DOCKET NUMBER 507-17-2066

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
REGISTERED NURSE	**§**	
LICENSE NUMBER 590166,	**§**	**OF**
ISSUED TO	**§**	
GWENDOLYN MAE DANIEL	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: GWENDOLYN MAE DANIEL
C/O MARC MEYER, ATTORNEY
33300 EGYPT LANE, SUITE C600
MAGNOLIA, TX 77354

BETH BIERMAN
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 26-27, 2017, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD without changes; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

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

The Board, after review and due consideration of the PFD; Staff's recommendations; and the presentation by the Respondent during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD without modification as if fully set out and separately stated herein. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

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[1], the Board agrees with the ALJ that the most appropriate sanction in

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[1] 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

this matter is an order requiring the Respondent to complete remedial education courses and pay a fine of $250[2].

The Board agrees with the ALJ and finds that the Respondent's conduct warrants a first tier, level I sanction, for her violations of §301.452(b)(10) and a first tier, level I sanction, for her violations of §301.452(b)(13)[3]. For a first tier, level I sanction for a violation of §301.452(b)(10), the Board's Disciplinary Matrix[4] authorizes remedial education and a fine of $250. For a first tier, sanction level I sanction for a violation of §301.452(b)(13), the Board's Disciplinary Matrix also authorizes remedial education and a fine of $250. Based upon the aggravating and mitigating factors in this case, the Board agrees with the ALJ and finds that completion of remedial education courses and payment of a fine of $250 is the most appropriate sanction.

In determining the appropriate sanction in this case, the Board must consider the aggravating and mitigating factors. The Respondent's conduct, particularly that outlined in adopted Findings of Fact Numbers 2-11, and Conclusion of Law Number 5 posed a risk of harm to her patient, who was in critical condition following a liver transplant[5]. However, the patient suffered no adverse effects[6] and the Respondent took responsibility for the error[7]. Additionally, the Respondent has a good work history without prior discipline from the Board[8].

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[9] and the Board's rules, including 22 Tex. Admin. Code §213.33, that the Respondent should be required to complete remedial education courses and pay a fine of $250.

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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.). *See also* Tex. Occ. Code §301.459(a-1), effective September 1, 2017, which reserves the determination of the appropriate sanction solely to the Board.

[2] See pages 10-12 of the PFD.

[3] *See id.*

[4] 22 Tex. Admin. Code §213.33(b).

[5] See adopted Finding of Fact Number 3 and page 12 of the PFD.

[6] See adopted Finding of Fact Number 13 and page 12 of the PFD.

[7] See page 12 of the PFD.

[8] See *id.*

[9] 22 Tex. Admin. Code §213.33(b).

IT IS THEREFORE ORDERED that RESPONDENT SHALL receive the sanction of **REMEDIAL EDUCATION WITH A FINE** in accordance with the terms of this 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.

I. 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.

II. 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 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. **A Board-approved course in medication administration** 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: a review of proper administration procedures for all standard routes; computation of drug dosages; the six (6) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper

administration. The clinical component SHALL focus on tasks of medication administration only. 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.

C. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

In order to receive credit for completion of this/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.*

III. MONETARY FINE

RESPONDENT SHALL pay a monetary fine in the amount of two hundred and fifty dollars ($250). RESPONDENT SHALL pay this fine within forty five (45) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

IV. 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 26th day of October, 2017.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-17-2066 (July 31, 2017).

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

July 31, 2017

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

RE: Docket No. 507-17-2066; In the Matter of Permanent Certificate Number 590166 & 110832 Issued to Gwendolyn Mae Daniel

Dear Ms. Thomas:

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

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

Sincerely,

Beth Bierman
Administrative Law Judge

BB/eh
Enclosures

xc: John R. Griffith, 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 1 CD) – **VIA INTERAGENCY**
Marc Meyer, 33300 Egypt Lane, Suite C600, Magnolia, TX 77354 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-17-2066

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
GWENDOLYN MAE DANIEL, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) brought this disciplinary action against Respondent Gwendolyn Mae Daniel, a Registered Nurse (RN) licensed by the Board. Staff alleges that Ms. Daniel violated the Nursing Practice Act (Act) and Board rules by failing to utilize two patient identifiers prior to administering platelets to a patient, which resulted in Ms. Daniel administering the wrong platelets to that patient. After considering the evidence and applicable law, the Administrative Law Judge (ALJ) finds that Staff established the violation and recommends that Ms. Daniel be required to undergo remedial education and pay a fine of $250.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Notice and jurisdiction were undisputed and are therefore set out in the Findings of Fact and Conclusions of Law without further discussion. The hearing convened on June 12, 2017, before ALJ Beth Bierman at the State Office of Administrative Hearings (SOAH), William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by John Griffith, Assistant General Counsel. Ms. Daniel was represented by attorney Marc Meyer. The hearing concluded and the record closed the same day.

II. APPLICABLE LAW

Under the Act,[1] the Board is authorized to take disciplinary action against a nurse for, among other things:

- Unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public;[2] or
- Failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm.[3]

Board Rule 217.12[4] defines "unprofessional conduct" to include "unsafe practice," which in turn is defined to include:

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11;[5]
- Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;[6] and
- Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established.[7]

Board Rule 217.11(1) addresses standards of nursing practice to include requirements that nurses:

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[1] Chapter 301 of the Texas Occupations Code.

[2] Act § 301.452(b)(10).

[3] Act § 301.452(b)(13).

[4] Rules promulgated by the Board are found in chapters 211-228, part 11, title 22 of the Texas Administrative Code and may be referenced in the text as "Board Rule _____."

[5] 22 Tex. Admin. Code § 217.12(1)(A).

[6] 22 Tex. Admin. Code § 217.12(1)(B).

[7] 22 Tex. Admin. Code § 217.12(4).

- Know and conform to the Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;[8]
- Implement measures to promote a safe environment for clients and others;[9]
- Know the rationale for and the effects of medications and treatments and shall correctly administer the same;[10] and
- Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.[11]

When a nurse has violated the Act or related Board rules, the Board is required to impose a disciplinary sanction, which can range from the issuance of a written warning to revocation of the nurse's license.[12] Board Rule 213.33 includes a Disciplinary Matrix that SOAH is required to use in all disciplinary matters.[13] The Disciplinary Matrix categorizes violations into three tiers, with two sanction levels each, based on the seriousness of the offense and risk of harm to patients or the public. The Disciplinary Matrix also lists certain aggravating and mitigating factors that must be considered. Board Rule 213.33(c) includes another list of factors that the Board and SOAH must consider in determining the appropriate disciplinary sanction, including: evidence of actual or potential harm to patients or the public; whether the licensee has been subject to previous disciplinary action by the Board; the length of time the licensee has practiced; the extent to which system dynamics in the practice setting contributed to the problem; and evidence of good professional character as set forth and required by Board Rule 213.27.

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[8] 22 Tex. Admin. Code § 217.11(1)(A).

[9] 22 Tex. Admin. Code § 217.11(1)(B).

[10] 22 Tex. Admin. Code § 217.11(1)(C).

[11] 22 Tex. Admin. Code § 217.11(1)(M).

[12] Act § 301.453(a); 22 Tex. Admin. Code § 213.33(e).

[13] 22 Tex. Admin. Code § 213.33(b).

III. EVIDENCE

At the hearing, Staff offered nine exhibits[14] into evidence as well as testimony from Ms. Daniel, Kelly Murphy, RN, and Kristen Sinay, RN. After Staff rested its direct case, Ms. Daniel offered no other evidence.

A. Background

Ms. Daniel has been a licensed RN in the State of Texas since 1986 and holds License Number 590166. Ms. Daniel has 31 years of experience with transplant patients and has worked almost exclusively with intensive care patients. The incident in question occurred on April 12, 2015. On this date, Ms. Daniel was working for the University of Texas Southwestern Medical Center (Southwestern) as a level 2 RN in the surgical intensive care unit (ICU).

B. Testimony of Ms. Daniel

According to Ms. Daniel, she was employed at Southwestern for a little over three years and ceased working there July 3, 2015.

Ms. Daniel testified that on the night in question, she was working the night shift (generally 7:00 p.m. to 7:00 a.m.) when Patient A was brought into the ICU in severely critical condition after a liver transplant. Ms. Daniel was assigned to Patient A as a one-to-one nurse.[15] Ms. Daniel testified that Patient A's physicians placed an order for blood platelets, which was sent to the technician at the blood bank. Because Patient A was in critical condition, Ms. Daniel asked another nurse to retrieve the blood platelets. Shortly thereafter, the nurse came into the room and handed Ms. Daniel a bag of blood platelets. Then, while Ms. Daniel had the blood platelets in her hands, the other nurse read off the patient name and number of the blood product

[14] Staff Exhibits 1-5 and 7-8 were admitted in their entirety. With the exception of pages 110-123 and 127-138, Staff Exhibit 6 was also admitted.

[15] "One-to-one nursing" is when a nurse is assigned to care for only one patient because of the patient's critical condition.

written on the requisition form. Because the patient name and number on the requisition form matched the information on the bag of blood platelets, Ms. Daniel administered the platelets to Patient A beginning at 10:19 pm.[16]

After Ms. Daniel administered the blood platelets to Patient A, the nurse for another ICU patient (Patient B) informed Ms. Daniel that the platelets she administered to Patient A were actually designated for Patient B. Ms. Daniel stated that after she was made aware of the error, she followed procedure and notified the blood bank, the physicians, and the night charge nurse of the situation. After these individuals were informed, Ms. Daniel testified that Patient A's physicians directed her to do nothing. According to Ms. Danial, no orders were given for any follow-up blood tests or labs. After receiving the platelets, Patient A was stable and there were no complications or known harm to Patient A.[17] Patient A received a kidney transplant the next day.

When recounting the incident, Ms. Daniel stated that if the blood product had been any other blood product besides platelets, she would have also checked the information on the bag of platelets against the blood cross-match band found on the patient's wristband. However, because platelets were involved, Ms. Daniel stated that she did not have to cross-match the bag of platelets to Patient A's wristband. She opined that platelets are "interchangeable" and "universal" as long as they are irradiated. Ms. Daniel believed that the platelets for Patient B were the same as the platelets for Patient A, except for having different labels on the bags. In addition, Ms. Daniel explained that Patient A's wristband was cut off during surgery before Patient A arrived in the ICU and had not yet been replaced. She acknowledged there was a new wristband for Patient A by the computer in the room, which she did not read closely before administering the platelets.[18] Because the first three letters of the last names for Patient A and Patient B were the same, Ms. Daniel said she was not aware she had administered Patient B's platelets to Patient A until Patient B's nurse came looking for the platelets for Patient B.

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[16] Staff Ex. 5 at 149-150.

[17] Staff Ex. 5 at 68.

[18] Staff Ex. 6 at 125.

Ms. Daniel agreed that she should always check a patient's wristband and that by not doing so, she failed to use two patient identifiers. Ms. Daniel also stated that she did not check Patient A's wristband because it was an emergency situation and the doctors were yelling at her to administer the platelets.

Ms. Daniel testified that she received verbal counseling on April 23, 2015, regarding the incident from Kelly Murphy (the day shift assistant nurse manager) and Ruben Castillo (the acting nurse manager). Ms. Daniel stated that Ms. Murphy told her that she would have to complete the verbal counseling session and sign an Informal Discussion and Verbal Counseling Form, which stated that Ms. Daniel should be re-educated on policy and procedures.[19] Ms. Daniel testified that she did not receive any re-education on policy and procedures. Further, Ms. Daniel testified that after this incident she continued to administer blood products to patients without any further issues.

C. Testimony of Ms. Murphy

Ms. Murphy has been a licensed RN in the State of Texas since 2004. Ms. Murphy is currently employed at Southwestern as a nurse manager in the ICU. On the day of the incident, Ms. Murphy was the day shift charge nurse. Although her shift had ended, she stayed to finish her duties. Ms. Murphy testified that the night shift charge nurse came into the office and asked her to help sort through the events that had just taken place in Patient A's room.

Ms. Murphy said that she went into Patient A's room to talk with Ms. Daniel about the incident. Ms. Murphy testified that a physician had written an order for Patient A to receive blood platelets. She explained that the ICU was set up with 12 beds on each side of the unit and at each end of the unit there is a printer. When a nurse is informed that their patient's blood product is ready to be picked up, the nurse must print off the blood product's requisition form from the electronic system and give it to a technician to take to the blood bank to collect the product. Ms. Murphy stated that because Patient A was unstable and Ms. Daniel could not leave

[19] Staff Ex. 6 at 124.

the room, the night shift charge nurse went to the printer to pick up the requisition form for the blood platelets. Meanwhile, there were other patients in the ICU for whom requisition forms for blood platelets were being printed at the same time. The charge nurse accidentally took Patient B's requisition form for platelets from the printer because Patient B's last name was very similar to Patient A's. Then, the charge nurse gave Patient B's requisition form to the technician who went to the blood bank to retrieve the platelets.

When the technician handed the requisition form to the blood bank personnel, the blood bank personnel saw that there was an order for blood platelets for Patient B and that they were ready to be picked up. Thus, the blood bank personnel gave Patient B's blood platelets to the technician. The technician then brought the blood platelets for Patient B into Patient A's room. Ms. Murphy testified that, per hospital policy, Ms. Daniel had another nurse come into Patient A's room to help verify the blood product was for the correct patient. That nurse had the platelet requisition form for Patient B in her hand and Ms. Daniel had the bag of platelets. The nurse read off the information from the requisition form, including the patient's name, and Ms. Daniel confirmed that the information on the requisition form matched the information printed on the bag of platelets. Because Patient A was not awake and there was no family in the room, no one was able to inform the nurses that the name on the requisition form was not Patient A's name. Ms. Murphy stated that the next procedure would have been to check a second patient identifier to confirm that the information on the bag matched to the correct patient. Ms. Murphy testified that if a patient was awake, then the nurse could ask the patient to say their name. However, because Patient A was unconscious, then Ms. Daniel should have confirmed that the information on the platelet bag matched the information on the Patient A's wristband.

Ms. Murphy stated that when she walked into Patient A's room, Patient A did not have a wristband on, but she did notice that a new wristband was located next to the computer. Ms. Murphy testified that Ms. Daniel told her she had not done the second step of the patient verification procedure. Further, Ms. Murphy stated that Ms. Daniel was visibly upset and remorseful. Ms. Murphy testified that she was not aware of any adverse outcomes to Patient A because of the error and that there were no significant changes in Patient A's vital signs.

Ms. Murphy testified that she had personally administered blood platelets before and to her knowledge, blood platelets are not universal. Ms. Murphy stated that unless it was an absolute emergency, the policy of the hospital blood bank requires nurses to collect a type-and-screen sample on each patient and the blood bank will type the blood product specifically to that patient. Ms. Murphy testified that every blood product, including platelets, is typed by the blood bank and matched to the patient for whom the blood product was ordered. According to Ms. Murphy, the platelets meant for Patient B were typed for Patient B. Ms. Murphy testified that when Ms. Daniel failed to utilize two patient identifiers as required and did not verify Patient A's name, Ms. Daniel did not meet the "five rights" of medication administration, which she identified as "the right patient, the right time, the right drug, the right dosage, and the right route."

D. Testimony of Ms. Sinay

Ms. Sinay has been licensed by the Board as an RN since 2008. She received her Master of Science in Nursing in 2012. She has been employed by the Board for approximately two and a half years, one year as a nurse investigator and a year and a half as a Nursing Consultant for Practice. Ms. Sinay testified as an expert on the Act, Board rules, and Board policies. She admitted she was not an expert with regard to blood platelets.

Ms. Sinay testified that Ms. Daniel's conduct violated Board Rule 217.11(1)(A) by failing to conform with Board rules and Southwestern's policies[20] when she failed to use two patient identifiers prior to administering the platelets to Patient A. According to Ms. Sinay, Board rules, as well as Southwestern's Standard Operating Procedure,[21] specifically require nurses to use two patient identifiers.

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[20] Staff counsel stated during the hearing that Staff did not allege in the notice that Ms. Daniel had violated any policies. Therefore, no sanction may be imposed based on an allegation that Ms. Daniel failed to comply with a facility policy. Digital recording, Vol. II at 13:40-14:20.

[21] Staff Ex. 6.

Ms. Sinay testified that Ms. Daniel's failure to use two patient identifiers also violated Board Rule 217.11(1)(B). According to Ms. Sinay, using two patient identifiers prior to administering medicine is a basic function that every nurse learns in nursing school, and its purpose is to promote safety and to guard against errors like the one at issue.

Because she administered a blood product to Patient A that was meant and labeled for another patient, Ms. Sinay concluded that Ms. Daniel also violated Board Rule 217.11(1)(C). Ms. Sinay stated that Ms. Daniel's conduct was not consistent with "correctly administering" medications and treatments as ordered, as required by the rule.

In her opinion, Ms. Daniel's conduct also violated the "and/or prevent complications" language of Board Rule 217.11(1)(M). Ms. Sinay explained that Ms. Daniel did not exercise the fundamentals of nursing by checking two patient identifiers; therefore, she was not acting in a way that would prevent complications for a patient.

Finally, Ms. Sinay testified that Ms. Daniel's conduct of not checking two patient identifiers is also a violation of Board Rules 217.12(1)(A), (1)(B), and (4). Specifically, not checking two patient identifiers is a "careless failure" to provide patient care consistent with the minimum standards previously set out in Board Rule 217.11. Further, not checking two patient identifiers is a "careless failure" to conform to the accepted standards in the Act, Board rules, and Ms. Daniel's environment, as implied by the policies in place, and could have endangered the patient's life, health, or safety.

After addressing each alleged violation, Ms. Sinay testified as to which Tier levels and Sanction levels of the Disciplinary Matrix she believed were appropriate for Ms. Daniel's misconduct. Ms. Sinay testified that Ms. Daniel's failure to meet nursing standards is sanctionable under both Act § 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) and § 301.452(b)(13) (failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm).

First, Ms. Sinay turned to the appropriate sanction. She stated that under the Board's Disciplinary Matrix,[22] Ms. Daniel's conduct constituted unprofessional conduct under Act § 301.452(b)(10) and was a Second Tier violation because it created a "serious risk"[23] to Patient A. Although Ms. Sinay agreed that there was no evidence that the physicians or blood bank personnel involved thought there was a serious risk to Patient A from receiving Patient B's platelets, Ms. Sinay opined that not checking for two patient identifiers constitutes, by itself, a serious risk of harm to a patient. Ms. Sinay also considered the aggravating factor of patient vulnerability because Patient A was unconscious and unable to communicate with the nurses. In her opinion, this increased Patient A's vulnerability and required Ms. Daniel to be extra prudent in making certain Patient A was receiving the correct platelets. Ms. Sinay identified mitigating factors, including that: Ms. Daniel has practiced for many years without previous discipline by the Board; Patient A was not harmed; and Ms. Daniel accepted responsibility right away and showed remorse. Ms. Sinay determined that this violation fell under Sanction Level I and opined that the less stringent sanction at this level—warning (as opposed to reprimand)—is the appropriate sanction because of the mitigating factors.

As to the allegation that Ms. Daniel violated Act § 301.452(b)(13) by failing to conform to nursing standards, Ms. Sinay undertook a similar analysis. She determined that Ms. Daniel's conduct was a Second Tier violation due to the patient risk,[24] and that Ms. Daniel should be sanctioned at Level I with a warning due to the mitigating factors.

IV. ANALYSIS

Staff argued that disciplinary sanctions consisting of a warning with stipulations, including minimal nursing supervision, remedial education courses, and a nursing jurisprudence exam were appropriate given the facts of this case. Ms. Daniels contended that, because there

[22] 22 Tex. Admin. Code § 213.33(b).

[23] First Tier violation includes an "isolated failure...resulting in no adverse patient effects," Second Tier violation includes conduct resulting in a "serious risk" to patient safety, and Third Tier violation includes conduct resulting in "serious patient harm."

[24] First Tier violation includes a "low risk of patient harm," Second Tier violation includes a "risk of patient harm," and Third Tier violation includes a "serious risk of harm."

was no harm to the patient, no evidence of a serious risk of harm, and no indication that the physicians or blood bank personnel considered the error a serious issue, this incident should have fallen under the minor incident rule found in Board Rule 217.16 and been handled in-house.[25] In the alternative, Ms. Daniel argued that mitigating factors indicated that her conduct should be sanctioned under Tier 1, which would result in remedial education and/or a $250 fine.

Staff alleged that there were multiple violations of the Act and Board rules based on one instance of conduct: Ms. Daniel's failure to use two patient identifiers before administering the platelets to Patient A. Her conduct did not meet the minimum standards of acceptable nursing practice and may have exposed Patient A to a risk of potential harm, albeit not quantified in the evidence. Because the Board's rule 217.12 defines "unprofessional conduct" to include "unsafe practice," which in turn includes a failure to practice in conformity with the minimum standards of acceptable nursing practice, this one error is facially both a violation of Act § 301.452(b)(10) (unprofessional conduct) and Act § 301.452(b)(13) (failure to meet the minimum standards of acceptable nursing practice). In reality, however, the admitted error was at bottom a failure to meet the minimum standards of acceptable nursing practice, which more directly implicates Act § 301.452(b)(13) rather than Act § 301.452(b)(10). In any event, as will be discussed below, the ALJ finds that the error is appropriately classified as a Tier I, Sanction Level I event under either subsection of the statute.

In deciding the appropriate sanction for Ms. Daniel's conduct, the issue becomes the amount of risk there was to the patient. Ms. Sinay testified that, under the Disciplinary Matrix, Ms. Daniel's conduct violating Act § 301.452(b)(10) is appropriately analyzed as a Second Tier violation because there was a serious risk to the patient. However, the ALJ was not persuaded by this argument based on the evidence presented. While administering some blood products to the wrong patient may result in serious harm to the patient (as Ms. Sinay testified), there is no credible evidence in this record that administering platelets to the wrong patient may result in serious harm, even though the platelets may be typed and matched to a specific patient. In fact,

[25] The ALJ disregarded this argument because Ms. Daniel did not raise it until her closing statement; therefore, it was not addressed by the evidence or testimony.

the evidence indicated that although the wrong platelets were administered to Patient A, a critically ill patient, no subsequent action was taken by the physicians to guard against any complications to Patient A, and Patient A was able to have surgery the next day. Furthermore, Ms. Sinay admitted that Ms. Daniel's conduct could be considered an isolated incident resulting in no adverse patient effects, which would classify the error as a First Tier violation.

Thus, the ALJ finds Ms. Daniel's violation of Act § 301.452(b)(10) was a First Tier offense because her conduct was an isolated failure with no adverse patient effects. Ms. Sinay accurately analyzed the aggravating and mitigating factors. Therefore, a Sanction Level I (remedial education and a fine of $250) sanction is appropriate under Act § 301.452(b)(10).

With regard to the alleged violation of Act § 301.452(b)(13) (failure to conform to nursing standards), the conduct is again appropriately analyzed as a First Tier violation rather than a Second Tier violation. The evidence presented by Staff does not show that there was more than a low risk of harm to Patient A from receiving the wrong platelets, for the reasons noted in the prior paragraph. Ms. Sinay accurately noted the aggravating factor of Patient A's vulnerability. Further, Ms. Sinay correctly noted the mitigating factors, including Ms. Daniel's years of practice without previous disciplinary action from the Board, the lack of harm to Patient A, and Ms. Daniel's good professional character in quickly taking responsibility for the error. Given the aggravating and mitigating factors, the ALJ finds that Sanction Level I is applicable, resulting in the imposition of remedial education and a fine of $250.

For these reasons, the ALJ recommends that Ms. Daniel be sanctioned with remedial education and a fine of $250.[26]

[26] In Staff's Formal Charges, Staff stated that they would seek to impose on Ms. Daniel the administrative costs of the proceeding, pursuant to Act § 301.461. Because Staff offered no evidence of administrative costs, no costs will be awarded.

V. FINDINGS OF FACT

1. Gwendolyn Mae Daniel is a registered nurse (RN) licensed by the Texas Board of Nursing (Board) since 1986.

2. On the night of April 12, 2015, Ms. Daniel worked for the University of Texas Southwestern Medical Center (Southwestern) as a level 2 RN in the surgical intensive care unit (ICU) and was assigned to Patient A as a one-to-one nurse during the nightshift.

3. Patient A was in critical condition after a liver transplant.

4. Patient A's physicians placed an order into the computer for Patient A to receive blood platelets, and the order was sent to the technician at the blood bank.

5. Because Patient A was in critical condition, Ms. Daniel sent another nurse to retrieve the blood platelets.

6. The nurse brought back and gave to Ms. Daniel a bag of blood platelets ordered for Patient B, rather than the platelets ordered for Patient A.

7. Ms. Daniel and the other nurse performed the first step of the two patient identifier protocol by matching the information on the requisition form for the blood platelets with the information printed on the bag of blood platelets.

8. Ms. Daniel failed to perform the second step of the two patient identifier protocol, which would have included matching the information on the bag of blood platelets with the information on Patient A's wristband.

9. Ms. Daniel did not check Patient A's wristband closely and failed to use two patient identifiers before administering the platelets to Patient A.

10. Patient A's wristband was cut off during the prior surgery and a newly-made wristband was in Patient A's room near the computer.

11. Ms. Daniel administered blood platelets ordered for Patient B to Patient A.

12. Ms. Daniel was informed of the error by Patient B's nurse.

13. There was no known actual harm to Patient A from having received the blood platelets ordered for Patient B. There were no significant changes in Patient A's vital signs. The physicians ordered no corrective action after Patient A received the platelets intended for Patient B. Patient A had surgery the following day.

14. On April 23, 2015, Ms. Daniel received verbal counseling in regards to the incident.

15. Ms. Daniel ceased working at Southwestern on July 3, 2015.

16. At Southwestern, the blood bank requires nurses to collect a type-and-screen sample on each patient, and then the blood bank will type the blood product specifically to that patient.

17. The platelets meant for Patient B were typed and matched for Patient B.

18. On February 9, 2017, the Board's staff (Staff) sent its Notice of Hearing to Ms. Daniel. The notice contained: (1) a statement of the time, place, and nature of the hearing; (2) a statement of the legal authority and jurisdiction under which the hearing is to be held; (3) a reference to the particular sections of the statutes and rules involved; and (4) a short, plain statement of the factual matters asserted.

19. The hearing convened on June 12, 2017, before Administrative Law Judge Beth Bierman in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Staff was represented by John Griffith, Assistant General Counsel. Ms. Daniel was represented by attorney Marc Meyer. The record closed at the conclusion of the hearing on the same day.

VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code ch. 301.

2. The State Office of Administrative Hearings has jurisdiction over contested cases referred by the Board, including the authority to issue a proposal for decision with proposed findings of fact and conclusions of law. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

3. Ms. Daniel received adequate and proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.

4. Staff had the burden of proof by a preponderance of the evidence. 1 Tex. Admin. Code § 155.427.

5. Ms. Daniel failed to conform to the minimum standards of acceptable nursing practice by failing to utilize two patient identifiers and administering platelets to a patient that were designated to be administered to another patient. Ms. Daniel is therefore subject to sanction. Tex. Occ. Code §§ 301.452(b)(10), (13); 22 Texas Administrative Code §§ 217.11(1)(A), (1)(B), (1)(C), and (1)(M); and 217.12(1)(A), (1)(B), and (4).

6. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license, and which may include assessment of a fine. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

7. To determine the appropriate disciplinary sanction to be imposed, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33 and the Board's Disciplinary Matrix. 22 Tex. Admin. Code § 213.33.

VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board sanction Ms. Daniels by requiring her to take remedial education and pay a $250 fine.

SIGNED July 31, 2017.

Beth Bierman

BETH BIERMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS