knowledge other than to determine which guideline to open.

The following summary of the evidence includes the documentary evidence, beginning with audio/video recordings, as well as the witness testimony for each patient.

1. Patient 1

a. Audio/Video Recording

On April 25, 2011, at 7:38 a.m., Respondent answered a call from Patient 1's wife who asked, "If I'm in pain or anything else of that nature, I just need to come to the emergency room?" The audio/video recording of the call shows that in response, Respondent told Patient 1's wife that pain is not an emergency, but did ask how Patient 1 was injured. Patient 1's wife stated that Patient 1 had injured his hip the day before while he was playing football, had since been in bed, and was in severe pain. When Respondent asked Patient 1's wife how she intended to get Patient 1 out of the house to take him to see a doctor, Patient 1's wife said she and the children were going to have to get him out of bed. Respondent told Patient 1's wife that she needed to speak with Patient 1, but Patient 1's wife was in her car and not with her husband. Patient 1's wife did not refuse to give Respondent information and was cooperative. Respondent did not open the guidelines during the entire conversation and did not document the conversation.[33]

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[30] Staff Ex. 7 at 7-12.

[31] Staff Ex. 5c and 5d at 15-43.

[32] Dr. Hester obtained her Doctorate of Nursing Practice degree from the Texas Tech University Health Science Center in 2011. She has been employed by the Board since 2005 and is currently the Board's lead nursing practice consultant. As such, Dr. Hester interprets the application of the Act and Board rules to the practice of nursing in Texas.

[33] Staff Ex. 11.

b. Ms. Savage's Testimony and Call Review Summary

Ms. Savage agreed that pain alone does not constitute an emergency, but testified that it was essential for Respondent to query Patient 1's wife further to determine the cause of Patient 1's hip pain. According to Ms. Savage's testimony and her call review summary, Respondent's comment that "pain is not an emergency" was "dangerous" because Respondent failed to gather more information from Patient 1's wife about Patient 1's pain, failed to select the proper assessment guideline, and failed to follow the guidelines.[34] Having failed to do so, Ms. Savage testified that Respondent failed to triage Patient 1 to determine the urgency of his medical needs despite his having symptoms that should have been assessed.

c. Respondent's Written Response

According to Respondent's June 24, 2012 letter to Staff, Respondent represented that she appropriately selected the chest pain guideline and ruled out a "911" call. This was not evident from the audio/video record. Respondent also noted that because Patient 1 refused to give her any "identifiable information" and discontinued the call, Respondent properly closed the computer file without making any data entries.[35]

d. Dr. Hester's Testimony

Dr. Hester stated that Respondent did not properly assess Patient 1's symptoms or choose the right triage guideline. She noted that Respondent appreciated that the patient had a medical problem because she asked Patient 1's wife if Patient 1 was okay and in response, the wife said "No, he is not." Respondent then asked her how she was going to get Patient 1 to the doctor and Patient 1's wife told her than she and her son were going to carry him to the doctor.

According to Dr. Hester, because Respondent did not access the triage guidelines for hip trauma,[36] Respondent did not evaluate the patient's inability to bear weight or walk. Had she done so, Respondent she would have directed Patient 1's wife to call EMS 911 immediately as required by the triage guideline. Instead, Respondent downplayed the information that Patient 1's wife was trying to relay, and made a conscious decision not to triage the patient by

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[34] Staff Ex. 6 at 2.

[35] Staff Ex. 5c at 1.

[36] Staff Ex. 9 at 2-10

saying that pain is not an emergency. Dr. Hester emphasized that Respondent was not excused from triaging Patient 1 simply because Patient 1's wife was calling on his behalf to relay his symptoms, as suggested by Respondent during cross-examination. Dr. Hester also noted that Respondent did not complete a record of this call, as required. In conclusion, Dr. Hester found that Respondent's conduct was below the minimum standards of nursing because Respondent did not demonstrate sound, prudent, reasonable nursing practices when she failed to assess Patient 1's symptoms, and then failed to access the triage guideline for the most urgent and serious symptom, hip trauma. As a result, Dr. Hester testified that Respondent's conduct may have caused a delay in this patient seeking the medical care he required.

2. Patient 2

a. Audio/Video Recording

Shortly after concluding Patient 1's call, Respondent received another call on April 25, 2011, at 8:53 a.m. The audio/video recording showed that the caller, Patient 2, said that she had seen a doctor the previous day who had prescribed Celexa and an antibiotic. Patient 2 had not taken Celexa before, and after taking the medication her blood pressure dropped to 70/44 and her heart rate dropped to 44. In addition, Patient 2 reported that she could not stand up without feeling faint, felt like she was going to pass out, was lethargic, and had runny, watery stools. However, Patient 2 said that her blood pressure improved later that day and the following morning her blood pressure had returned to 119/67, and her heart rate to 59.[37]

While Patient 2 was talking, the video portion of the recording showed that Respondent went onto "Google" to search for "Celexa" to view information about the drug. Patient 2 clearly told Respondent that she wanted to find out whether the Celexa had caused her symptoms from the day before because if it had she would try to have the medication changed. She specifically asked Respondent if the drop in her blood pressure was a reaction to the Celexa, to which Respondent stated, "I don't hear a reaction," but that she did hear the effects of the medication. Respondent told Patient 2 that Celexa took time to work and that it would cause her to be very sleepy. The audio/video recording also showed that Respondent asked Patient 2 what blood pressure medication she was taking even though Patient 2 had already told her she did not take

[37] Staff Ex. 11.

any blood pressure medication. At that point, Respondent stated, "Oh, I'm sorry, that's where I got lost."

As for her low blood pressure, Respondent told Patient 2 that she did not know if it was related to Celexa, and recommended she talk to a pharmacist about her medications. Although Respondent told Patient 2 about the medication's possible side effects, she did not document any medical reference source for this information.[38] During the triage call, Respondent documented in the computer system that Patient 2 had "no new" symptoms, and told Patient 2 that "obviously there is no problem today" and to follow up with her doctor. Respondent did not open any triage guidelines.[39]

b. Ms. Savage's Testimony and Call Review Summary

Ms. Savage's call review summary documented that Respondent failed to select a triage guideline or to assess the urgency of Patient 2's need to seek medical care, despite Patient 2's low blood pressure and heart rate. Ms. Savage testified that Respondent should have assessed Patient 2's low blood pressure (70/44) and heart rate (44); documented Patient 2's symptoms, specifically her inability to stand, sleepiness, and loose stools; and used the computerized triage guideline for low blood pressure. Instead, Respondent failed to evaluate whether Patient 2 continued to experience these symptoms or if Patient 2 had any new symptoms. Furthermore, Ms. Savage clarified, Parkland required the call center nurse to enter the callers'/patients' symptoms or lack of symptoms into the record, not simply delete the record as Respondent did.

Ms. Savage also contends that Respondent's comments about Patient 2's reaction to Celexa were below the standard of care because Respondent used the internet, not an approved medical resource, to advise Patient 2 about the side effects of the new medication. Typically, Ms. Savage explained, medication questions were referred to Parkland's pharmacy. Ms. Oliver agreed with Ms. Savage and added that the call center nurses could also refer to a Quick Reference Guideline on the computer to find answers regarding medication. However, she stressed that the call center nurses were limited to providing that information about a medication contained in the triage guidelines because Parkland does not allow the triage nurses to provide information about a medication "off the top of their head."

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[38] Staff Ex. 11.

[39] Staff Ex. 11.

c. Respondent's Written Response

Respondent's written response to the call review summary indicated that Patient 2 saw her treating physician on Thursday, April 21, 2011, and called the call center the following Monday, April 25, 2011, wanting to know which medication had caused her symptoms the previous day. Because the medication books were no longer in the call center's reference library, Respondent wrote that she relied on her nursing experience in giving Patient 2 advice about the recently prescribed anti-depressant, Celexa. According to Respondent, the only reason that she checked the internet sites was to "verify the classification of the medication."[40] Respondent also maintained that she opened the blood pressure guideline, but did not use this guideline because Patient 2's symptoms were from the previous day. According to Respondent's response, Patient 2 was asymptomatic so it was unnecessary to select a guideline.[41]

d. Dr. Hester's Testimony

According to Dr. Hester, RNs are required to provide systematic, individualized, goal-directed assessments of a patient's symptoms. During this call, Dr. Hester noted that Respondent appeared very distracted and admitted to the caller that "she got lost." Dr. Hester explained that nurses are taught that a blood pressure of 70/44 and a heart rate of 44 may indicate a reduction in the blood flow to the patient's brain. Dr. Hester disagreed with Respondent's argument that Patient 2's symptoms were irrelevant because they occurred the previous day. Patient 2 told Respondent about the symptoms she had the previous day, specifically low blood pressure and low heart rate, because she was concerned that if she took the medicine again she would experience the same symptoms.[42]

In Dr. Hester's opinion, Respondent should have selected the triage guidelines for low blood pressure.[43] Dr. Hester testified that by telling Patient 2, "I don't actually hear a problem today," Respondent minimized the patient's complaints rather than following the nursing process of systematically and methodically assessing the urgency of Patient 2's need for medical care. Dr. Hester stated that Respondent did not evaluate the worst situation, the most serious medical

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[40] Staff Ex. 5d at 16.

[41] Staff Ex. 5d at 16.

[42] Staff Ex. 6 at 60-69.

[43] This guideline can be found at Staff Ex. 5e at 61.

condition, or ask the right questions to obtain necessary information about the patient's symptoms, and consequently put the patient at risk of harm.

3. Patient 3

a. Audio/Video Recording

On April 28, 2011, Respondent answered a call from Patient 3, a woman who said she had been breast-feeding for 3 months and wanted to know how she could get her breast milk to dry up quickly because she was in pain. As reflected in the audio/video recording, Patient 3 told Respondent that her blood pressure had been 174/101 the night before, that she had a severe headache, and that her vision was being affected.[44] Patient 3 also told Respondent that she had not taken her blood pressure medication for a month. Respondent told Patient 3 that the pain was not the problem. The problem, Respondent told Patient 3, was her high blood pressure and that she was going to have a stroke and might not be able to move from the neck down if she did not get medical treatment.[45]

b. Ms. Savage's Testimony and Call Review Summary

According to Ms. Savage's call review summary, Respondent incorrectly documented Patient 3's responses to the triage guideline initial assessment questions, and therefore, did not use the triage guidelines properly. Ms. Savage also noted that Respondent failed to assess either Patient 3's breast pain, which may have been chest pain, or her severe headache, which may have been related to an aneurysm.[46] Ms. Savage testified that despite complaints of a severe headache and visual changes, Respondent did not acknowledge these symptoms as she went through the triage guidelines relating to high blood pressure. Instead, she marked "no" to these initial assessment question, "OTHER SYMPTOMS: Do you have any symptoms (e.g. headache, chest pain, blurred vision, difficulty breathing, weakness)?"[47] Had Respondent properly

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[44] Staff Ex. 11.

[45] Staff Ex. 11.

[46] Staff Ex. 6 at 4.

[47] Staff Ex. 6 at 49.

answered "yes" to this question, the triage guidelines would have instructed Respondent to tell Patient 3 to "Call EMS 911 Now."[48]

Ms. Savage underscored how important it was for the call center nurse to open the triage guideline for symptoms with the highest level of urgency first. If the caller answers "no" to all the questions at this level, the triage guidelines progressed to the next lower level of urgency. Ms. Savage further clarified that the triage nurse may be required to advise the patient to call 911 or to go to an emergency room, but the nurse should not try to scare the caller. She opined that it was inappropriate for Respondent to tell Patient 3 that she could have a stroke and not be able to walk or talk if she did not seek medical attention. Ms. Savage stated that contrary to Respondent's claim, the call center nurses did not have a duty to scare the callers/patients so they will seek prompt medical care. Moreover, Ms. Savage pointed out that Patient 3 was not refusing to comply with Respondent's advice so Respondent had no need to scare the patient. In conclusion, Ms. Savage testified that while Respondent may have opened the correct guideline, she did not use it correctly.

c. Respondent's Written Response

In response to this allegation, Respondent wrote that Patient 3 called because she wanted to know why her blood pressure had gone up. Respondent maintained that she listened to Patient 3 and after opening the guideline for hypertension, explained to Patient 3 the serious risk of waiting to seek medical treatment. She also asked Patient 3 if she had any other complaints, and was told by Patient 3 that her breast pain was causing her blood pressure to go up. Respondent wrote that Patient 3 did not report having a current headache or blurred vision, and therefore these symptoms were not current symptoms and did not need to be triaged[49] She noted that Ms. Oliver had previously in-serviced the call center's nurses to "make callers understand the consequences of not getting the medical attention they need."[50] Respondent wrote that she did as instructed and impressed on Patient 3 the severity of the situation if she delayed getting medical attention.[51]

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[48] *See* Staff Ex. 6 at 49.

[49] Staff Ex. 5d at 17.

[50] Staff Ex. 7 at 8.

[51] Staff Ex. 7 at 10.

d. Ms. Oliver's Testimony

Ms. Oliver testified that because Patient 3's high blood pressure and headaches were the most severe symptoms, it was incumbent on Respondent to access the guideline related to these two symptoms. She agreed that Respondent could have opened three guidelines—the severe headache, hypertension, and vision guidelines, but insisted that Respondent had to assess the most urgent symptoms first.

e. Dr. Hester's Testimony

According to Dr. Hester, Patient 3 required emergency treatment because the night before Patient 3 had very high blood pressure with a severe headache and blurred vision. Dr. Hester explained that Patient 3's blood pressure reading of 174/101 indicated she had hypertensive stage 2 blood pressure, and maintained that Respondent should have asked Patient 3 questions from the high blood pressure guidelines.[52] Parkland's triage guideline for high blood pressure emphasized that a patient who has a severe headache which he or she describes as being the "worst headache" or as "sudden-onset (thunderclap)" required emergency evaluation.[53] A patient with such high blood pressure, a severe headache, and blurred vision may be experiencing a stroke, according to Dr. Hester.

Although Respondent did access the high blood pressure triage guideline, Dr. Hester stated that she did not follow it and did not ask Patient 3 about her severe headache or her vision problems. Equally disturbing to Dr. Hester was Respondent's instructions to Patient 3. Although Respondent told Patient 3 that it was an emergency if her blood pressure was 160/100, she did not tell her to call EMS 911. Instead, Respondent told Patient 3 to be seen "today." In Dr. Hester's opinion, Respondent's handling of this triage call was below the standard of care and could have caused a serious delay in Patient 3 seeking the medical treatment she required.

Regarding Respondent's failure to properly address Patient 3's complaints of breast pain to determine whether it was chest, not breast pain, Dr. Hester stated Respondent failed to adequately assess the symptom.[54] Dr. Hester pointed out that because women may experience

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[52] Staff Ex. 5d at 32.

[53] Staff Ex. 5d at 32.

[54] Staff Ex. 6 at 13-23.

cardiac signs in the form of breast pain, it was essential that Respondent ask Patient 3 questions to rule out whether Patient 3 had chest pain rather than breast pain, and whether she was experiencing a cardiac problem. Dr. Hester noted that the breast symptom guidelines required Respondent to assess whether the patient had chest rather than breast pain. If so, the triage guidelines directed Respondent to go to the chest pain guidelines. According to Dr. Hester, Respondent did not do this assessment.[55]

4. Patient 4

a. Audio/Video Recording

On May 10, 2011, the audio/video recording showed that Respondent answered a call from a man calling about his wife, Patient 4, who had complaints of chest pain, hot flashes, and insomnia. Patient 4, who is 60 years old, then got on the telephone and spoke to Respondent. Patient 4's voice sounded weak and breathless. Patient 4 told Respondent that she could not sleep, had bad hot flashes, and had previously been on hormone replacement therapy. Patient 4 reported that she thought her symptoms were due to her thyroid medication, so she started taking the medication every other day. Patient 4 then stated, "I don't know if my chest pains are just from exhaustion from lack of sleep, or hormone related, or if it's actually my heart. Today I feel terrible."[56]

The synchronized video showed that Respondent typed in the word "menopause" as the key word on the computer system, and then inquired if Patient 4 still had periods. Patient 4 stated that she had not had a period in years. Respondent then typed in the word "thyroid" to access the thyroid guidelines, before changing the entry to "no new." Respondent told her that she needed to be seen because Patient 4 was medicating herself, but that she did not know how quickly Patient 4 needed to be seen. Respondent did not address Patient 4's complaints of chest pain or document that Patient 4 complained of chest pain. After Patient 4 hung up, Respondent entered information about Patient 4's hot flashes, lack of energy, and medication issues, but did not reference Patient 4's chest pains.[57]

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[55] Staff Ex. 6 at 13.

[56] Staff Ex. 11.

[57] Staff Ex. 11.

b. Ms. Savage's Testimony and Call Review Summary

According to Ms. Savage's call review summary, Respondent did not use the triage guidelines to perform an assessment or ask any further questions about Patient 4's chest pain. She noted that Respondent typed in the word "menopause" as the key word to access that guideline on the computer triage system, and then inquired if Patient 4 still had periods. Patient 4 stated that she had not had a period in years. Respondent then typed in the word "thyroid" to access the thyroid guidelines, but then changed the entry to "no new." Respondent told Patient 4 that she needed to be seen, but she did not inform Patient 4 as to how quickly she needed to be seen.[58]

Ms. Savage testified that chest pain is a red flag to a nurse and has priority over hot flashes. She maintained that Respondent should have gone to the chest pain guidelines, but instead accessed the menopause guidelines. She stressed that Respondent never addressed Patient 4's complaint of chest pain. Without any assessment, Respondent told Patient 4 that she thought she needed to be seen, and told her that she should not medicate herself. Ms. Savage pointed out that this was the third call in a short period in which Respondent failed to assess the patient's symptoms.

c. Respondent's Written Response

In her written response, Respondent represented that Patient 4 called the call center about her hot flashes. At first, Respondent reported, she opened the guidelines for menopause but found it inapplicable because Patient 4 had not had a menstrual cycle for years. Although Respondent tried to find a guideline for thyroid problems, she found none. As a result, Respondent chose "NO GUIDELINE"[59]

d. Dr. Hester's Testimony

Dr. Hester stated that Respondent's handling of Patient 4's call was the most alarming to her of all 4 calls. Dr. Hester observed that despite Patient 4's age, complaints of chest pain, and weakened voice, Respondent did not access the triage guidelines for chest pain. Instead, Respondent gave Patient 4 information "off the top of her head" about Patient 4's change in the

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[58] Staff Ex. 6 at 5.

[59] Staff Ex. 5d at 19.

dosage of her thyroid medication without her physician's approval and her menopause issues. Respondent then told Patient 4 that there was no guideline regarding her complaints and so she could not tell Patient 4 how quickly she needed to seek medical treatment. According to Dr. Hester, Respondent should have opened the triage guidelines for chest pain to rule out the highest level of urgency. Dr. Hester also noted that Respondent did not even use the menopause triage guideline correctly.

In summary, Dr. Hester testified that Respondent's nursing practices were below the standards of nursing practices set out in Board rule 217.11 and exposed all 4 patients to a risk of harm. Dr. Hester concluded that Respondent's failure to meet nursing standards constituted a violation of the Nursing Practice Act.

C. Sanctions and Administrative Costs

Staff recommends Respondent be sanctioned with: (1) a formal warning; (2) a requirement that Respondent take remedial education courses in Nursing Jurisprudence and Ethics, Critical Thinking, and Physical Assessments (targeted to remediate Respondent's triage deficiencies); (3) a one-year employer incident reporting requirement; and (4) quarterly employer status reports to the Board for one year.

Staff also seeks recoupment of administrative costs for three areas of expenditure: (1) court reporting fees totaling $2,474.25; (2) witness fess of $2,436.39; and (3) courtroom security costs of $450.00.[60]

IV. ANALYSIS

A. Alleged Violations

The alleged violations involve 4 separate triage calls to Parkland's call center on April 25, 28, and May 10, 2011, handled by Respondent. Staff alleges that Respondent failed to appropriately triage these calls and consequently deprived the callers/patients of physician-approved information about how quickly to seek medical care. As a result, Staff maintains that Respondent deprived these patients information on how soon they needed to seek medical attention, and thus, placed these patients at risk of harm.

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[60] Staff Ex. 15.

It is uncontested that Parkland only hired registered nurses to take the triage calls because of the need for an immediate clinical assessment based on information elicited from the caller/patient. In 2011, the call center triage nurses were required to access the computer software programs, including E-Centaurus, that contained physician-approved guidelines to assess the urgency of a patient's need to seek medical attention. The main issues are whether Respondent properly used the physician-approved triage guidelines, and whether she accurately assessed and documented the caller/patient's symptoms to properly assess the urgency of the patient's need for medical care.

The most compelling evidence regarding Respondent's triage of these 4 calls are the 4 audio/video recording of the calls. Respondent offered no testimony to explain her conduct and her efforts discredit Ms. Oliver's and Ms. Savage's testimony was unsuccessful. After considering the credible evidence and the law, the ALJs find that during these 4 calls, Respondent failed to appropriately assess the patients' symptoms, failed to properly utilize the physician-approved triage guidelines, failed to properly document the calls, and failed to provide these callers/patients information about the urgency of the need to seek medical care. Respondent failed to consult with and utilize health care resources she was required to use for continuity of care and failed to conform to generally accepted nursing standards. Such conduct was careless and could have placed these patients at risk of harm.

1. Patient 1

The credible evidence shows that Patient 1's wife reported to Respondent that her husband was in pain and had been unable to get out of bed after injuring his hip the day before. She also informed Respondent that the injured area was very swollen and that she and her children would have to get Patient 1 out of bed. Respondent did not ask Patient 1 any further information about Patient 1's pain, did not assess the computer guidelines for hip trauma, did not complete a record of this call, and did not follow the physician-approved triage guidelines. Dr. Hester's testimony regarding Respondent's conduct was most persuasive. Dr. Hester noted that Respondent should have, but did not, evaluate Patient 1's ability to bear weight or walk, and simply did not triage Patient 1. Instead, she downplayed his wife's concern that Patient 1 was unable to get out of bed. Consequently, Respondent did not provide the patient with the proper response, which was to instruct the patient to call 911. Respondent's conduct on this occasion was below the minimum standards of nursing practice and exposed Patient 1 to the risk of harm

in violation of 22 Texas Administrative Code §§ 217.11(1)(B), (Q) and 3(A) and 217.12(1)(B) and (4).

2. Patient 2

Patient 2 called concerned that a newly-prescribed medication (Celexa) had caused her blood pressure and heart rate to drop and left her unable to stand without feeling faint. Although Respondent could have added the pharmacy on the line to address Patient 2's concerns about taking the medication, Respondent instead googled information about the drug and, without referring any medical resource approved by Parkland, proceeded to tell Patient 2 about the side effects of this drug. As verified by Ms. Oliver and Ms. Savage, Google was not an approved resource about medications. Although Respondent argued that she only went online to confirm what she already knew about anti-depressants, the audio/video recording showed that she immediately went on line and only then started to advise Patient 2 about the medication's side effects. Although Respondent recommended Patient 2 talk to a pharmacist about her medication, Respondent did not open any triage guidelines. She also incorrectly reported that Patient 2 had no new symptoms when she had reported low blood pressure and low heart rate after taking the Celexa.

Additionally, even after Patient 2 told Respondent that she was not taking any blood pressure medication, Respondent asked her what blood pressure medication she was taking and then confessed to the patient that she had "gotten lost" during their conversation. Respondent did not document in the record that Patient 2 had experienced low blood pressure (70/44) and a low heart rate (44) after taking this medication even though it was important to document as a record for future medical providers. Instead, Respondent deleted the record.

The ALJs find that Respondent's conduct failed to provide a systematic, individualized assessment of this patient's symptoms by failing to assess Patient 2's low pressure, and failed to document Patient 2's symptoms for future reference by other medical providers. By failing to appropriately assess Patient 2's symptoms and failing to document her symptoms, Respondent could have delayed Patient 2 from seeking appropriate medical care. As a result, Respondent's conduct was below the minimum standards of nursing practice and exposed Patient 2 to the risk of harm in violation of 22 Texas Administrative Code §§ 217.11(1)(B), (Q) and 3(A) and 217.12(1)(B) and (4).

3. Patient 3

Patient 3, a young woman, wanted to know how to dry up her breast milk because her breasts hurt. However, it was undisputed that the most urgent symptom Patient 3 disclosed to Respondent was that she experienced extremely high blood pressure (174/101), a severe headache, and blurred vision. Although Respondent told Patient 3 that she needed to get medical attention, she did not tell Patient 3 to call EMS 911. Respondent incorrectly marked "no" to the high blood pressure guideline question regarding Patient 3's other symptoms, specifically her headache and blurred vision. Had Respondent marked "yes" to this question, the physician-approved triage guidelines would have directed Respondent to tell Patient 3 to call EMS 911 immediately. Although Respondent opened the correct guideline for high blood pressure, she inaccurately answered the question regarding Patient 3's symptoms. Respondent was careless in entering information into the physician-approved triage guidelines and her carelessness may have caused a serious delay in Patient 3's medical care. The ALJs are persuaded by the testimony of Ms. Oliver, Ms. Savage, and Dr. Hester, that Respondent's faulty assessment of Patient 3 and failure to accurately answer the triage questions was conduct below the minimum nursing standards of care and exposed this patient to the possibility of serious harm.

Similarly, the credible evidence showed that Respondent had a duty to inquire further about Patient 3's breast pain to ensure Patient 3 did not really have chest pain. According to the evidence, women may experience cardiac problems in the form of breast pain. Therefore, it was essential that Respondent query Patient 3 about her complaints of breast pain to rule out whether it was chest pain. Had Respondent followed the breast symptoms triage guidelines, she would have asked Patient 3 questions to determine whether she had chest pain, and if her assessment indicated that Patient 3 had chest pain, the guideline would have directed Respondent to go to the chest pain guidelines. Because Respondent failed to assess whether Patient 3 had chest rather than breast pain, she failed to properly assess the urgency of this patient's need for medical intervention, thus exposing Patient 3 to a risk of serious harm by delaying appropriate medical care. In conclusion, Respondent's conduct on this occasion was below the minimum standards of nursing practice and exposed Patient 3 to the risk of harm in violation of 22 Texas Administrative Code §§ 217.11(1)(B), (Q) and 3(A) and 217.12(1)(B) and (4).

4. Patient 4

Patient 4 was a 60-year-old woman who appeared to be short of breath and weak based on the audio/video recording. Patient 4 told Respondent she was having severe hot flashes and chest pain. According to the evidence, Patient 4's most urgent symptom that needed to be assessed was her chest pain because it could have been indicative of a cardiac issue. Instead, Respondent gave Patient 4 information without referring to the guidelines for chest pain, and incorrectly focused on Patient 4's hot flashes (a menopause issue) and her statement that she had changed the amount of her thyroid medication without her physician's approval. Respondent also incorrectly told Patient 4 that there was no guideline regarding her complaints, and that she could not tell Patient 4 how quickly she needed to be seen for medical evaluation. The evidence clearly established that Respondent should have opened the triage guidelines for chest pain to rule out the highest level of urgency, and by not doing so she deprived this patient of information about how soon she needed to seek medical attention. Respondent's conduct on this occasion was below the minimum standards of nursing practice and exposed Patient 4 to the risk of harm in violation of 22 Texas Administrative Code §§ 217.11(1)(B), (Q) and 3(A) and 217.12(1)(B) and (4).

5. Violation Summary

The ALJs are mindful that Respondent was not treating these caller/patients, but she was required to evaluate the patients' symptoms by asking the patients questions about those symptoms that required the most urgent level of care. The ALJs find that Respondent's conduct during these 4 calls fell below the minimum standards of nursing care by failing to (1) appropriately use the triage guidelines for Patients 1, 2, 3 and 4; (2) assess the most urgent symptoms for Patients 1, 2, and 4; (3) accurately answer the questions in the guidelines for Patient 3; and (4); document the complaints reported to her by Patients 1, 2, and 4.

The ALJs find that Respondent's failure to meet the minimum standards of nursing care on these occasions deprived these callers/patients of physician-approved triage information about the urgency of their need for medical treatment, and exposed these patients to the risk of harm by potentially causing a delay in their seeking the appropriate medical treatment, in violation of Board Rules 217.11(1)(B),(Q), and 3(A) and 217.12(10(B) and (4). Respondent's failure to conform to the minimum standards of acceptable nursing practice exposed these 4

callers/patients unnecessarily to the risk of harm, and, therefore, warrants disciplinary action by the Board pursuant to §§ 301.452(b)(10) and (14) of the Texas Occupations Code.

B. Sanctions

Dr. Hester testified that sanctions are based upon the entire record, including any evidence of aggravation and mitigation. Dr. Hester characterized Respondent's conduct as Second-Tier offenses most appropriately sanctioned at Level I under the Board's Disciplinary Matrix.[61]

Opining on the appropriate sanction to be imposed in this case, Dr. Hester stressed that during each of the 4 calls, Respondent's actions failed to meet the minimum standards of the Act and posed a risk of harm to the callers/patients. In her opinion, Respondent's conduct placed callers/patients 1 and 2 at risk of harm, and callers/patients 3 and 4 were put at risk of "serious" harm. The Disciplinary Matrix lists the "number of events" and "severity of harm" as aggravating factors for violations of Texas Occupations Code § 301.452(b)(13), which addresses 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.

Staff met its burden of proving by a preponderance of the evidence the aggravating circumstance of "multiple events" for violating the nursing practice standards set out in Texas Occupations Code § 301.452(b)(13), and for unprofessional conduct under Texas Occupations Code § 301.452(b)(10). Staff also met its burden of proving the aggravating factor that the callers/patients were exposed to "potential harm."[62]

Respondent did not offer any evidence in mitigation.

C. Administrative Costs

The ALJs find portions of Staff's request for administrative costs to be reasonable and appropriate, but other portions were not. Staff has requested that Respondent be assessed the full cost of court reporting fees totaling $2,474.25. This was a disciplinary action brought by the Board and it would be unfair to assess Respondent the full cost of the court reporter fees.

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[61] 22 Tex. Admin. Code § 213.33(b) (Disciplinary Matrix). *See* attached Appendix.

[62] 22 Tex. Admin. Code § 213.33(c)(1) ("Evidence of actual or potential harm to patients, clients, or the public."). This rule requires the ALJs to consider the rule's 18 factors in conjunction with the Disciplinary Matrix.

Similarly, Staff required the attendance of its witnesses at the hearing for its direct case. However, Respondent's cross-examination of these witnesses was disorganized and protracted, and so the expense of which should not be born entirely by Staff. Therefore, the ALJs recommend that Respondent should be required to pay for half the costs related to these witnesses.

Thus, Respondent should pay one-half of the witness expenses ($1,531.24) and one-half the court reporting costs ($1,237.13). As to the $450.00 for courtroom security, the ALJs find it unreasonable to assess Respondent with that cost. Respondent comported herself properly throughout the hearing and never posed a security risk.[63] Staff, out of an abundance of caution, chose to assume the financial risk of stationing a Department of Public Safety trooper in the hearing room to maintain order. There was simply no evidence that Respondent posed a security risk, and it would be fundamentally unfair to assess a $450.00 security fee against her.

In conclusions, the ALJs recommend that the Board assess administrative costs against Respondent in the amount of $2,768.37, which is one-half the court reporting costs and the witness expenses. The ALJs agree with Staff's request for remedial sanctions of:

(1) a formal warning with continuing professional education stipulations;

(2) a requirement that Respondent take remedial education courses in Nursing Jurisprudence and Ethics, Critical Thinking, and Physical Assessments (targeted to remediate Respondent's triage deficiencies);

(3) a one-year employer incident reporting requirement; and

(4) quarterly employer status reports to the Board for one-year.

D. Summary

As stated by Staff in its closing argument, "Respondent is a good nurse, but this is a case that merits attention." The preponderance of the evidence clearly shows that during the 4 calls at issue, Respondent's nursing practice fell below the minimum standard of care and violated Texas Occupations Code §§ 301.452(b)(10), and (13). Her repetitive failure to meet the minimum standards of care during these 4 calls exposed the callers/patients to a risk of harm and denied them the benefit of physician-approved medical advice. The recommended sanctions are

[63] *See* Tex. Admin. Code § 155.431(a).

remedial, as opposed to punitive, in nature. The ALJs recommend that the Board approve the proposed findings listed below and implement the corrective sanctions proposed by Dr. Hester.

V. FINDINGS OF FACT

1. Rosemary Hall (Respondent) is a licensed registered nurse holding license number 567816 issued by the Texas Board of Nursing (Board) in March 1991.

2. On May 9, 2014, the Board's staff (Staff) mailed its First Amended Notice of Hearing to Respondent. In accordance with Order No. 7, the hearing was reset to begin on October 6, 2014.

3. The notice of hearing contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

4. The hearing convened October 6-7, 2014, before Administrative Law Judges David A. Berger and Catherine C. Egan at the State Office of Administrative Hearings (SOAH) in Austin, Texas. Assistant General Counsel John F. Legris represented Staff. Respondent appeared and represented herself. The hearing was reconvened on March 9-10, 2015, pursuant to Order No. 14, with both parties in attendance. At the request of Staff, the record remained open for the filing of administrative costs and for objections until March 25, 2015, at which time the record closed.

Parkland's Call Center

5. In 1997, Parkland Health and Hospital System (Parkland) in Dallas, Texas, created the call center to provide 24-hour medical triage advice to the public.

6. Parkland only hires registered nurses to answer the call center triage calls.

7. During the relevant periods involved in this case, the Parkland call center utilized computer software programs with physician-approved triage guidelines.

8. The Parkland call center recorded all calls, synchronizing the oral communications with what was displayed on the nurse's computer screen.

9. The call center nurses did not treat the callers/patients, but used their clinical nursing judgment to assess the caller's/patient's most severe symptoms to determine which triage guideline to open so they could inform the caller/patient on how quickly they needed to seek medical treatment.

10. When using the physician-approved triage guidelines, the call center nurses were required to use the guidelines to rule out the most serious medical conditions that required urgent care before moving on to less serious symptoms.

11. The call center nurses were required to listen to the caller/patient, ask open-ended questions to gather more information about the patient's symptoms, determine and

document the patient's level of urgency, and then advise the caller/patient on when and where the patient should seek medical care, based on the triaged level of urgency.

12. A call center nurse could refer to a Quick Reference Guideline on the computer to address questions about medication, or add Parkland's pharmacy to the call, but the nurse could not rely not on memory, nursing experience, or the nurse's independent internet search for medication information.

13. Between April 14, 2008, through May 31, 2011, Respondent was employed by Parkland as a call center registered nurse.

14. Parkland terminated Respondent's employment on May 31, 2011, for "unsatisfactory work performance."

Patient 1

15. On April 25, 2011, at 7:38 a.m., Respondent answered a call from Patient 1's wife who asked, "If I'm in pain or anything of that nature, I should just go to an emergency room?" Respondent told Patient 1's wife that, "pain is not an emergency." Respondent did not assess the patient's condition or select a physician-approved triage guideline.

16. On April 25, 2011, Respondent failed to appropriately assess Patient 1's symptoms by failing to evaluate Patient 1's inability to get out of bed after he injured his hip playing football the day before, and by failing to open the triage guideline related to hip trauma.

17. By failing to select and properly use the appropriate hip trauma triage guideline, and failing to gather more information about Patient 1's pain, Respondent deprived Patient 1 of physician-approved information about how urgently he needed to seek medical care.

18. Respondent failed to document Patient 1's symptoms. Instead, she deleted the record.

Patient 2

19. On April 25, 2011, Patient 2 called Parkland's call center and spoke to Respondent about the possible side effects of Celexa, a new medication she had been prescribed.

20. Respondent was distracted during her conversation with Patient 2.

21. Patient 2 informed Respondent that she had not felt well the day before. Patient 2's blood pressure had been 70/44 and her heart rate had been 44. She also complained that she could not stand up, felt faint, had loose stools, and was lethargic, and questioned whether these symptoms were related to the Celexa.

22. A blood pressure of 70/44 and a heart rate of 44 may indicate a reduction in the blood flow to the patient's brain.

23. Respondent conducted a Google search regarding Celexa and then advised Patient 2 about its side effects, but did not document the medical source she referenced and did not use the physician-approved triage guidelines in providing this information to Patient 2.

24. Respondent failed to select a triage guideline to assess the urgency of Patient 2's need to seek medical care despite Patient 2's low blood pressure and low heart rate after taking the Celexa.

25. The appropriate triage assessment guideline for Patient 2 was low blood pressure.

26. By failing to select and properly use the appropriate triage assessment guideline, and by failing to gather more information from Patient 2 about her symptoms, Respondent created a risk of harm to Patient 2 by potentially delaying the medical care she required.

27. Respondent minimized Patient 2's complaints rather than following the nursing process of systematically and methodically assessing the patient's need for medical care.

Patient 3

28. Patient 3 called Parkland's call center and spoke to Respondent on April 28, 2011.

29. Patient 3 told Respondent that she wanted to know how to dry up her breast milk quickly because she was in pain, her blood pressure was 174/101, she had a severe headache, and her vision was being affected.

30. Patient 3's blood pressure reading of 174/101 indicated that Patient 3 had hypertensive stage 2 blood pressure, and that she was at risk for a stroke.

31. Respondent opened the correct high blood pressure triage guideline.

32. Respondent did not correctly document and assess Patient 3's severe headache and visual changes as she went through the high blood pressure guideline with Patient 3, and marked "no" to the question regarding whether Patient 3 had other symptoms.

33. Parkland's triage guideline for high blood pressure stated that a patient with a severe headache, described as being sudden-onset or the worst headache they have had, must seek emergency medical care.

34. If Respondent had correctly answered "yes" to the question asking whether Patient 3 had other symptoms such as a severe headache or blurred vision, the triage guideline would have instructed her to advise Patient 3 to "call EMS 911 now."

35. Instead, Respondent told Patient 3 that she needed to be seen by a physician "today."

36. Respondent also failed to assess Patient 3's complaints of breast pain, which may have been chest pain that was related to cardiac problems.

37. According to the breast symptom guidelines, if the patient has chest pain, the guidelines would direct Respondent to go through the chest pain guidelines with the patient.

38. By failing to select and properly use the appropriate triage assessment guidelines, then gathering more information from Patient 3 about her symptoms, Respondent created a "serious" risk of harm to Patient 3.

Patient 4

39. On May 10, 2011, Patient 4's husband called the call center and spoke to Respondent about his 60-year-old wife. Shortly after the call began, Patient 4 started talking to Respondent about severe hot flashes, chest pain, and insomnia.

40. Chest pain was Patient 4's most serious symptom and should have been triaged first before addressing the complaints of hot flashes and insomnia.

41. Respondent never assessed Patient 4's complaint of chest pain, and chose "NO GUIDELINE" in her documentation of Patient 4's symptoms.

42. By failing to select and properly use the appropriate triage assessment guideline, then gathering more information from Patient 4 about her symptoms, Respondent created a "serious" risk of harm to Patient 4.

Summary

43. Respondent's conduct during the telephone assessments of Patients 1 through 4 failed to conform to the minimum standards of nursing practice in a manner that exposed all 4 patients to an unnecessary risk of harm.

44. Respondent's conduct during the telephone assessments of Patients 1 through 4 constituted multiple events.

45. Respondent has no other disciplinary history with the Board.

Administrative costs

46. Staff for the Texas Board of Nursing incurred reasonable administrative costs of $4,910.64, of which Respondent is responsible for $2,768.37.

VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter. Tex. Occ. Code ch. 301.

2. Respondent is subject to disciplinary action by the Board. Tex. Occ. Code § 301.452.

3. SOAH has jurisdiction over all matters relating to the conduct of a hearing in this matter, including the preparation of a proposal for decision with findings for fact and conclusions of law. Tex. Gov't Code ch. 2003.

4. Respondent received proper notice of the complaint and of the hearing. Tex. Gov't Code §§ 2001.051-.052.

5. Staff had the burden of proof in this proceeding. 1 Tex. Admin. Code § 155.427.

6. Respondent failed conform to the minimum standards of nursing practice in a manner that exposed the 4 patients at issue to an unnecessary risk of harm. 22 Tex. Admin. Code § 217.11; Tex. Occ. Code § 301.452(b)(13).

7. Respondent's conduct while triaging the 4 callers/patients constituted unprofessional conduct under Texas Occupations Code § 301.452(b)(10).

8. Staff met its burden of proving by a preponderance of the evidence the aggravating circumstance of multiple events for violating the nursing practice standards set out in Texas Occupations Code § 301.452(b)(13) and for unprofessional conduct under Texas Occupations Code § 301.452(b)(10). Staff also met its burden of proving the aggravating factor that the patients were exposed to potential harm.

9. Staff's proposed remedial sanctions are appropriate under the circumstances of this case, and are tailored to address deficiencies in Respondent's nursing practice. 22 Tex. Admin. Code § 213.33(b) (Disciplinary Matrix).

9. Respondent should be assessed administrative fees in the amount of $2,768.37. Tex. Occ. Code § 301.461; 22 Tex. Admin. Code § 213.22(n)(2).

VII. RECOMMENDATION

The ALJs recommend that the Board adopted Staff's proposed sanctions against Respondent by imposing: (1) a formal warning with continuing professional education stipulations; (2) a stipulation that Respondent take remedial education courses in Nursing Jurisprudence and Ethics, Critical Thinking, and Physical Assessments (targeted to remediate Respondent's triage deficiencies); (3) a one-year employer incident reporting requirement; (4) quarterly employer status reports to the Board for one-year; and (5) assess $2,768.37 of administrative costs against Respondent .

SIGNED May 22, 2015.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

D. A. BERGER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX

§301.452(b)(10) unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public;

First Tier Offense:	Sanction Level I:	Sanction Level II:
Isolated failure to comply with Board rules regarding unprofessional conduct resulting in unsafe practice with no adverse patient effects. Isolated violation involving minor unethical conduct where no patient safety is at risk, such as negligent failure to maintain client confidentiality or failure to honestly disclose or answer questions relevant to employment or licensure.*	Remedial Education and/or a fine of $250 or more for each additional violation. Elements normally related to dishonesty, fraud or deceit are deemed to be unintentional.	Warning with Stipulations that may include remedial education; supervised practice; perform public service; limit specific nursing activities; and/or periodic Board review; and/or a fine of $500 or more for each additional violation. Additionally, if the isolated violations are associated with mishandling or misdocumenting of controlled substances (with no evidence of impairment) then stipulations may include random drug screens to be verified through urinalysis and practice limitations.
Second Tier Offense:	Sanction Level I:	Sanction Level II:
Failure to comply with a substantive Board rule regarding unprofessional conduct resulting in serious risk to patient or public safety. Repeated acts of unethical behavior or unethical behavior which places patient or public at risk of harm. Personal relationship that violates professional boundaries of nurse/patient relationship.	Warning or Reprimand with Stipulations which may include remedial education, supervised practice, and/or perform public service. Fine of $250 or more for each violation. If violation involves mishandling or misdocumenting of controlled substances, misdemeanor crimes or criminal conduct involving alcohol, drugs or controlled substances, then the stipulations will also include abstention from unauthorized use of drugs and alcohol, to be verified by random drug testing through urinalysis, limit specific nursing activities, and/or periodic Board review. Board will use its rules and disciplinary sanction polices related to drug or alcohol misuse in analyzing facts. http://www.bon.state.tx.us/disciplinaryaction/dsp.html.	Denial of Licensure, Suspension, or Revocation of Licensure. Any Suspension would be enforced at a minimum until nurse pays fine, completes remedial education and presents other rehabilitative efforts as prescribed by the Board. If violation involves mishandling of controlled substances, misdemeanor crimes or criminal conduct involving alcohol, drugs or controlled substances then suspension will be enforced until individual has completed treatment and one year verifiable sobriety before suspension is stayed, thereafter the stipulations will also include abstention from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities and/or periodic Board review. Probated suspension will be for a minimum of two (2) or three (3) years with Board monitored and supervised practice depending on applicable Board policy. Financial exploitation of a patient or public will require full restitution before nurse is eligible for unencumbered license.

SOAH DOCKET NO. 507-14-2098

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER 567816	§	OF
ISSUED TO	§	
ROSEMARY HALL	§	ADMINISTRATIVE HEARINGS

STAFF'S EXCEPTIONS TO THE PFD

COMES NOW, Staff of the Texas Board of Nursing, in the above-entitled and numbered cause, and respectfully files its exceptions to the PFD as follows:

Staff excepts to Finding of Fact Number 46, Conclusion of Law Number 9, and the analysis of the ALJs on pages 25-26 of the PFD because the ALJs did not properly apply or interpret applicable law. The analysis recommended by the ALJs regarding the imposition of administrative costs is not contemplated by the Nursing Practice Act. The Texas Occupations Code §301.461 provides that the Board may assess a person who is found to have violated Chapter 301 the administrative costs of conducting a hearing to determine the violation. The statute does not contemplate or authorize a balancing of interests or analysis of "reasonableness" or "fairness" in assessing administrative costs. The ALJs' analysis in this regard contravenes the clear language of the statute and introduces an arbitrary and subjective analysis that is not authorized by law.

The administrative costs in this case consist of court reporter fees and witness fees. The court reporter fees were incurred by the Board as a result of SOAH Rule §155.423(b). Section 155.423(b) requires the Board to provide a court reporter for any hearing set to last longer than one day. The Board complied with this requirement by providing a court reporter, and in so doing, incurred associated costs. Additionally, witnesses for the Board are entitled to reimbursement pursuant to the Government Code §2001.103 and 22 Tex.

Admin. Code §213.12. The costs for Staff's witnesses were incurred in compliance with this statute and rule and state reimbursement policies[1].

Historically, SOAH has awarded administrative costs in compliance with §301.461, without inclusion of a "reasonableness" and/or "fairness" analysis. See Docket Numbers 507-13-5433; 507-14-2093; 507-13-4349; 507-13-5439; 507-13-2752; 507-13-4733; and 507-13-2793. Only recently have individual ALJs began recommending analysis of administrative costs. This has resulted in inconsistency among contested cases. As such, the Board considered this issue in two recent contested case matters (see Docket Numbers 507-14-2129 and 507-14-3092). After reviewing the ALJs' recommendations regarding the imposition of costs in these cases, the Board rejected the ALJ's analyses and re-iterated its position that §301.461 authorizes the imposition of all administrative costs, without a further showing being required.

When reviewing an agency's interpretation of a statute that it is charged with enforcing, courts will first consider whether the statute is ambiguous. *See R.R. Comm'n of Tex. vs. Tex. Citizens for a Safe Future & Clean Water*, 336 S.W.3d 619, 625 (Tex.2011). If the legislature's intent is "clear and unambiguous under the language of the statute, that is the end of the inquiry." *Id.* If the statute is ambiguous, however, courts will uphold the agency's construction if it is reasonable and in accord with the statute's plain language. *Id. See also* Hallmark Marketing Company, LLC vs. Combs, 2014 WL 6090574, Tex.App.-Corpus Christi, 2014.

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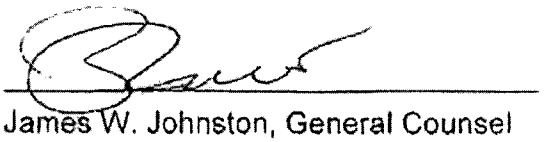
[1] Meal reimbursement is paid in compliance with state reimbursement policies. Meal reimbursement varies depending upon whether an overnight stay is required and upon geographic location (i.e., Austin).

There is no ambiguity in the language of §301.461. Nonetheless, the ALJs presume that additional analysis is required. However, the ALJs provide no legal authority for their recommended analysis. Unilaterally interjecting a subjective analysis, without authorization, statutory or otherwise, is error. The Board is entitled to assess the administrative costs of the hearing against the Respondent under the plain meaning of §301.461. In this case, that includes the court reporter costs and the witness costs. Staff concedes that the costs for security should not be included as an administrative cost of the hearing.

Wherefore, Staff requests that the PFD be amended to delete, or amend, as appropriate, the ALJ's analysis on pages 25-26 of the PFD and amend proposed Finding of Fact Number 46 and Conclusion of Law Number 9 to include the entire amount of the court reporter costs and witness costs, as set out in Staff's Final Affidavit of Administrative Costs.

Respectfully submitted,

TEXAS BOARD OF NURSING



James W. Johnston, General Counsel
State Bar No. 10838300
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6821
F: (512) 305-8101

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Staff's Exceptions to the PFD has been sent by First Class Mail and Email on June 9, 2015, to:

Rosemary Hall
301 Binney Lane
Wylie, TX 75098

James W. Johnston, General Counsel

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

July 10, 2015

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

VIA FACSIMILE NO. (512) 936-3809

RE: Docket No. 507-14-2098, *Texas Board of Nursing v. Rosemary Hall, R.N.*

Dear Ms. Thomas:

On May 22, 2015, the undersigned Administrative Law Judges (ALJs) issued the Proposal for Decision (PFD) in this case. On June 8, 2015, the staff (Staff) for the Texas Board of Nursing (Board) filed exceptions to the PFD regarding the recommended administrative costs to impose against Rosemary Hall (Respondent). Respondent did not file exceptions, and did not file a response to Staff's exceptions. However, on June 11, 2015, Respondent filed a "Financial Hardship Statement" asking the Board not to impose "financial sanctions."[1] Having reviewed the PFD, Staff's exceptions to the PFD, Respondent's Statement of Financial Hardship, and the applicable law, the ALJs respectfully decline to modify the PFD for the reasons set forth below.

Staff excepted to the ALJs' interpretation and application of Texas Occupations Code § 301.461, which states that the Board may assess "the administrative costs of conducting a hearing to determine the violation" if a person is found to have violated Chapter 301. Staff originally asked that the Board impose the following administrative costs against Respondent: (1) court reporting fees totaling $2,474.25; (2) witness fess of $2,436.39; and (3) courtroom security costs of $450.00. In the PFD, the ALJs recommended that the Board assess Respondent with half the court reporting fees, half the witness fees, but none of the courtroom security fees.

Staff concedes that the $450.00 it originally requested for courtroom security costs was inappropriate and has withdrawn that request. Despite Staff reconsideration of its request for courtroom security costs, Staff argues that the statute does not allow an analysis of "reasonableness" when assessing administrative costs, and therefore Respondent must bear all such costs without consideration to the reasonableness of the expense. The ALJs disagree. Section 301.461 states that the Board may impose administrative costs. Assessment of costs is

[1] Recoupment of costs is not a financial sanction, but a collateral consequence of pursuing a contested hearing

discretionary. The statute does not prohibit consideration of the reasonableness or fairness of assessing such costs to the licensee. Had legislature intended such an outcome, the statute would clearly state so. Therefore, the ALJs recommend that no changes to the PFD be made.

Although the PFD was issued on May 22, 2015, Respondent has continued to file various motions with SOAH.[2] Because the record was closed and the PFD issued and sent to the Board for review and final action, the matter is properly before the Board. Respondent should file such motions with the Board for consideration, not with SOAH. All future filings in this matter must be filed with the Board.

Sincerely,

D. A. BERGER
ADMINISTRATIVE LAW JUDGE

Catherine C. Egan
Administrative Law Judge

DAB:CCE:daa

cc: John F. Legris, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA FACSIMILE (512) 305-8101**
Rosemary Hall, 301 Binney Lane, Wylie, TX 75098 – **VIA REGULAR MAIL**

[2] On June 11, 2015, Respondent filed a motion for a "Cease and Desist Order and Request for Hearing" and a "Response to Staff's Extension and to the Judge's Decision, Proposal for Final Decision, and Judicial Review." On June 18, 2015, Respondent filed a "Motion for Summary Disposition." On June 26, 2015, Respondent filed a motion for "Subpoenas Duces Tecum Parkland Hospital Call Center" and a "Motion for Summary Disposition."