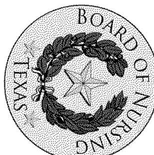

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§
Registered Nurse License Number 826040	§
issued to CHRISTOPHER DUNNING	§

ORDER OF THE BOARD

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 826040, issued to CHRISTOPHER DUNNING, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived representation by counsel, informal proceedings, notice and hearing.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Respondent is currently licensed to practice professional nursing in the State of Texas.

2. Respondent waived representation by counsel, informal proceedings, notice and hearing.

3. Respondent received a Diploma in Nursing from St. Lawrence College, Brockville, Ontario, Canada, on May 30, 1997. Respondent was licensed to practice professional nursing in the State of Texas on September 12, 2012.

4. Respondent's nursing employment history includes:

10/12 - 12/12	Unknown	
01/13 - 04/13	RN	North Cypress Medical Center Cypress, Texas

Respondent's nursing employment history continued:

04/13 - 03/14	RN	HealthSouth Rehabilitation Hospital of Cypress Houston, Texas
04/14 - Present	Unknown	

5. On or about December 29, 2014, Respondent was issued a Confidential Agreed Order for Peer Assistance Program by the Board which required him to participate and successfully complete the Texas Peer Assistance Program for Nurses (TPAPN). Respondent has not successfully completed the terms of the order. A copy of the Findings of Fact, Conclusions of Law, and Confidential Agreed Order for Peer Assistance Program dated December 29, 2014, is attached and incorporated, by reference, as part of this Order.

6. On or about April 30, 2015, an Accusation against Respondent's California registered nurse license was brought by the California Board of Registered Nursing, Sacramento, California. A copy of the California Board of Registered Nursing's Accusation dated April 30, 2015, is attached and incorporated, by reference, as part of this Order.

7. On or about September 22, 2015, Respondent became noncompliant with the Confidential Agreed Order for Peer Assistance Program issued to him by the Texas Board of Nursing on December 29, 2014. Noncompliance is the result of Respondent's failure to comply with all requirements of the Texas Peer Assistance Program for Nurses (TPAPN) in that he withdrew from TPAPN. The Confidential Agreed Order for Peer Assistance Program dated December 29, 2014, reads, in pertinent part:

   "RESPONDENT SHALL comply with all requirements of the TPAPN participation agreement during its term..."

   On or about September 22, 2015, Respondent was dismissed from TPAPN and referred to the Texas Board of Nursing.

8. On October 17, 2015, the Board received a statement from Respondent voluntarily surrendering the right to practice nursing in Texas. A copy of Respondent's statement, is attached and incorporated herein by reference as part of this Order.

9. The Board policy implementing Rule 213.29 in effect on the date of this Agreed Order provides discretion by the Executive Director for consideration of conditional reinstatement after proof of twelve (12) consecutive months of abstinence from alcohol and drugs followed by licensure limitations/stipulations and/or peer assistance program participation.

10. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.12(9) & (11)(B).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(1), (8) & (10), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 826040, heretofore issued to CHRISTOPHER DUNNING, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

5. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

6. Under Section 301.453(d), Texas Occupations Code, the Board may impose conditions for reinstatement of licensure.

7. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TAC§§213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

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ORDER

NOW, THEREFORE, IT IS ORDERED that the voluntary surrender of Registered Nurse License Number 826040, heretofore issued to CHRISTOPHER DUNNING, to practice nursing in the State of Texas, is/are accepted by the Executive Director on behalf of the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice professional nursing, use the title of "registered nurse" or the abbreviation "RN" or wear any insignia identifying himself as a registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered nurse during the period in which the license/s is/are surrendered.

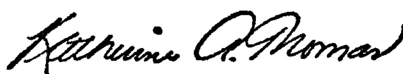
2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order; and, RESPONDENT has obtained objective, verifiable proof of twelve (12) consecutive months of sobriety immediately preceding the petition.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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

Effective this 17th day of October, 2015.

TEXAS BOARD OF NURSING



By: ______________________

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board

To: Texas State Board of Nursing
c/o Paul Longoria

On this date, October 15th, 2015,
on voluntarily relinquish my Texas
Nursing License, with deep saddness.
and Regret.
I would like to thank the
Board for all of their time.

Sincerely, Chris [illegible]

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	CONFIDENTIAL
Registered Nurse License Number 826040	§	AGREED ORDER FOR
issued to CHRISTOPHER DUNNING	§	PEER ASSISTANCE PROGRAM

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of CHRISTOPHER DUNNING, Registered Nurse License Number 826040, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived notice and hearing and agreed to the entry of this Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on November 24, 2014.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived notice and hearing, and agreed to the entry of this Order.

3. Respondent's license to practice as a professional nurse in the State of Texas is in current status.

4. Respondent received a Diploma in Nursing from St. Lawrence College, Brockville, Ontario, Canada, on May 30, 1997. Respondent was licensed to practice professional nursing in the State of Texas on September 12, 2012.

5. Respondent's professional nursing employment history includes:

10/12 - 12/12	Unknown	
01/13 - 04/13	RN	North Cypress Medical Center Cypress, Texas

Respondent's professional nursing employment history continued:

04/13 - 03/14	RN	HealthSouth Rehabilitation Hospital of Cypress Houston, Texas
04/14 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with North Cypress Medical Center, Cypress, Texas, and had been in that position for three (3) months.

7. On or about February 21, 2013, through March 15, 2013, while employed as a Registered Nurse with North Cypress Medical Center, Cypress, Texas, Respondent withdrew Morphine Sulfate 4mg/1ml, Lorazepam 2mg/1ml, Hydromorphone HCL 2mg/1ml, Hydrocodone/Acetaminophen 5/325mg, Zolpidem Tartrate 5mg, Alprazolam 25mg, Temazepam 15mg, and Morphine Sulfate 5mg/1ml from the Medication Dispensing System (Pyxis) for Patients Medical Record Numbers V00000845370, V00000845164, V00000845804, V000008501000, and V00000850842, but failed to document, or accurately and completely document the administration of the medications in the patients' Medication Administration Record (MAR) and/or Nurse's Notes. Respondent's conduct created inaccurate medical records and was likely to injure the patients, in that subsequent care givers would rely on her documentation to further medicate the patients, which could result in an overdose. Furthermore, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act).

8. On or about February 21, 2013, through March 16, 2013, while employed as a Registered Nurse with North Cypress Medical Center, Cypress, Texas, Respondent withdrew Morphine Sulfate 4mg/1ml, Lorazepam 2mg/1ml, Hydromorphone HCL 2mg/1ml, Hydrocodone/Acetaminophen 5/325mg, Zolpidem Tartrate 5mg, Alprazolam 25mg, Temazepam 15mg, and Morphine Sulfate 5mg/1ml, from the Medication Dispensing System (Pyxis) for Patients Medical Record Numbers V00000845370, V00000845164, V00000845804, V000008501000, and V00000850842, but failed to follow the facility's policy and procedure for wastage of the unused portions of the medications. Respondent's conduct left medications unaccounted for, was likely to deceive the hospital pharmacy, and placed the pharmacy in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

9. On or about February 21, 2013, through March 16, 2013, while employed as a Registered Nurse with North Cypress Medical Center, Cypress, Texas, Respondent misappropriated Morphine Sulfate, Lorazepam, Hydromorphone, Hydrocodone/Acetaminophen, Zolpidem Tartrate, Alprazolam, and Temazepam, belonging to Patients Medical Record Numbers V00000845370, V00000845164, V00000845804, V000008501000, and V00000850842, or failed to take precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients, thereof, of the cost of the medications, and is a violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

10. On or about February 22, 2013, through February 23, 2013, while employed as a Registered Nurse with North Cypress Medical Center, Cypress, Texas, Respondent withdrew six (6) Hydromorphone HCL 2mg/1ml injections from the Medication Dispensing System (Pyxis) for Patient Medical Record Number V00000845370, in excess frequency and/or dosage of physicians' orders. Respondent's conduct was likely to injure the patients in that the administration of medication in excess dosage of the physicians' orders could result in the patients suffering from adverse reactions, and is in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

11. On or about January 24, 2014, through February 22, 2014, while employed as a Registered Nurse with HealthSouth Rehabilitation Hospital of Cypress, Houston, Texas, Respondent withdrew two (2) Hydromorphone 2mg injections, two (2) Hydromorphone 2mg tablets, two (2) Clonazepam 0.5mg tablets, and one (1) Lunesta 2mg tablet, from the Medication Dispensing System (Pyxis) for Patients Medical Record Numbers 503936, 503968, 503977, and 504090, but failed to document, or accurately and completely document, the administration of the medications in the patients' Medication Administration Record (MAR). Respondent's conduct created inaccurate medical records and was likely to injure the patients, in that subsequent care givers would rely on her documentation to further medicate the patients, which could result in an overdose. Furthermore, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act).

12. On or about January 25, 2014, through February 22, 2014, while employed as a Registered Nurse with HealthSouth Rehabilitation Hospital of Cypress, Houston, Texas, Respondent withdrew two (2) Hydromorphone 2mg tablets, four (4) Clonazepam 0.5mg tablets, and one (1) Lunesta 2mg tablet, from the Medication Dispensing System (Pyxis) for Patients Medical Record Numbers 503936, 503968, 503977, and 504090, but failed to follow the facility's policy and procedure for wastage of the unused portions of the medications. Respondent's conduct left medications unaccounted for, was likely to deceive the hospital pharmacy, and placed the pharmacy in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

13. On or about January 25, 2014, through February 22, 2014, while employed as a Registered Nurse with HealthSouth Rehabilitation Hospital of Cypress, Houston, Texas, Respondent misappropriated two (2) Hydromorphone 2mg tablets, four (4) Clonazepam 0.5mg tablets, and one (1) Lunesta 2mg tablet, belonging to the facility and patients, thereof, or failed to take precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients, thereof, of the cost of the medications, and is a violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

14. In response to Findings of Fact Numbers Seven (7) through Thirteen (13), Respondent admits that his documentation was lacking and believes that while some of those problems were due to staffing problems on a busy unit, he acknowledges that some of his documentation difficulties may stem from his past injuries.

15. On August 15, 2014, Respondent presented for a chemical dependency evaluation to Kit W. Harrison, Ph.D. During the evaluation, Respondent stated he had a motorcycle accident in 2011 and 2012, and started experiencing short-term memory problems and charting problems soon after. Respondent stated he underwent neuropsychological testing in January 2014 and the test results indicated deficits which did not affect his ability to work. In addition, Respondent stated he attended an outpatient 30-day rehabilitation program in Modesto, California, after he accepted responsibility for a substance dependence prior to coming to Texas. Dr. Harrison concludes that results of the chemical dependency assessment reveal evidence of a past dependence on narcotic pain medications which arose out of two motorcycle accidents. Dr. Harrison states that in light of Respondent's past problems with substance dependence, his persisting mild neurocognitive status could predispose him to potential problems with alcohol consumption in the amounts he reports to be presently drinking. Dr. Harrison states Respondent may present with risk factors associated with his current drinking patterns which could intermittently give him some occasional difficulties as a nurse. Dr. Harrison recommends Respondent refrain from consuming any alcohol if he wishes to optimize his potential in nursing activities. Dr. Harrison recommends random drug and alcohol testing as well as participation in an outpatient rehabilitation program to abstain from alcohol.

16. Formal Charges were filed on March 17, 2014.

17. Formal Charges were mailed to Respondent on March 18, 2014.

18. Respondent's conduct as described in the preceding Finding(s) of Fact was reportable under the provisions of Sections 301.401-301.419, Texas Occupations Code.

19. Respondent's conduct as described in the preceding Finding(s) of Fact resulted from or was significantly influenced by Respondent's substance use disorder.

20. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or substance use disorder.

21. Respondent's compliance with the terms of a Board approved peer assistance program should be sufficient to protect patients and the public.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §§217.11(1)(A),(1)(C)&(1)(D) and 217.12(1)(A),(1)(B),(1)(C),(4),(6)(G),(10)(C)&(11)(B).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 826040, heretofore issued to CHRISTOPHER DUNNING, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

5. The Board may, in its discretion, order a nurse to participate in a peer assistance program approved by the Board if the nurse would otherwise have been eligible for referral to peer assistance pursuant to Section 301.410, Texas Occupations Code.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL comply with the following conditions for such a time as is required for RESPONDENT to successfully complete the **Texas Peer Assistance Program for Nurses (TPAPN)**:

A. **Within forty-five (45) days** following the date of entry of this Order, RESPONDENT SHALL apply to TPAPN;

B. **Within ninety (90) days** following the date of entry of this Order, RESPONDENT SHALL sign and execute the TPAPN participation agreement and complete the enrollment process, which SHALL include payment of a non-refundable participation fee payable to TPAPN in the amount of five hundred dollars ($500.00);

C. Upon acceptance into the TPAPN, RESPONDENT SHALL waive confidentiality and provide a copy of the executed TPAPN participation agreement to the Texas Board of Nursing;

D. RESPONDENT SHALL comply with all requirements of the TPAPN participation agreement during its term and SHALL keep all applicable license(s) to practice nursing in the State of Texas current; and

E. RESPONDENT SHALL CAUSE the TPAPN to notify the Texas Board of Nursing of any violation of the TPAPN participation agreement.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to 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)

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 entry of this Order:**

> **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.
>
> 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. CONFIDENTIALITY REQUIREMENTS

While RESPONDENT remains in compliance with the terms of this Order, this Order shall remain confidential in accordance with the authority outlined in Section 301.466(d), Texas Occupations Code. However, should Respondent fail to successfully complete the terms of this Order or should Respondent commit a subsequent violation of the Nursing Practice Act or Board Rules, this Order shall be treated as prior disciplinary action and will become public information.

V. EFFECT OF NONCOMPLIANCE

SHOULD RESPONDENT fail to comply with this Order or the terms of the participation agreement with the TPAPN, such noncompliance will result in further disciplinary action including TEMPORARY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of Respondent's license(s) and nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

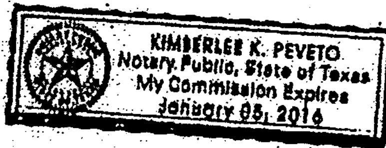
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. I do acknowledge possessing a diagnosis that deems me eligible to participate in the Texas Peer Assistance Program for Nurses. By my signature on this Order, I agree to the entry of this Order and all conditions of said Order to obtain disposition of the allegations through peer assistance and to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes effective upon acceptance by the Executive Director on behalf of the Texas Board of Nursing, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 23 day of December, 2014.

CHRISTOPHER DUNNING, Respondent

Sworn to and subscribed before me this 23 day of December, 2014.

SEAL



Notary Public in and for the State of Texas

Approved as to form and substance.

Joyce Stamp Lilly, Attorney for Respondent

Signed this 28 day of December, 2014

WHEREFORE PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby accept and enter the Confidential Agreed Order for Peer Assistance Program that was signed on the 23rd day of December, 2014, by CHRISTOPHER DUNNING, Registered Nurse License Number 826040, and said Order is final.

Effective this 29th day of December, 2014.

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board

I hereby certify the
foregoing to be a true copy
of the documents on file in our office.

BOARD OF REGISTERED NURSING

Louise R. Bailey, M. ED., RN
Interim Executive Officer

KAMALA D. HARRIS
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General
KAREN R. DENVIR
Deputy Attorney General
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1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5333
Facsimile: (916) 327-8643
Attorneys for Complainant

**BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against: **CHRISTOPHER J. DUNNING** 3018 Powers Avenue Riverbank, California 95367 **Registered Nurse License No. 629326** Respondent.	Case No. 2015-826 ACCUSATION

Louise R. Bailey, M.Ed., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about November 19, 2003, the Board issued Registered Nurse License Number 629326 to Christopher J. Dunning, also known as Christopher Stephen John Dunning, and Christopher John Dunning ("Respondent"). The registered nurse license expired on December 31, 2012, and has not been renewed.

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///

///

1 **JURISDICTION**

2 3. This Accusation is brought before the Board, Department of Consumer Affairs, under
3 the authority of the following laws. All section references are to the Business and Professions
4 Code ("Code") unless otherwise indicated.

5 4. Code section 2750 provides, in pertinent part, that the Board may discipline any
6 licensee, including a licensee holding a temporary or an inactive license, for any reason provided
7 in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

8 5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not
9 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or
10 to render a decision imposing discipline on the license.

11 **STATUTORY PROVISIONS**

12 6. Code section 2761 provides, in pertinent part:

13 The board may take disciplinary action against a certified or licensed nurse or
14 deny an application for a certificate or license for any of the following:

15 (a) Unprofessional conduct . . . .

16 (1) Incompetence or gross negligence in carrying out usual certified or licensed nursing functions.

17 7. Code section 2762 states, in pertinent part:

18 In addition to other acts constituting unprofessional conduct within the meaning
19 of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:

20 (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible
21 entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

22 **REGULATORY PROVISIONS**

23 8. California Code of Regulations, title 16 ("Regulations"), section 1442, states:

24 As used in Section 2761 of the code, "gross negligence" includes an extreme
25 departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure
26 means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

27 ///

28 ///

9. Regulations, section 1443, states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

10. Regulations, section 1443.5, states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

11. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

///

FIRST CAUSE FOR DISCIPLINE

(Grossly Incorrect/Inconsistent and/or Unintelligible Entries in Hospital or Patient Records)

12. Respondent is subject to discipline pursuant to section 2761(a), on the grounds of unprofessional conduct, as defined in Code section 2762(e), in that Respondent falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital or patient records, as set forth below in paragraphs 13, subparagraphs a through i, and 14, subparagraphs a through q.

13. **Sutter Delta Medical Center in Antioch, California**

While working as a registered nurse in or around December 2011 through February 2012 at Sutter Delta Medical Center in Antioch, California , Respondent did the following:

Patient A

a. Patient A had a physician's order for 1 mg. Dilaudid IV Q3 as needed. On December 23, 2011, at 7:55 p.m., Respondent withdrew from the Pyxis 2 mg. of Dilaudid and documented the administration of 1 mg. of Dilaudid to this patient at 7:52 p.m. Respondent failed to chart the administration or wastage of the remaining 1 mg. of Dilaudid in any patient or hospital record or otherwise account for its disposition.

b. On December 23, 2011, at at 9:45 p.m., Respondent withdrew from the Pyxis for this patient 2 mg. of Dilaudid. Respondent documented that he wasted 1 mg. of Dilaudid at 11:14 p.m. (one hour and 44 minutes after withdrawing it) and documented the administration of 1 mg. of Dilaudid to this patient at 10:48 p.m. (one hour and three minutes after its withdrawal).

c. On December 23, 2011, at 11:55 p.m., Respondent withdrew from the Pyxis for this patient 2 mg. of Dilaudid. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

Patient D

d. Respondent documented the administration of 12 mg. Dilaudid to this patient on December 3, 2011, at 7:34 p.m. There was no record that Respondent withdrew Dilaudid for this patient on December 3, 2011, and there was no physician's order for Dilaudid for this patient.

e. On December 3, 2011, at 8:55 p.m., Respondent withdrew from the Pyxis for this patient 2 mg. of Lorazepam. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

Patient E

f. On February 4, 2012, at 7:25 p.m., Respondent withdrew from the Pyxis 4 mg. of Dilaudid for this patient and documented that he wasted 1 mg. of the Dilaudid. Respondent documented that on February 4, 2012, he administered to this patient 1 mg. of Dilaudid at 3:58 a.m. (15 hours, 27 minutes before its withdrawal) and 2 mg. of Dilaudid at 6:48 p.m. (37 minutes before its withdrawal).

g. On February 4, 2012, at 3:17 a.m., Respondent withdrew from the Pyxis 10 mg. of Diazepam (Valium) for this patient, and documented that at 3:58 a.m. and 7:20 a.m. he administered 2 mg. of Valium each time to this patient. Respondent failed to chart the administration or wastage of the remaining 6 mg. of Valium in any patient or hospital record or otherwise account for its disposition.

Patient F

h. On January 9, 2012, at 8:29 p.m., Respondent withdrew from the Pyxis 2 mg. of Dilaudid for this patient, and documented that he administered 2 mg. of Dilaudid to this patient at 10:26 p.m. (1 hour, 57 minutes after its withdrawal).

i. On January 10, 2012, at 7:34 p.m., Respondent withdrew from the Pyxis 2 mg. of Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

14. **Doctor's Medical Center in Modesto, California**. While working as a registered nurse at Doctor's Medical Center in Modesto, California, in or around March 2012, Respondent did the following:

Patient 1

a. On March 10, 2012, at 20:42 hours, Respondent withdrew from the Omnicell 8 mg. of Morphine for this patient. Respondent documented that he administered 5 mg. of morphine to this patient at 21:00 hours. Respondent failed to chart the administration or wastage of the

remaining 3 mg. of Morphine in any patient or hospital record or otherwise account for its disposition.

b. On March 11, 2012, at 03:04 hours, Respondent withdrew from the Omnicell 4 mg. of Morphine for this patient. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

c. On March 11, 2012, at 0302 hours, Respondent withdrew from the Omnicell 8 mg. of Morphine for this patient and documented on this patient's medication administration record (MAR) the administration of Morphine on March 11, 2012, at 03:15 hours. The quantity administered is illegible.

Patient 3

d. On March 24, 2012, at 0000 hours, Respondent withdrew from the Omnicell 2 mg. of Morphine for this patient and documented in the wrong column on the patient's MAR that he administered 2 mg. of Morphine to this patient at 00:10 hours on March 23, 2012.

Patient 4

e. On March 16, 2012, at 1928 hours, Respondent withdrew from the Omnicell 1 mg. of Dilaudid for this patient and documented in the wrong column on the patient's MAR that he administered 1 mg. of Dilaudid to this patient at 19:30 hours on March 16, 2012.

Patient 5

f. On March 20, 2012, at 20:48 hours, Respondent withdrew from the Omnicell 1 mg. of Dilaudid for this patient. Respondent documented that he administered .5 mg. of Dilaudid to this patient at 21:00 hours. Respondent failed to chart the administration or wastage of the remaining .5 mg. of Dilaudid in any patient or hospital record or otherwise account for its disposition.

g. On March 21, 2012, at 00:29 hours, Respondent withdrew from the Omnicell 1 mg. of Dilaudid for this patient. Respondent documented that he administered .5 mg. of Dilaudid to this patient 56 minutes later, at 01:25 hours. Respondent failed to chart the administration or wastage of the remaining .5 mg. of Dilaudid in any patient or hospital record or otherwise account for its disposition.

h. Patient 5 had a physician's order for 0.5 to 1.5 mg. Dilaudid every two hours PRN. On March 21, 2012, at 01:57 hours Respondent withdrew 1.0 mg. Dilaudid from the Omnicell under this patient's name. The withdrawal was only 32 minutes after he documented the administration of .5 mg. of Dilaudid to this patient at 01:25 hours (see subparagraph f, above). Respondent failed to chart the administration or wastage of the 1.0 mg. Dilaudid that he withdrew at 01:57 hours in any patient or hospital record or otherwise account for its disposition.

Patient 6

i. On March 24, 2012, at 20:58 hours, Respondent withdrew from the Omnicell 2 mg. of Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

Patient 7

j. Patient 7's physician ordered 4 mg. Morphine every two hours PRN for this patient. On March 24, 2012, at 22:35 and 22:36 hours, Respondent withdrew from the Omnicell a 2 mg. syringe of Morphine each time for this patient, when there were 4 mg. syringes of morphine available for withdrawal.

Patient 9

k. On March 25, 2012, at 23:24 hours, Respondent withdrew from the Omnicell 2 mg. of Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

l. On March 26, 2012, at 05:22 hours, Respondent withdrew from the Omnicell 2 mg. of Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

Patient 10

m. On March 26, 2012, at 00:19 hours, Respondent withdrew from the Omnicell 2 mg. of Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

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n. On March 26, 2012, at 05:33 hours, Respondent withdrew from the Omnicell 2 mg. of Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

Patient 11

o. On March 6, 2012, at 21:22 hours, Respondent withdrew from the Omnicell 2 mg. of Morphine for this patient. Respondent failed to chart the administration or wastage of the drug in any patient or hospital record or otherwise account for its disposition.

Patient 12

p. On March 25, 2012, at 06:41 hours, Respondent withdrew from the Omnicell 8 mg. of Morphine for this patient. Respondent documented that he administered 4 mg. of Morphine to this patient at 06:46 hours. Respondent failed to chart the administration or wastage of the remaining 4 mg. of Morphine in any patient or hospital record or otherwise account for its disposition.

Patient 13

q. On March 12, 2012, at 06:04 hours, Respondent withdrew from the Omnicell one 5 mg. tab of Norco for this patient. Respondent failed to chart the administration or wastage of any of the drug in any patient or hospital record or otherwise account for its disposition.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent is subject to discipline pursuant to Code section 2761(a)(1), on the grounds of unprofessional conduct, in that in or around while working as a registered nurse, Respondent committed gross negligence within the meaning of the California Code of Regulations, title 16, section 1442, as follows:

a. Respondent failed to provide nursing care as required by repeatedly failing to account for controlled substances, as set forth above in paragraph 13, subparagraphs a, c, d, e, g, and i, and paragraph 14, subparagraphs a, b, f, g, h, i, k, l, m, n, o, p, and q.

b. On or about March 25, 2012, and March 26, 2012, during his shift as a registered nurse at Doctor's Medical Center in Modesto, California, Respondent was observed by his

coworkers to appear confused, disoriented, and sleepy. He was unable to recall the name, gender, or location of his patients. Respondent stated that one patient had a diagnosis of "penicillin", reported that an obtunded patient was alert and oriented x 4, and continually repeated himself. When Respondent reported to "K.C.", the oncoming nurse at the end of his shift, his speech was slurred and rambling, he appeared confused, disoriented, and exuberantly happy. When reporting to K.C. he gave her MARs for the wrong dates or patients, and failed to transfer a MAR at all for some of his patients. Such behavior potentially jeopardized the health of Respondent's patients.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

16. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that Respondent committed acts constituting incompetence within the meaning of Regulations, section 1443, as set forth above in paragraph 13, subparagraphs a through i; paragraph 14, subparagraphs a through q; and paragraph 15, subparagraph b.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

17. Respondent is subject to discipline pursuant to Code section 2761(a), on the grounds of unprofessional conduct, in that Respondent demonstrated unprofessional conduct, as set forth above in paragraph 15, subparagraphs a and b; and, paragraph 16.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 629326 issued to Christopher J. Dunning, also known as Christopher Stephen John Dunning, and Christopher John Dunning;

2. Ordering Christopher J. Dunning, also known as Christopher Stephen John Dunning, and Christopher John Dunning, to pay the Board of Registered Nursing the reasonable costs of

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the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: April 30, 2015

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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