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

DOCKET NUMBER 507-19-6591

IN THE MATTER OF PERMANENT CERTIFICATE	**§**	**BEFORE THE STATE OFFICE**
NUMBER 664853, ISSUED TO	**§**	**OF**
TERRY DOUGLAS WILMORE	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: TERRY DOUGLAS WILMORE
C/O ELIZABETH HIGGINBOTHAM, ATTORNEY
1100 NW LOOP 410
SUITE 700
SAN ANTONIO, TX 78213

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 22-23, 2021, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Staff's recommendation to the Board regarding the PFD and order; and 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 recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

Pursuant to Tex. Occ. Code. §301.459 (a-1), an Administrative Law Judge may make a recommendation regarding an appropriate action or sanction. The Board, however, has the sole authority and discretion to determine the appropriate action or sanction.

The ALJ found that the Respondent's conduct warrants a second tier, sanction level I sanction for his violations of §301.452(b)(10) & (13)[1]. A Warning with Stipulations or a Reprimand with Stipulations is authorized by the Boards Disciplinary Matrix for a second tier, sanction level I sanction[2]. The Board agrees with the ALJ that a Reprimand with Stipulations is the most appropriate sanction in this case.

The Respondent's conduct resulted in actual harm to patients, including a delay in a blood transfusion and severe IV infiltration[3]. Respondent committed more than one violation, and the violations are very serious and involved vulnerable patients[4]. The Respondent made no attempts to correct or stop his practice deficiencies[5]. He did not show progress despite multiple interventions during his orientation, and he dismissed specific, legitimate criticisms of his practice as animosity[6]. Further, the ALJ found that, if the Respondent's practice deficiencies are not remedied, the Respondent's continued practice poses an ongoing risk to public safety[7]. Finally, it is questionable whether the Respondent can function autonomously, exercise appropriate judgment in client care, conform to applicable law, and promptly recognize and self disclose errors and omissions that affect patient health[8].

With respect to mitigating factors, the Respondent had a successful career as a flight nurse, has been practicing as a nurse for over twenty years, and appears to be practicing within standards at his current place of employment[9].

Pursuant to the Occupations Code §301.4531, when multiple violations are present, the Board must consider taking a more severe disciplinary action than would be taken for a single violation.

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e), that a Reprimand with Stipulations is the most appropriate sanction in this case.

Consistent with the ALJ's recommendation, the Board finds that the Respondent should be required to complete a nursing jurisprudence and ethics course, a documentation course, a physical assessment course, a critical thinking course, and a

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[1] See page 36 of the PFD.

[2] 22 Tex. Admin. Code §213.33(b).

[3] See page 35 of the PFD.

[4] See *id.*

[5] See *id.*

[6] See *id.*

[7] See *id.*

[8] See *id.*

[9] See pages 35- 36 of the PFD.

medication administration course[10]. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas and to prevent future violations from occurring. The Board also agrees with the ALJ that the Respondent's practice should be directly supervised for the first year of the Order and indirectly supervised for the remainder of the Order. The Board further agrees with the ALJ that the Respondent should be prohibited from working in independent practice settings, like home health or hospice. These supervisory requirements are intended to prevent additional violations from occurring and to ensure that any deficiencies in the Respondent's practice can be discovered quickly and remediated appropriately. The Board also agrees with the ALJ that the Respondent should be required to inform his employers of this Order and to submit quarterly employer reports to the Board so the Board can monitor the Respondent's progress and completion of the Order. These requirements are consistent with 22 Tex. Admin. Code §213.33(e)(4)[11].

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

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 Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Order.

II. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp. Upon successful completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

III. REMEDIAL EDUCATION COURSE(S)

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[10] 22 Tex. Admin. Code §213.33(f) requires every order issued by the Board to include participation in a program of education, which at a minimum, shall include a review course in nursing jurisprudence and ethics.

[11] 22 Tex. Admin. Code §213.33(e)(4), which authorizes reasonable probationary stipulations that may include remedial education courses and practice for at least two years under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings.

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 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. **A Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. Home study courses and video programs will not be approved.

D. **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.

E. **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.*

IV. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. 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. **Direct Supervision.** For the first year [four (4) quarters] of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

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

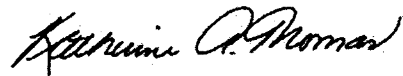
E. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

V. 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, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, RESPONDENT may be eligible for nurse licensure compact privileges, if any.

Entered this 22nd day of April, 2021.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; 507-19-6591 (February 22, 2021)

STATE OFFICE OF ADMINISTRATIVE HEARINGS RECEIVED ON 2/22/2021 10:06 AM

ACCEPTED
507-19-6591
02/23/2021 9:23 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Donnie Roland, CLERK

FILED
507-19-6591
2/22/2021 10:06 AM
STATE OFFICE OF
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Donnie Roland, CLERK

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State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

February 22, 2021

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

VIA EFILE TEXAS

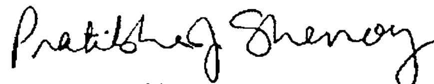
RE: Docket No. 507-19-6591; Texas Board of Nursing v. Terry Douglas Wilmore, RN

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, a SOAH rule which may be found at www.soah.texas.gov.

Sincerely,



Pratibha J. Shenoy
Administrative Law Judge

PJS/eh

xc: Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD) – **VIA EFILE TEXAS and INTERAGENCY MAIL**
Elizabeth L. Higginbotham, R.N. J.D., Higgenbotham & Associates, LLC, One Castle Hills, 1100 NW Loop 410, Suite 700, San Antonio, TX 78213 – **VIA VIA EFILE TEXAS**

SOAH DOCKET NO. 507-19-6591

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
	§	
	§	
v.	§	OF
	§	
TERRY DOUGLAS WILMORE, RN	§	
Respondent	§	ADMINISTRATIVE HEARINGS

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SOAH DOCKET NO. 507-19-6591

TEXAS BOARD OF NURSING,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
TERRY DOUGLAS WILMORE, RN	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The Staff of the Texas Board of Nursing (Board) seeks to sanction the Registered Nurse (RN) license held by Terry Douglas Wilmore (Respondent) based on allegations of substandard practice and unprofessional behavior in patient care, medication administration, and documentation. Staff argues Respondent should be sanctioned with a Reprimand and a two-year order with stipulations (Order). The Administrative Law Judge (ALJ) concludes that Staff proved its allegations by a preponderance of the evidence and recommends the Board issue a Reprimand and Order with terms described below.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

ALJ Pratibha J. Shenoy convened the hearing via videoconference September 28-30, 2020. Deputy General Counsel Jena Abel represented Staff. Respondent appeared and was represented by attorney Elizabeth Higginbotham. The record closed December 21, 2020, after submission of written closing arguments.[1] Matters of notice and jurisdiction were undisputed and are therefore set out in the Findings of Fact and Conclusions of Law without further discussion.

II. APPLICABLE LAW

The Texas Nursing Practice Act, found in chapter 301 of the Texas Occupations Code (Code), empowers the Board to discipline licensees for, among other things, unprofessional conduct (Code § 301.452(b)(10)), or practice below minimum standards of acceptable nursing

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[1] SOAH was closed due to bad weather February 16-19, 2021, delaying the issuance of this Proposal for Decision.

practice (Code § 301.452(b)(13)). Staff asserts that Respondent's conduct is grounds for disciplinary action under both Code provisions, as well as pursuant to a number of Board rules.[2] With respect to unprofessional conduct, Staff asserts Respondent failed to comply with:

- **Board Rule 217.12(1)(A)**: careless or repeated failure or inability to practice in conformity with minimum standards set out in Board Rule 217.11.[3]
- **Board Rule 217.12(1)(B)**: careless or repeated failure to conform to generally accepted nursing standards in applicable practice settings.
- **Board Rule 217.12(4)**: careless or repetitive conduct that may endanger a client's life, health, or safety, without the need for actual injury to a client to be established.

With respect to minimum standards of nursing practice, Staff alleges Respondent did not comply with provisions that require a nurse to:

- **Board Rule 217.11(1)(A)**: know and conform to the Texas Nursing Practice 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.
- **Board Rule 217.11(1)(B)**: implement measures to promote a safe environment for clients and others.
- **Board Rule 217.11(1)(C)**: know the rationale for and the effects of medications and treatments and correctly administer the same.
- **Board Rule 217.11(1)(D)**: accurately and completely report and document required matters, including client status, care rendered, doctors' orders, medications and treatments administered, client response, and contacts with other members of the health care team.
- **Board Rule 217.11(1)(M)**: institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.

[2] For ease of reference, the Board's rules, found in title 22, chapters 211 to 228 of the Texas Administrative Code, shall be referred to in the text as "Board Rule ____."

[3] A number of subsections of Board Rule 217.12 were amended effective February 25, 2018, and October 17, 2019. Citations to the rule are to the version in effect in July 2017, when the conduct at issue occurred.

Board Rule 213.33 sets out a disciplinary matrix (Matrix) intended to match the severity of the sanction imposed to the nature of the violation, taking into account mitigating and aggravating factors listed in the Matrix.[4] The Matrix categorizes violations into tiers and into sanction levels within tiers, based on the seriousness of the offense and risk of harm to patients or the public. Board Rule 213.33 includes another list of factors that the Board and the State Office of Administrative Hearings (SOAH) must consider in determining the appropriate disciplinary sanction, including evidence of potential harm to patients or the public and evidence of present fitness to practice.[5]

Staff had the burden of proving its allegations by a preponderance of the evidence, and Respondent has the burden of proving mitigating factors, if any.[6]

III. STAFF'S FORMAL CHARGES AND BACKGROUND

Staff's two charges in this case relate to Respondent's treatment of pediatric intensive care unit (PICU) patients in July 2017, when he was working as a Staff Nurse at Children's Medical Center in Dallas (Children's). Charge 1 alleges that on July 9, 2017, Respondent failed to timely administer a "stat" blood infusion to Patient A[7] and did not notify the treating physician of the delay, and also failed to administer a fentanyl drip at the prescribed rate. Charge 2 asserts that on July 24, 2017, Respondent did not monitor the intravenous (IV) site where Patient B[8] was being administered fluids and sedation, failed to accurately document his assessments of the IV site, and did not notify the physician that the IV site had become infiltrated (fluids were infusing into the patient's tissues instead of into the bloodstream, causing swelling and irritation at the IV site).

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[4] 22 Tex. Admin. Code § 213.33(b); *see also* Tex. Occ. Code § 301.4531 (requiring the Board to adopt a schedule of sanctions). Parts of 22 Texas Administrative Code § 213.33 were amended effective April 1, 2019, but the changes do not alter the analysis in this Proposal for Decision.

[5] 22 Tex. Admin. Code § 213.33(c).

[6] 1 Tex. Admin. Code § 155.427.

[7] The patient referred to herein as Patient A is identified in the record as Patient Number 4207093.

[8] The patient referred to herein as Patient B is identified in the record as Patient Number 4169606.

The following background facts are undisputed. Respondent lived in Hawaii in his youth, but moved home to Texas when his grandfather became ill with lung cancer.[9] While helping care for his grandfather, Respondent realized nursing was "the perfect profession" for him.[10] In 1996, Respondent began working as a valet, parking cars at Texas Children's Hospital in Houston (TCH) "just to get [his] foot in the door." After a few months, he was hired in the guest services department of TCH, helping escort patients to and from procedures. He then moved to the PICU as a patient-care assistant, a job he held for two years while he attended nursing school. In 1999, Respondent obtained his RN license and was hired at TCH as a PICU nurse. After a year of bedside nursing in the PICU, Respondent joined the transport team.

Respondent explained that the transport team consists of a nurse and a respiratory therapist who accompany pilots to reach patients in rural or remote areas and take them safely back to the hospital. Because no physician accompanies the transport team, Respondent was trained in intubation and advanced techniques for maintaining patient airways, placing IV lines in premature infants, placing intraosseous (in the bone) IV lines, and inserting chest tubes, among other things. Respondent worked as a transport nurse for nearly 20 years, when an opportunity arose for him and his wife, Jonné Wilmore, to move to Hawaii. He secured a job as a flight nurse, and Ms. Wilmore was hired as an advanced practice RN (APRN).

Respondent felt his fond memories of Hawaii were a far cry from what he and Ms. Wilmore encountered when they arrived there. He found the experience "very traumatizing" and "not what [he] expected at all." After six months, they decided to move back to Texas, and chose Dallas, where Ms. Wilmore is from. Respondent secured the PICU position at Children's, and his wife was also hired there, as an APRN. Ms. Wilmore's contract in Hawaii required her to remain for several more months, so Respondent moved to Dallas alone. He said he "left all [his] things, [his] wife, [and his] dogs," and arrived in an unfamiliar city with "no furniture [and] no car." In addition, Respondent perceived that he "immediately was treated like an outsider" at Children's, where he

[9] Transcript of the Hearing on the Merits (Tr.) at 449. The transcript was prepared in three volumes, but the pages are numbered sequentially across the volumes. Accordingly, the volume numbers are omitted.

[10] The remainder of this section is summarized from Respondent's testimony at pages 449-57 of the transcript. This testimony was uncontested; therefore, specific citations to the transcript are not included.

"didn't know anybody or anything about" the hospital. He had been hired after a telephone interview, so he had no previous face-to-face contact with any of the staff.

After a week of hospital-wide orientation classes in April 2017, Respondent was rotated through various positions in the PICU with preceptors (established nurses at Children's). The training included the use of Epic, the electronic medical record system for Children's. When he provided care in July 2017 to the two patients who are the subject of Staff's charges, Respondent was solely responsible for the patients without an assigned preceptor. Respondent was fired by Children's in August 2017. As discussed below, he maintained that his employment was terminated out of animosity and as retaliation for his reports about another nurse's practice.

III. DISCUSSION

Staff called six witnesses. Respondent testified on his own behalf and called his wife as a witness. Twelve exhibits were admitted for Staff and six for Respondent, as specified on the evidentiary certification.

To simply this discussion, the testimony of the various witnesses is grouped by charge. For Charge 1, the fact witnesses were Margaret Giddens, RN, and Respondent. For Charge 2, the fact witnesses were Christa Rogers, RN, and Respondent. For both charges, Kimberly Clipp, RN, MSN, DNP, testified as an expert for Staff on the standard of care. Ms. Wilmore testified for Respondent as an expert on the standard of care. She also testified as a fact witness on matters within her personal knowledge. The aggravating and mitigating circumstances, as well as Respondent's assertion of unfair retaliation, are discussed after the charges. The ALJ's analysis of each charge and of the aggravating and mitigating circumstances immediately follows the related evidence. The sanction analysis is in Section IV and includes testimony from Kristin Benton, RN, MSN, DNP, a practice consultant for Staff, who testified regarding the appropriate sanction if the ALJ found the facts support Staff's charges.

A. Charge 1

Ms. Giddens has worked at Children's in the PICU since she obtained her nursing license in 2008. She testified that at shift change, the outgoing nurse gives a report on each patient to the oncoming nurse, lasting 40 to 45 minutes on average. They review the patient's medications, do "a quick head-to-toe" together, and discuss any outstanding doctors' orders.[11] Nurses in the PICU are typically assigned one patient but may be assigned to cover two patients depending on patient acuity and staffing needs. On July 9, 2017, Ms. Giddens was working the day shift, from 7:00 a.m. to 7:00 p.m., and took over care for two patients assigned to Respondent, including Patient A.

1. Fentanyl Drip

Ms. Giddens said that when care is being transferred for a patient who has an IV, both nurses do a "drip check," which includes ensuring the IV line is infusing with the correct medications and at the correct rate, and tracing the line from the pump to the insertion site.[12] Fentanyl is a "high-risk medication" and requires a drip check each time a new syringe is started. Each nurse must independently confirm that the pump settings match the order and the "three Cs, which are the clamps, connection, and concentration, are correct."[13] Any wasted fentanyl must be measured and disposed of by two nurses.[14]

According to Ms. Giddens, Respondent told her he had started a new fentanyl syringe for Patient A earlier that morning and he used the "restore settings" option on the IV pump.[15] She testified that she found Respondent's verbal report to be unclear, so they looked up the medication order and "confirmed that the fentanyl infusion was indeed at the wrong rate, and [then they]

[11] Tr. at 122.

[12] Tr. at 148-49.

[13] Tr. at 150-51.

[14] Tr. at 151.

[15] Tr. at 150.

corrected the problem together."[16] The order for fentanyl was written for 1 microgram per kilogram of patient weight per hour (mcg/kg/hr), and Ms. Giddens said it was set at 1.33 mcg/kg/hr, a faster rate than prescribed.[17]

Per Ms. Giddens, choosing "restore settings" will reset the IV pump back to the last programmed settings for the rate and dose of the drug. For example, if the pump is set to infuse at 1.33 mcg/kg/hr when a new syringe is attached, pressing "restore settings" will reset the pump to 1.33 mcg/kg/hr. The danger, Ms. Giddens pointed out, is that if the restore settings function is used and "it was at the wrong setting before, it will continue to be at the wrong setting."[18]

It appeared to Ms. Giddens that the wrong setting on the pump was not detected during Respondent's shift because Respondent had not gotten a second nurse to sign off on the new syringe of fentanyl that he documented starting at 6:22 a.m. She explained that if a second nurse does not sign off on this type of entry, the entry will remain pending in the system and will "continuously pop up" as a reminder. Respondent's entry was still pending.[19] According to Ms. Giddens, when she confirmed with Respondent that he had set the pump at the wrong rate, he said "write me up for it" and left the PICU.[20]

Ms. Giddens testified that the morning was very busy and, because her second patient was in acute distress, another nurse took over the care of Patient A.[21] She explained that is why she did not have time to make an entry in Epic concerning Patient A's drip check error until 9:56 a.m., but she pointed out that the entry correctly reflected that the check was done at 7:26 a.m. and it was done with Respondent.[22] In addition, she wrote an email the same day to document the fentanyl

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[16] Tr. at 122.

[17] Tr. at 150.

[18] Tr. at 153.

[19] Tr. at 156-57.

[20] Tr. at 186.

[21] Tr. at 180-81.

[22] Tr. at 156-57.

drip error, as well as Respondent's failure to timely administer blood (discussed below), and sent it to her supervisor, Respondent's team leader, and the unit educator.[23]

Respondent testified that he recalled starting a new syringe for Patient A at 6:22 a.m. as documented in the records. He said he did not specifically remember having another nurse cosign the new syringe, but it was not his habit to skip any part of the process, especially because fentanyl is "a narcotic and it's very important" to document accurately.[24] At the 7:00 a.m. shift change, Respondent recalled giving a report to Ms. Giddens because he had not met her before, and she "immediately approached [him] with an attitude" and gave him "a hard time during report."[25] Respondent agreed that they did a drip check together, but he denied the pump was infusing at the wrong rate or any other problems were discovered. He said he would have been notified about a narcotic discrepancy by a manager or supervisor and he was never told of such an error.[26]

Dr. Clipp[27] testified that a higher rate of infusion for a narcotic medication increases the patient's degree of sedation. She noted that Patient A's records reflected a plan to wean the baby from the fentanyl drip so she could be sent home.[28] Setting a narcotic drip at a higher rate than prescribed could cause "a setback in the weaning protocol" because weaning is done slowly to avoid drug withdrawal symptoms.[29] In Dr. Clipp's opinion, if the facts support Ms. Giddens's account of events, Respondent failed to meet the standard of care because he set the fentanyl drip at the incorrect rate (1.33 mcg/kg/hr) but documented that it was running at the correct rate (1 mcg/kg/hr) throughout his shift. She also found a failure to meet minimum standards because,

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[23] Tr. at 158-59; Staff Ex. 7 at 11.

[24] Tr. at 489.

[25] Tr. at 491.

[26] Tr. at 493.

[27] Dr. Clipp holds a bachelor's degree, a master's, and a doctoral degree, all in nursing. Dr. Clipp's qualifications are contained in her *curriculum vitae* (Staff Ex. 12) and are discussed in the transcript at pages 337-357. She was accepted by the ALJ as an expert in the field of neonatal nursing, which includes primary, acute, chronic, and critical care to patients under the age of two. Tr. at 357.

[28] Tr. at 373.

[29] Tr. at 373, 376.

after he was notified of the error, he did not alert a charge nurse or physician about the mistake so that they could take any necessary corrective steps.[30]

Ms. Wilmore[31] testified that, after considering the medical records and witness testimony, she believed Respondent "infused the drip per the orders at the correct rate throughout his shift until he left for the day."[32] She based her opinion in part on the fact that Ms. Giddens did not document a "rate change" but instead made an entry for a "rate verify"[33] with a note referring to the drip being found running at 1.33 mcg/kg/hr instead of 1 mcg/kg/hr. In addition, Ms. Giddens's entry was made at 9:56 a.m. but it states the drip check was done at 7:26 a.m. Ms. Wilmore contended that, if Respondent had admitted to setting the incorrect rate as Ms. Giddens claimed, he would have cosigned the entry, and it would have been made before he left his shift.

2. Blood Order

Children's has a multi-step process for administering a blood product, as described by Ms. Giddens. First, if necessary, blood is drawn from the patient for a "type-and-screen" test (T/S), which confirms that the blood products ordered for the patient are correctly matched to the patient's blood type.[34] The T/S blood draw is sent to the in-house lab. Once the results of the T/S are obtained, the nurse sends a pickup slip through a pneumatic tube system to the hospital's blood bank, which alerts the blood bank that the nurse is "ready to receive the product and administer it."[35] The blood bank sends the package of blood back through the pneumatic tube system and the nurse enters a code to retrieve the blood.

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[30] Tr. at 374-75.

[31] Ms. Wilmore holds bachelor's degrees in psychology and nursing and a master's degree in nursing, and she is currently enrolled in a doctoral program in nursing. Her qualifications are contained in Respondent Exhibit 7 and are discussed in the transcript at pages 588-601. She was accepted by the ALJ as an expert in pediatric acute care nursing.

[32] Tr. at 639.

[33] Tr. at 646.

[34] Tr. at 125.

[35] Tr. at 126.

This basic process—sending the T/S blood draw to the blood bank, waiting for the T/S results, and then sending the pickup slip—has some exceptions. According to Ms. Giddens, the PICU has a "neonatal protocol" allowing a T/S for a patient under four months of age[36] to be valid from the time it is taken until the patient is four months old or discharged, whichever occurs first. For older patients, a T/S is valid for 72 hours. Because Children's is a teaching hospital, the physicians are at various stages of training, including interns, residents, fellows, and attending physicians. Ms. Giddens said the "more experienced doctors know... that not every patient needs a new type-and-screen."[37] However, less experienced doctors may order a T/S every time a blood product is ordered. The practice for PICU nurses is to check the lab results already in a patient's file to see if a valid T/S exists.[38] This is important, Ms. Giddens explained, because if a patient has low hemoglobin, "the last thing you want to do is draw more blood."

The blood administration process is also accelerated if the order is marked "stat." Ms. Giddens distinguished a "routine" order, which might be used if a patient "had low blood counts from surgery loss that weren't critical," from a stat order, which "usually means that the patient's care is dependent on receiving the blood[.]"[39] Given the increased importance of a stat order, Ms. Giddens said the nurse should send the T/S order, the blood she has drawn for the T/S test, and the pickup slip for the blood product all at the same time to the blood bank.[40] She added that if a new T/S is not required under the neonatal protocol, drawing one will unnecessarily delay the administration of blood.[41]

Ms. Giddens said Patient A's electronic medical records reflect two orders entered by a physician at 4:33 a.m. on July 9, 2017: one for a T/S test and one for stat administration of packed

[36] Initially, Ms. Giddens said that the cutoff date for requiring a new T/S was six months of age. Tr. at 130. Subsequently, Ms. Giddens reviewed the policy (Staff Exhibit 9 at 1) and stated that the actual cutoff is four months. However, Patient A was three months old, so she still would not have required a new T/S. Tr. at 212.

[37] Tr. at 140.

[38] Tr. at 211.

[39] Tr. at 125.

[40] Tr. at 141.

[41] Tr. at 139.

red blood cells.[42] The records show that Respondent acknowledged the orders at 4:57 a.m. Ms. Giddens testified that when Respondent gave her his report on Patient A, he told her he had drawn blood for a T/S test, but he had not yet received the T/S results or sent a pickup slip to the blood bank. She said Respondent did not advise her the blood order was marked stat.[43] When she logged into the medical records system and realized the blood was a stat order, Ms. Giddens sent the pickup slip to the blood bank immediately, at 7:39 a.m.[44] Later that morning, when the physicians began doing their morning rounds, Ms. Giddens alerted Patient A's care team that the blood administration had been delayed.

Respondent testified that as soon as he acknowledged the order for a T/S and blood administration, he went into Patient A's room and drew blood for the T/S test.[45] He believed that he would be called by the blood bank when the T/S results were available, and said he did not realize that he needed to check the Epic system for the results.[46] Respondent remembered viewing Patient A's records and finding a previous T/S, but he did not recall checking the date of that T/S test.[47] He also recalled that Patient A had received a blood transfusion the previous day, but he was unsure if there was a T/S in the records for that transfusion.[48]

As a general matter, Respondent agreed that a nurse has a duty to question a physician's order if the nurse believes it may pose a risk to the patient, including if the order is contraindicated by facility policy.[49] However, he said, he had no reason to question the T/S order and he was following the doctor's orders by drawing a new T/S sample. He added that, prior to the shift change, a physician had come by Patient A's room and had talked "very nonchalantly about giving

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[42] Tr. at 136, 138-39.

[43] Tr. at 124.

[44] Tr. at 143.

[45] Tr. at 492.

[46] Tr. at 559.

[47] Tr. at 580 (citing Staff Ex. 6 at 44-46).

[48] Tr. at 533.

[49] Tr. at 532.

blood on a patient that receives [it] daily or every two days, and everybody knew that," so he "would not question her" about the need for a T/S.[50]

While he was waiting for the T/S results to come back, Respondent did not send the pickup slip to the blood bank as a proactive measure. He said he was not familiar with the pickup slip process because it was the first time one of his patients at Children's had required blood. He remembered asking another nurse about the process and "there was never a mention of sending a blood bank form down."[51] Also, in Respondent's experience at other facilities, the blood bank would notify the nurse when the blood product was ready.[52]

Respondent denied that the marking of "stat" on the blood order meant that there was an urgent need to give blood. He first agreed that "stat" means "as soon as possible," but later clarified that "a stat order doesn't mean as soon as possible; there's a difference."[53] Rather, he explained, stat means "as soon as you can get it" and, for Patient A, it meant he was required to administer the blood "as soon as [it] was ready."[54] He added that in Patient A's records, there is a line stating "Begin Transfusion As soon as available."[55]

Dr. Clipp testified that it is common practice to get one T/S test for a neonatal patient "right off the bat so that you can give them blood whenever you need to."[56] It is "pretty standard" for hospitals to have a cutoff at four months of age, after which a new T/S is required more frequently. Performing a T/S when it is unnecessary can cause harm, according to Dr. Clipp. A baby who already has low hemoglobin levels should not have more blood taken without good reason, and every injection presents the possibility of pain and infection, especially in an immunocompromised

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[50] Tr. at 553.

[51] Tr. at 529.

[52] Tr. at 551.

[53] Tr. at 572.

[54] Tr. at 549-50.

[55] Tr. at 559.

[56] Tr. at 366.

infant.[57] The bottom line is that "you don't want to stick a baby again for a screen that's already available and usable."[58] Dr. Clipp stated that Patient A's hemoglobin level of 6.9 was "severely low," making it inadvisable and possibly harmful to obtain a T/S if it was not strictly necessary.[59] As the advocate for patients, the nurse is responsible for asking the doctor, "are you sure this [a new T/S] is what you want, because we already have one, and you do not need another one."[60]

With respect to stat orders, Dr. Clipp testified that knowing the meaning of "stat" is "a basic nursing skill"[61] and the term is commonly understood in nursing as meaning "it's critical that [the order] gets done."[62] If a nurse is busy or unable to carry out a stat order, the nurse has the obligation to seek help from other nurses or a charge nurse/supervisor. If a stat order cannot be completed promptly, the nurse must notify the provider so the provider can change the plan of care, if necessary.[63] Dr. Clipp noted that Patient A was being prepared for extubation, meaning that the physicians wanted to see if she could breathe on her own. Without adequate hemoglobin levels, Patient A's ability to breathe unassisted would be impaired.[64] Therefore, the blood needed to be administered expeditiously, or else the provider needed to be notified. In Dr. Clipp's opinion, Respondent should have been able to start the blood infusion within an hour.[65]

Ms. Wilmore disagreed with Dr. Clipp's testimony regarding a nurse's obligation to question a doctor's order for a T/S if the screen is already on file and is potentially unnecessary. She said a nurse has a duty to question a provider's order if there are indications that the order would hurt or harm the patient or if the nurse requires clarification.[66] Otherwise, a nurse "needs to

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[57] Tr. at 367-68.

[58] Tr. at 367.

[59] Tr. at 360.

[60] Tr. at 418.

[61] Tr. at 362-64.

[62] Tr. at 362.

[63] Tr. at 362-63.

[64] Tr. at 371-72.

[65] Tr. at 369.

[66] Tr. at 732-33.

follow the doctor's orders, if they are safe and appropriate orders."[67] Ms. Wilmore said it is not her practice to write a T/S for every blood order,[68] but it is in the ordering provider's discretion to require one.[69] She opined that by following the T/S order for Patient A, Respondent provided an additional safeguard to ensure the correct blood products were ordered and administered.[70]

Ms. Wilmore has used Epic at various employers. She testified that Epic permits providers to designate their orders as routine, or "ASAP, which is more [urgent] than routine," or "stat, which is more [urgent] than ASAP."[71] She stated that a provider has access to view the status of a lab order, so the ordering physician could have seen that Patient A's T/S test results were in process and had not been completed, and that the blood administration had not started.[72] However, she agreed that it remains the nurse's responsibility to monitor the patient records for new test results and to ensure the blood is administered promptly.[73]

3. ALJ's Analysis of Evidence for Charge 1

The ALJ finds that Staff proved the matters alleged in Charge 1 by a preponderance of the evidence. With respect to the fentanyl drip, Ms. Giddens testified persuasively that she looked up the order in Respondent's presence, verified the correct rate of 1 mcg/kg/hr, and corrected the pump, which was set at 1.33 mcg/kg/hr. The fact that Respondent admitted using "restore settings" and did not get a second nurse to cosign his syringe change that morning makes it very likely that the fentanyl was running at the wrong rate for that portion of his shift, if not the entire shift.

Although Ms. Giddens classified the fentanyl drip error as a "rate verify" rather than a "rate change," her comments in the medical record are unequivocal and state that the incorrect rate was

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[67] Tr. at 739.

[68] Tr. at 739.

[69] Tr. at 607.

[70] Tr. at 633-34.

[71] Tr. at 605.

[72] Tr. at 739-41.

[73] Tr. at 741.

"changed with offgoing RN to correct rate."[74] That documentation was made contemporaneously with the events in question and within a reasonable amount of time (at 9:56 a.m.) given Ms. Giddens's need to care for another acutely ill patient. Respondent's contention that he was never notified about a narcotic discrepancy is hard to reconcile with Ms. Giddens's testimony that she changed the pump in his presence, documented it in the record, and notified her supervisor and Respondent's team leader of the matter the same day.

With respect to the blood transfusion, Ms. Giddens and Dr. Clipp explained that a neonatal protocol that allows a T/S to be valid until four months of age protects very young, very fragile babies by avoiding unnecessary blood draws. Each injection poses the risk of injury, pain, and infection, especially in immunocompromised infants. As a PICU nurse, it was Respondent's responsibility to be aware of the neonatal protocol and, if it appeared a T/S test was unnecessary, to question the ordering provider. At a minimum, Respondent should have asked a colleague or charge nurse for help or looked up the policy on the computers available in each patient room.

Respondent suggested that a provider's "nonchalant" remark about giving blood very frequently to Patient A could somehow relieve him of the responsibility of verifying that the neonatal protocol was being followed for T/S blood draws. He testified that he saw a T/S on file for the patient, but he did not recall checking the date. He also said he was aware that Patient A had received a transfusion the previous day, but that did not prompt him to consider whether he should talk to the provider before drawing blood again. Respondent's actions call into question his ability to think critically when providing nursing care for very vulnerable patients.

The ALJ notes that all of the nurses who testified—including Ms. Wilmore—agreed that "stat" means the order is urgent, critical, and must be implemented right away. Respondent quibbled regarding what "stat" meant in the context of the blood order. If he did not know what stat meant for this order, he should have asked a peer or the provider for clarification. Or, if Respondent *did* understand that stat indicated urgency, he should have taken steps to expedite all parts of the blood ordering and administration process. He admitted he did not know that he needed

74 Tr. at 741.

to check Epic to see when the T/S results were ready. He also acknowledged not knowing how the blood bank operated at Children's. He assumed that the process would be the same as at his former employer, where the blood bank would call when the blood was ready. During shift change, he did not advise Ms. Giddens that the blood order he was waiting for was a stat order. She only learned that from looking up the records herself.

Respondent argued that Ms. Giddens and others were biased and charges were trumped up to retaliate for his reporting of a colleague (discussed below), but the facts do not support such a claim. Ms. Giddens is a nurse who had a decade of experience in the PICU before the date of the incident with Patient A. She documented in writing her findings regarding the incorrect drip rate and the delay in administering blood and sent the report to her supervisor and Respondent's team leader the same day. Such accusations, if false, would put Ms. Giddens's own employment and licensure at risk, and there is no evidence she had motive to do so.

Based on the facts established by a preponderance of the evidence, the ALJ concludes that Respondent's conduct was unprofessional within the meaning of Code § 301.452(b)(10), as specified further by Board Rules 217.12(1)(A), (B), and (4).[75] However, the ALJ finds the facts in this case are more squarely encompassed by Code § 301.452(b)(13), which addresses a failure to meet minimum standards of nursing practice, specifically:

- Board Rule 217.11(1)(B): Respondent did not provide a safe environment for his client because he programmed the fentanyl drip at a rate faster than prescribed and did not administer a stat blood order to a patient with severely low hemoglobin;
- Board Rule 217.11(1)(C): Respondent did not correctly administer medications and treatments, specifically the fentanyl drip and the blood transfusion;
- Board Rule 217.11(1)(D): Respondent's documentation was inaccurate (stating that the fentanyl drip was running at 1 mcg/kg/hr when it was actually running at 1.33 mcg/kg/hour) and he did not accurately report required information (that the

[75] Respondent's conduct is covered by Board Rule 217.12(1)(A) (a failure to comply with minimum standards set forth in Board Rule 217.11, as discussed below); Board Rule 217.12(1)(B) (a failure to conform to generally accepted nursing standards in applicable practice settings); and Board Rule 217.12(4) (careless conduct that endangered a client's life, health, or safety).

blood transfusion was a stat order) to another member of the health care team (Ms. Giddens); and

- Board Rule 217.11(1)(M): by running the fentanyl drip at the wrong rate, taking an unnecessary T/S blood draw, and delaying the blood transfusion, Respondent failed to institute appropriate nursing interventions to stabilize a client.[76]

B. Charge 2

1. Evidence

Ms. Rogers has held an RN license in Texas for 10 years, and also holds a critical care RN certificate in pediatrics. She has worked in the PICU at Children's since 2010. She arrived for her day shift (7:00 a.m. to 7:00 p.m.) around 6:45 a.m. on July 24, 2017, and received a report on Patient B from Respondent, who had cared for him overnight.[77] Ms. Rogers said that Patient B had an IV inserted in the dorsal vein on his right foot.[78] He was receiving IV Precedex and Versed, which are both sedating medications, as well as fentanyl for pain.[79] Ms. Rogers explained that the IV site for a PICU patient is covered with a transparent dressing over the insertion site so that it can be viewed without having to remove any of the dressing or securing tape.[80] She stated that an IV site is required to be monitored on an hourly basis.

Nurses must check for phlebitis (an irritation of the blood vessel) and infiltration (fluid from the IV infusing into the surrounding tissue instead of the vein).[81] Nurses also check the pedal pulse (the pulse on the top of the foot) and assess it on a scale of zero to "three-plus," with zero

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[76] The ALJ does not find a violation of Board Rule 217.11(1)(A), which generally requires a nurse to know and conform to the Act and Board Rules. Respondent's violations of the Act and Rules are already covered by the specific subsections of Board Rule 217.11(1) cited here.

[77] Tr. at 14-15.

[78] Tr. at 33.

[79] Tr. at 17.

[80] Tr. at 21.

[81] Tr. at 19.

indicating that the nurse cannot feel a pulse and "two-plus" indicating a normal pulse.[82] If a pulse cannot be felt by hand, the nurse can use a Doppler device to hear the pulse.[83] The nurse also checks capillary refill, which is the time it takes for color to return after the skin is pressed. Less than three seconds is considered a good capillary refill rate for the PICU patients.[84] Ms. Rogers explained that capillary refill is a measure of blood circulation.

Infiltration in an IV site can be detected by comparing the insertion site to the other extremity, Ms. Rogers stated. She said that since Patient B had an IV in his right foot, the nurse would compare the right and left feet to see if the right foot appeared larger or swollen, the skin on the right foot was becoming more taut than the skin on the left foot, and if a temperature differential could be felt.[85] Ms. Rogers noted that Versed is considered a "high-risk vesicant," meaning that if it infiltrates into the tissues, there is a high risk of damage or injury.[86]

Ms. Rogers testified that when she went into Patient B's room with Respondent, they started by checking the doctor's orders and the IV pump and confirmed that the medications were infusing at the correct rate.[87] Respondent told Ms. Rogers that the IV site was transfusing properly with no issues overnight, Patient B's pulses were two-plus, and his capillary refill was less than three seconds.[88] Respondent also said that because Patient B was scheduled for an MRI exam that morning, he had attached longer tubing to the pump.[89] Ms. Rogers explained that the IV pump cannot be taken into the MRI room, so very long tubing is used to allow the IV pump to remain outside the room while the test is being done.[90]

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[82] Tr. at 24.

[83] Tr. at 25.

[84] Tr. at 17, 54.

[85] Tr. at 20.

[86] Tr. at 58-59.

[87] Tr. at 18.

[88] Tr. at 17.

[89] Tr. at 22.

[90] Tr. at 45.

Before Respondent and Ms. Rogers could look together at the IV site on Patient B's foot, an alarm for Ms. Rogers's other patient began sounding, so she left to check on it. When she returned to Patient B's room, Respondent had left the PICU. Ms. Rogers said she pulled back a blanket that had been covering Patient B's legs and realized his right leg was "significantly swollen" up to his knee, the right foot felt "very cold to the touch" and was pale compared to the left foot, and the "blanket below the foot was wet from fluids seeping out of the IV site."[91] Ms. Rogers could not feel a pulse in the right foot, so she got a Doppler device, which allowed her to confirm that there was still an audible pulse.[92] The capillary refill was five seconds.[93] She "knew immediately that [the IV site] was infiltrated," so she clamped the IV line to stop the infusions, and notified the IV team and the physician.[94] She explained that the IV team is a specialized team of nurses that has expertise in placing difficult IVs and treating infiltrates.[95]

The IV team examined the infiltration in Patient B's foot and graded it as "severe" at 8:58 a.m.[96] Patient B's leg was measured as 25 centimeters (cm) in length, and the edema (swelling) on his leg was measured as extending 17 cm, or "68% of the extremity being edematous."[97] The phlebitis (irritation of the vessel, indicated by redness and swelling) was rated as a "2," where zero indicates no phlebitis.[98] Ms. Rogers testified that in the seven years she had been working at Children's at that time, she had never seen an infiltration site that looked "as bad as [Patient B's]."[99]

Reviewing the documentation for Patient B, Ms. Rogers noted that Respondent had documented a check of the IV site every hour during his overnight shift until 5:38 a.m., when he

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[91] Tr. at 22.

[92] Tr. at 54.

[93] Tr. at 22.

[94] Tr. at 26-27.

[95] Tr. at 26.

[96] Tr. at 28.

[97] Tr. at 47; Staff Ex. 5 at 84.

[98] Tr. at 62.

[99] Tr. at 65.

added the long tubing for the MRI.[100] After that, he documented checking the IV site twice; the next entry is at 7:40 a.m., when Ms. Rogers documented that she found the infiltration and stopped the IV.[101] Each of Respondent's entries for the pedal pulse were "two-plus." He entered "elastic" for skin turgor for every IV check until 6:14 a.m., when he entered "taut."[102] Ms. Rogers said that the change from elastic to taut is a change in condition that would trigger a nurse's responsibility to notify a provider, but there is no indication that Respondent did so.[103] Respondent documented phlebitis scores of "zero" for each IV check, but Ms. Rogers graded the phlebitis as "2" at 7:41 a.m., and the IV team nurse graded it as "2" at 8:35 a.m.[104] The score of 2 indicates pain at the IV site with redness and swelling, per Ms. Rogers.[105]

Patient B's leg was elevated and monitored "frequently" by Ms. Rogers for the rest of her shift, and a new IV was started in Patient B's left hand.[106] When questioned about her documentation for the morning not being entered until 11:38 a.m., Ms. Rogers said that she was only able to make the entries after she returned from transporting Patient B to his MRI exam.[107] She also agreed that she made an entry at 7:46 a.m. (just five minutes after discovering the infiltrate and the wet bedding) that the IV dressing was dry, but she explained that the note referred to the fresh dressing she had placed.[108]

Respondent testified that he prepared the long tubing for the MRI as "a courtesy for the day shift nurse coming on," and he "saw with [his] own eyes" that the IV site was not infiltrated.[109] He stressed that if he had seen a swollen leg, he would have "brought it to someone's attention

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[100] Tr. at 45.

[101] Tr. at 22.

[102] Tr. at 57; Staff Ex. 5 at 195.

[103] Tr. at 57.

[104] Tr. at 61-62.

[105] Tr. at 63.

[106] Tr. at 29, 43.

[107] Tr. at 95.

[108] Tr. at 86.

[109] Tr. at 481-82.

immediately."[110] Contrary to Ms. Rogers's testimony, Respondent said that they both were present when he pulled back the baby's blanket and he "showed her the line, 10 feet of it, and that it was connected to [Patient B], and there was no IV infiltration at that time."[111] He did not recall Ms. Rogers having to leave the room to address another patient's alarm. Respondent pointed out that Ms. Rogers described the baby at shift change as sleeping comfortably, which is inconsistent with the sedatives flowing into the tissue instead of the vein.[112] He conceded, however, that enough of the medication could have been delivered to Patient B that the baby would be in a sedated state despite the infiltrate.[113]

Regarding his 6:14 a.m. entry that Patient B's skin was taut instead of elastic, Respondent agreed that such a change would be inconsistent with the IV infusing properly throughout the night shift.[114] However, he stated that he mistakenly checked the wrong box in the Epic menu.[115]

Dr. Clipp said IV infiltrates are not uncommon in the PICU setting because babies have very fragile, small veins.[116] She estimated that she has seen "a couple hundred" infiltrated IVs over her career.[117] In her experience, an infiltration when the pedal pulse cannot be manually detected indicates that the IV site is "severely compromised."[118] Although she has seen such severe infiltration before in other patients, she deemed it to be a "rare" occurrence.[119] At the rate the fluid was flowing—if Respondent in fact determined at 6:14 a.m. that the IV was infusing normally—Dr. Clipp opined that the IV could not have infiltrated to the extent found at 7:41 a.m. by

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[110] Tr. at 482.

[111] Tr. at 484.

[112] Tr. at 485.

[113] Tr. at 526.

[114] Tr. at 544-45.

[115] Tr. at 545.

[116] Tr. at 376.

[117] Tr. at 378.

[118] Tr. at 382.

[119] Tr. at 392.

Ms. Rogers.[120] Based on the evidence, Dr. Clipp found Respondent's assertion that he checked the IV every hour to be inconsistent with the patient's actual condition shortly after the end of Respondent's shift. She said neglecting to check the IV on an hourly basis and not notifying a provider of a change in condition or an infiltrate would be a failure to meet the standard of care.[121]

Ms. Wilmore has had specialized training as a member of a vascular access team, with expertise in placing and maintaining IV lines, drawing blood cultures, and the like.[122] She opined that Patient B's IV was not infiltrated at the time of the shift change, basing her opinion on the fact that Ms. Rogers and Respondent assessed the patient together and did not document the infiltrate, and Ms. Rogers identified the infiltrate only after shift change.[123] Ms. Wilmore was asked about a hypothetical situation in which Nurse A, the outgoing nurse, is giving report to Nurse B, the oncoming nurse, and Nurse B has to leave the room because an alarm is sounding for another of Nurse B's patients. In that case, Ms. Wilmore opined, it would be irresponsible and below the standard of care for Nurse A to leave because the handoff and report were incomplete.[124] However, she distinguished the hypothetical from what happened with Respondent and Ms. Rogers, noting that the handoff had already occurred.[125] She added that Ms. Rogers recalled receiving report on Patient B first during shift change, so it was unclear when she could have received a handoff for her other patient such that she had the responsibility to leave the room to check on the other patient's alarm.[126] Ms. Wilmore pointed out that the dressing was marked as "clean, dry, and intact by both nurses," which is consistent with the infiltrate having occurred after shift change.[127]

[120] Tr. at 391-92.

[121] Tr. at 396-97.

[122] Tr. at 670-71.

[123] Tr. at 677-78.

[124] Tr. at 719-20.

[125] Tr. at 485.

[126] Tr. at 718.

[127] Tr. at 679.

2. ALJ's Analysis of Evidence for Charge 2

Staff proved the allegations in Charge 2 by a preponderance of the evidence. Dr. Clipp, who has seen hundreds of infiltrated IV sites in her career, testified convincingly that, given the rate at which fluids were infusing, the severe level of infiltration of Patient B's leg would not have occurred in the time between 6:14 a.m. and 7:41 a.m. She also described infiltrates of this severity as "rare." Respondent relied on his own documentation of the IV as infusing normally throughout his shift, and claimed that his notation at 6:14 a.m. (that the skin at the IV site was taut instead of elastic) was due to an error in using the Epic system. He also testified that he pulled back the blanket covering Patient B's legs and viewed the IV site with Ms. Rogers, confirming with her that it was not infiltrated.

Ms. Rogers described the specific indicators of infiltration that she found at 7:41 a.m., including significant swelling, cool skin, a pulse that could not be detected manually, and capillary refill of five seconds. At 8:58 a.m., the IV team graded the infiltration as severe, with swelling affecting over 68% of Patient B's leg. These facts are documented in the medical record by independent medical professionals and there is no evidence that they were not honestly and accurately entered, or that any of the providers had a reason to falsify the record to blame Respondent. Rather, the evidence preponderates in favor of a finding that Respondent was negligent in monitoring and assessing the IV site and failed to identify the infiltration promptly and intervene appropriately.

Based on the facts established by a preponderance of the evidence, and similar to the analysis of Charge 1 above, ALJ concludes that Respondent's conduct was unprofessional within the meaning of Code § 301.452(b)(10), as specified further by Board Rules 217.12(1)(A), (B), and (4).[128] However, as with Charge 1, the ALJ finds the facts in this case are more squarely

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[128] Respondent's conduct is covered by Board Rule 217.12(1)(A) (a failure to comply with minimum standards set forth in Board Rule 217.11, as discussed below); Board Rule 217.12(1)(B) (a failure to conform to generally accepted nursing standards in applicable practice settings); and Board Rule 217.12(4) (careless conduct that endangered a client's life, health, or safety).

encompassed by Code § 301.452(b)(13), which addresses a failure to meet minimum standards of nursing practice, specifically:

- Board Rule 217.11(1)(B): Respondent did not provide a safe environment for his client because he failed to identify the infiltrate, which included a high-risk vesicant (Versed), and promptly intervene to halt its progression;
- Board Rule 217.11(1)(C): Respondent did not correctly administer medications because he permitted the medications to infiltrate the patient's leg such that 68% of the patient's leg was edematous;
- Board Rule 217.11(1)(D): Respondent either prepared inaccurate records by incorrectly documenting the IV site was "taut" instead of "elastic" at 6:14 a.m., or he correctly documented the IV site was taut but failed to report the change in condition to another member of the health care team, such as an IV team nurse or the physician; and
- Board Rule 217.11(1)(M): by failing to stop the infiltrate before it became severe, Respondent did not institute appropriate nursing interventions to stabilize a client.[129]

C. Aggravating and Mitigating Circumstances

The testimony in this section was not considered by the ALJ in making factual findings regarding the two formal charges. Staff stipulated that it presented this evidence to rebut Respondent's claims that his orientation was inadequate, not to charge any additional practice or unprofessionalism violations.[130] The ALJ finds this evidence is most relevant to the aggravating and mitigation circumstances that must be considered in the sanctions analysis, specifically Board Rule 213.33(c)(12) (the contribution of system dynamics in the practice setting to the problem), as explained below.

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[129] The ALJ does not find a violation of Board Rule 217.11(1)(A), which generally requires a nurse to know and conform to the Act and Board Rules. Respondent's violations of the Act and Rules are already covered by the specific subsections of Board Rule 217.11(1) cited here.

[130] Tr. at 275.

1. Testimony of Children's Staff

Tiffany Montgomery, RN, and Kendel Richards, RN, are nurses who worked as clinical educators for the PICU at Children's in 2017. Ms. Richards continues to work in that capacity, and Ms. Montgomery is now the nurse residency program manager. Their responsibilities in 2017 involved training and orienting new nurses to the PICU. Ms. Montgomery focused on nurses with prior experience, and Ms. Richards concentrated on nurses newly out of school.[131] Since Respondent was coming to Children's with an extensive nursing history, Ms. Montgomery was initially charged with his orientation.[132] She said the first week of orientation for all Children's employees is a hospital-wide introduction to the hospital's philosophy, practices, departments, and resources for all employees.[133] Employees are then assigned to learn Epic in two modules, each lasting approximately two hours. If an employee wants additional training with Epic, the hospital has an "Epic playground" that includes "fake patients [and fake] profiles where staff could go and play and click around and get familiar with it more."[134]

Ms. Montgomery distinguished the recordkeeping responsibilities of more experienced nurses from what is expected of student nurses. Experienced nurses like Respondent have their own licenses and are responsible for completing patient charts, whereas the charts prepared by student nurses must be cosigned by a licensed nurse. Nonetheless, Ms. Montgomery stated, experienced nurses still have their documentation "fully reviewed through their orientation [period.]"[135] The review is done by the assigned preceptor. Ms. Montgomery tried to assign preceptors to new employees based on similar prior experiences, scheduling availability, different learning and teaching styles, and other factors. She said the ideal situation would include two or three preceptors per employee for the day shift and two or three for the night shift, to provide

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[131] Tr. at 275.

[132] Tr. at 276.

[133] Tr. at 277.

[134] Tr. at 280.

[135] Tr. at 281.

exposure to different approaches while also maintaining some consistency.[136] If Respondent had been assigned eight or more preceptors, she would be "a little bit" surprised, Ms. Montgomery said. Nonetheless, she has seen new employees who had more than eight preceptors but were successful because they were open and frank in discussing their needs with their preceptors.[137]

Throughout each new employee's orientation period, Ms. Montgomery met with both the preceptors and the employee to assess the employee's progress in areas such as clinical skills, time management, and documentation.[138] She said she accommodated Respondent's scheduling issues related to his move from Hawaii as much as possible, but on two occasions, Respondent left his shift early without notice or with very little notice. When Ms. Montgomery checked on him, he said he was feeling "overwhelmed" and "traumatized" by the experience of moving to Dallas without his wife, dogs, and possessions.[139] Ms. Montgomery said Respondent's orientation period was "very much like a roller coaster."[140] He would have "one really good week" with positive feedback from preceptors that he was meeting objectives, but "three shifts later. . . the things he had done well previously, he started not doing well again."[141] Respondent did not seem to be aware that his progress was uneven, in Ms. Montgomery's view.

In an attempt to give Respondent an experience with fewer variables, Ms. Montgomery assigned him to "the exact same assignment three days in a row."[142] She said "Day 1 . . . he would do great and keep up with specific tasks and new experiences," but on "Day 2, it was as if Day 1 never happened," and Respondent would say he did not know how to do something he had done the day before.[143] About a month into the orientation process, on May 1, 2017, Ms. Montgomery and Respondent's team leader put him on an "orientation action plan," which identified areas in

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[136] Tr. at 282, 284.

[137] Tr. at 314.

[138] Tr. at 335.

[139] Tr. at 287-88.

[140] Tr. at 289.

[141] Tr. at 289.

[142] Tr. at 290.

[143] Tr. at 290.

which his orientation was not progressing as expected.[144] These included performing thorough hourly assessments of patients without being prompted by a preceptor, complete and accurate charting in Epic without copy-and-paste errors, and routine medication administration and lab collection in a timely manner without prompting.[145] On May 23, 2017, Ms. Montgomery documented that Respondent had "'graduated' from his orientation action plan" but that his preceptors still had concerns.[146] These concerns included charting tasks before completing them, failing to give report thoroughly, acting "as if he had never heard of [a drip check] before," leaving a shift early without proper notice, leaving his cellphone on during the shift, and becoming defensive when approached with feedback.[147]

On June 8, 2017, Ms. Montgomery documented a meeting with Respondent in which she noted he had successfully completed three shifts the prior week that met expectations, with a few lapses when the shifts became busy.[148] In this meeting, Ms. Montgomery required Respondent to be checked off by his preceptors for all remaining orientation tasks by the end of three work shifts.[149] Respondent completed that requirement by the end of June 2017.[150]

Ms. Montgomery was asked about one of Respondent's preceptors, Rebecca Eyres. She said the comments from Respondent about Ms. Eyres, and from Ms. Eyres about Respondent, were "largely positive."[151] The only issue that Ms. Montgomery recalled Respondent raising is that he found Epic charting was unfamiliar and he needed more time to become comfortable with it.[152] She felt Respondent's focus was on completing his charting very quickly, but his preceptors were troubled to see that he either delayed doing the actual task (for example, a head-to-toe assessment)

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[144] Tr. at 291-92; Staff Ex. 7 at 4-5.

[145] Tr. at 294-95; Staff Ex. 7 at 5.

[146] Staff Ex. 7 at 6.

[147] Staff Ex. 7 at 6.

[148] Staff Ex. 7 at 9.

[149] Staff Ex. 7 at 9.

[150] Tr. at 244, 306-07.

[151] Tr. at 314.

[152] Tr. at 327-28.

in favor of documenting it, or his records had inaccuracies because he would copy and paste his assessments.[153] Ms. Montgomery said that it was clear Respondent was using the copy-and-paste function because only certain items can be copied, and items such as vital signs and phlebitis scores must be entered individually. Respondent's records would show that he had used copy-and-paste for the same information for hourly checks but had failed to enter vital signs, phlebitis scores, and other information.[154]

Ms. Montgomery started maternity leave on June 19, 2017, and returned to work in September, after Respondent's employment with Children's had been terminated.[155] During that period, Ms. Richards took over the management of Respondent's orientation.

Ms. Richards said that before new employees are released from orientation, they must complete various computer-based training modules. Early on, they are introduced to "Policy Tracker," a program that allows a user to access all policies, hospital-wide. During their shifts working with preceptors, new employees need to refer to the policies to be able to complete patient care tasks in conformity with Children's practice requirements.[156] Ms. Richards noted that, while the computer modules must be completed prior to the end of orientation, she and Ms. Montgomery encouraged new employees "not to rush through it" because their shifts with preceptors helped them connect the computer-based information with real-life practice.[157]

Ms. Richards explained that she and Ms. Montgomery did not have "disciplinary" authority over new employees. Their role was to educate and facilitate the onboarding of new staff, but if serious practice lapses occurred, the issue was escalated to management.[158] After the patient care issues with Patients A and B occurred, Respondent's team leader placed him on

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[153] Tr. at 328-29.

[154] Tr. at 314.

[155] Tr. at 306-07.

[156] Tr. at 225-26.

[157] Tr. at 226-27.

[158] Tr. at 242.

administrative leave.[159] At that point, Ms. Richards realized that Respondent actually had not completed all of his computer-based training. She said she was unsure how the oversight occurred, but with Ms. Montgomery going on maternity leave and the other issues with Respondent's orientation that had arisen, "it just got missed."[160] Ms. Richards and Respondent's supervisor set a deadline of August 3, 2017, for Respondent to complete his computer modules, and he did so successfully.[161] Children's management decided that Respondent would be required to complete additional shifts with a preceptor when he returned from administrative leave on or about August 8, 2017.[162] On August 20, 2017, Ms. Richards received an email forwarded by a PICU supervisor noting that Respondent's preceptor on an August 11, 2017 shift had reported concerns about Respondent's clinical skills as well as documentation. Respondent's employment termination was verbally communicated to him by a supervisor on August 26, 2017,[163] and by letter dated September 1, 2017.[164]

2. Respondent's Testimony

As previously noted, Respondent said he was "immediately treated like an outsider" when he started working at Children's. He said he was not given proper training at Children's because he was rotated through eight or more preceptor nurses, preventing him from having a consistent learning environment. He said it was his "belief from the Day 1 that [he] started" at Children's that his preceptors were "out to get [him] or didn't want [him] on the floor."[165] Respondent described the preceptors he had as being "very harsh, very critical, always hovering over [him], questioning everything [he] did."[166] He found this "intimidating," and also thought that "they were pulling [him] around to different people to get different people's perspectives on [his] behavior, [his]

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[159] Tr. at 244-45.

[160] Tr. at 245.

[161] Tr. at 246.

[162] Tr. at 247-48; Staff Ex. 7 at 19-21.

[163] Tr. at 247-48; Staff Ex. 7 at 19-21.

[164] Staff Ex. 10 at 25.

[165] Tr. at 513-14.

[166] Tr. at 462.

charting, [his] skill set and those types of things, not to help [him], but to hurt [him]."[167] When he first started following his preceptors, Respondent had to get technical help for problems with his Epic log-in as well as his authorization to access the Pyxis medication drawer.[168] According to Respondent, his first preceptor was frustrated that Respondent could not do much work because of these obstacles, and the preceptor blamed him "as opposed to the hospital."[169] Later, Respondent felt that his preceptors "would check [his] charting every five minutes."

Respondent denied that any of his preceptors gave him feedback that they had problems with his assessments, patient safety, or clinical skills.[170] He said that the preceptors "for the most part, cut [him] loose" because they knew he was an experienced nurse, and several "would disappear for long periods of time" without informing him of their whereabouts.[171] As mentioned previously, Respondent remembered issues with one night shift preceptor in particular, Rebecca Eyres. On June 8, 2017, Respondent had a question for Ms. Eyres and could not locate her. He searched the unit and found her asleep in the breakroom around 5:00 a.m., with her head down on a table.[172] Respondent said Ms. Eyres normally took her break around 11:00 p.m. and the "busiest time for a night shift nurse [is between] 4:00 and 6:00 a.m."[173] Around the same time in the morning a week later, Respondent again had difficulty locating Ms. Eyres and finally found her in the break room on a computer, looking at a website that appeared to be selling medical scrubs.[174] On both occasions, Respondent said, he took pictures of Ms. Eyres on his phone so he could tell managers he felt the "orientation was not appropriate."[175] Respondent did not recall the specific persons to whom he showed the pictures.[176]

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[167] Tr. at 461.

[168] Tr. at 469.

[169] Tr. at 469.

[170] Tr. at 470-71.

[171] Tr. at 473.

[172] Tr. at 461.

[173] Tr. at 474.

[174] Tr. at 480.

[175] Tr. at 480.

[176] Tr. at 480.

Respondent also had trouble with his team leader, Kendra Shotts-Fraser, when she was his preceptor in August to help him finish all of his remaining modules and tasks. Respondent said that on "a few nights, [she] disappeared with her friend and was not even able to help [him] complete these modules."[177]

Regarding the testimony by Ms. Montgomery and Ms. Richards about the issues during his orientation and the patient care issues related to Patients A and B, Respondent said he "agreed that [he] could use some more help with [his] documentation" in Epic.[178] He rejected Ms. Montgomery's testimony that he had used the copy-and-paste function to duplicate his assessment entries, stating that he did not even know how to use those commands in Epic at that time.[179] Although he acknowledged having problems using Epic, Respondent insisted that he "was never made aware of any patient safety issues whatsoever until the Board of Nursing notified [him]" of the formal charges.[180] He said Ms. Montgomery and Ms. Richards both "were very combative with [him] and [would] talk down to [him] and were disrespectful."[181] In the end, Respondent stated, he did not think he was a good fit at the PICU at Children's, but he would not have done anything differently in the time he spent there.[182]

After he was fired from Children's, Respondent and Ms. Wilmore moved to Houston, where they currently live. Respondent was hired at Memorial Hermann Health System (MHHS) in the post-anesthesia care unit (PACU) to care for adult surgical post-operative patients.[183] He said he had a "typical orientation" with only one preceptor, and he had no problems learning Cerner, the electronic medical records system used by MHHS.[184] Respondent submitted an

[177] Tr. at 500.

[178] Tr. at 519.

[179] Tr. at 517.

[180] Tr. at 561.

[181] Tr. at 524.

[182] Tr. at 577.

[183] Tr. at 504.

[184] Tr. at 504.

evaluation from his supervisor for the period from July 1, 2018 to June 30, 2019.[185] The evaluation states that Respondent was given an overall rating of "3. Meets Expectations."[186] Respondent said that because of the timing of the evaluation cycles, he did not have a more current evaluation to offer.[187] However, he provided email messages from his colleagues in which he was praised for being flexible, helping take assignments as needed and without complaints, and taking on-call shifts.[188] He also provided a letter of recommendation (undated) from his supervisor when he was a flight nurse at TCH.[189] The letter commends Respondent for his ability to stay calm in a rapidly-changing environment, communicate well with patients, and solve problems.

Ms. Wilmore testified that she saw the photographs of Ms. Eyres that Respondent had taken, and she sent copies by email to human resources personnel and managers at Children's. She said she did so to document and protest what she thought was unfair treatment of Respondent by other staff, who were retaliating for his reporting of Ms. Eyres.[190] Ms. Wilmore contended that the testimony of Ms. Montgomery and Ms. Richards regarding Respondent's orientation difficulties was inconsistent with Respondent being released to care for patients on his own in July.[191] She also questioned why—if Respondent's preceptors were so concerned about his practice—Ms. Eyres felt "so comfortable that at 5 o'clock in the morning, the busiest time, to kind of go off and do her own thing," such as napping and shopping online.[192] Ms. Wilmore noted that just a few days after she sent the email to Children's, Respondent was fired.

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[185] Resp. Ex. 8 at 1. Although the document states that it was acknowledged and accepted by Respondent on December 19, 2019, the period covered by the evaluation appears to be the prior fiscal year.

[186] Resp. Ex. 8 at 1.

[187] Respondent's evaluation for the time period from July 1, 2019 to June 30, 2020, was not going to be available until December 2020, after the hearing on the merits. Tr. at 501.

[188] Resp. Ex. 9.

[189] Resp. Ex. 10.

[190] Tr. at 692.

[191] Tr. at 692.

[192] Tr. at 692.

According to Ms. Wilmore, the firing was not a surprise because she and Respondent both felt there had been retaliatory action and employment termination was likely.[193] She said Respondent was "upset, but [he] started looking for another job and then just moved on."[194] In September 2017, when Respondent received an investigatory letter from the Board, Ms. Wilmore said he was "quite upset [and] shocked."[195] She stated that the subsequent investigation by Staff and the hearings process, which has spanned three years, has caused them both "a great amount of anxiety [and] increased stress."[196] Ms. Wilmore said she is very proud of how hard Respondent has worked at MHHS and that he is "doing a great job."[197]

3. ALJ's Analysis of Evidence of Aggravating and Mitigating Circumstances

The evidence discussed above is most relevant to Board Rule 213.33(c)(12), which directs the Board and the ALJ to consider the "extent to which system dynamics in the practice setting contributed to the problem." Dr. Benton suggested that stress related to learning Epic could have distracted Respondent and might be considered a mitigating factor.[198] However, the burden of proving mitigating factors rests with Respondent. The credible evidence in this case is that significant attempts were made by Children's staff to assist Respondent and accommodate his needs, but he was unwilling or unable to improve his performance.

Respondent came to Children's believing "from Day 1" that his preceptors were attempting to find fault with him and were "out to get him." He said they were intimidating, harsh, critical, constantly hovering, and correcting his documentation "every five minutes." At the same time, Respondent said his preceptors "cut him loose" because they knew he was an experienced nurse, and they disappeared for long periods, went off with their friends when they should have been

[193] Tr. at 697.

[194] Tr. at 698.

[195] Tr. at 699.

[196] Tr. at 699-700.

[197] Tr. at 700.

[198] Tr. at 777.

working, and slept and did online shopping while on duty. The contradictory descriptions are difficult to reconcile. Respondent stated Ms. Montgomery and Ms. Richards were combative and disrespectful to him, but the ALJ found both of them testified credibly and sincerely that they made multiple attempts to help Respondent succeed. And, although he attributed his firing to retaliation for reporting Ms. Eyres, there is detailed documentation of issues with Respondent's practice beginning in April 2017.

It is true that Respondent's failure to complete some of his computer-based modules was not caught by Ms. Montgomery or Ms. Richards until after Respondent was released from orientation. At the same time, the problems identified with Respondent's practice, beginning with the orientation action plan, were not limited to computer-based skills. They included performing thorough hourly assessments of patients without being prompted, entering complete and accurate charting in Epic without copy-and-paste errors, and performing routine medication administration and lab collection in a timely manner without prompting. These are basic nursing skills that a nurse with two decades of experience should have been able to perform with minimal difficulty. Concerns raised in May 2017, after Respondent was released from his orientation action plan, still related to nursing practice competencies, such as charting tasks before completing them, failing to give report thoroughly, and failing to perform the same task (such as a drip check) accurately from one day to the next.

It is striking that Respondent seems to believe the vast majority of people he encountered at Children's had a personal animus toward him or a desire to harm his career. The witnesses from Children's all have nursing licenses of their own and careers that they could put at risk if they falsely accused a colleague of practice deficiencies. Yet they documented, in writing, detailed and numerous ways in which Respondent's practice was causing concern. In sum, the ALJ finds the system did not fail Respondent in the manner he asserts.

In addition to Board Rule 213.33(c)(12), the factors required to be considered by the ALJ and the Board are set forth in the Matrix (in graphical form at Board Rule 213.33(b)) and in the other subsections of Board Rule 213.33(c). For the analysis of factors in the Matrix, the ALJ

focuses on the mitigation and aggravating factors listed for Code § 301.452(b)(13) because, as discussed previously, the charges in this case are best addressed as failures to meet minimum standards of nursing practice rather than unprofessional conduct. The ALJ finds the following aggravating factors are applicable in this case:

- Board Rule 213.33(c)(1)/Matrix: the facts indicate actual or potential harm to patients because Patient A had her fentanyl drip set at the wrong rate and her blood transfusion was unnecessarily delayed, and Patient B suffered a severe infiltration of his IV;[199]
- Board Rule 213.33(c)(8)/Matrix: there was actual damage in the form of harm to patients, in particular Patient B, and the harm to Patient B was deemed severe;
- Board Rule 213.33(c)(10): Respondent made no attempts to correct or stop his practice deficiencies. He did not show progress despite multiple interventions during his orientation and he dismissed specific, legitimate criticisms of his practice as animosity;
- Board Rule 213.33(c)(13)/Matrix: Respondent is being disciplined for multiple violations of the Act and Board rules;
- Board Rule 213.33(c)(14): the violations at issue are very serious;
- Board Rule 213.33(c)(15): if Respondent's practice deficiencies are not remedied to the Board's satisfaction, there is a risk to public safety;
- Matrix: The patients at issue were very vulnerable; and
- Board Rule 213.33(c)(16): Respondent's professional character, when considered in light of the factors set out in Board Rule 213.27, is called into question with respect to whether he can function autonomously, exercise appropriate judgment in client care, conform to applicable law, and promptly recognize and self-disclose errors and omissions that affect patient health.

The following mitigating factors from Board Rule 213.33(c) and the Matrix are applicable in this case:

- Board Rule 213.33(c)(4): Respondent had a successful practice history as a flight nurse;

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[199] Tr. at 700.

- Board Rule 213.33(c)(5): Respondent appears to be practicing within expectations at his current position; and
- Board Rule 213.33(c)(7): Respondent has been practicing as a nurse for over 20 years.

IV. SANCTIONS ANALYSIS

Dr. Benton[200] provided testimony on the sanction that is appropriate if the ALJ found the charges were established by the evidence.[201] She testified that, whether analyzed under Code § 301.452(b)(10) or (13), a Second Tier, Sanction Level 1 offense would be appropriate, with issuance of a Reprimand and a two-year Order with stipulations.[202] The ALJ concurs.

The First Tier of the Matrix addresses isolated failures to comply with Board rules concerning unprofessional conduct with no patient risk or adverse effects (Code § 301.452(b)(10)) and practice below the standard of care with a low risk of patient harm (Code § 301.452(b)(13)). Respondent's conduct as established by Staff is more serious and exceeds the First Tier.

The Third Tier under Code § 301.452(b)(10) encompasses unprofessional behavior that results in serious harm to a patient or the public, and the Third Tier under Code § 301.452(b)(13) is meant to address substandard practice with a serious risk of harm or death that is known or should be known or a significant demonstration of incompetence. The ALJ defers to Dr. Benton, who, as Staff's expert, recommended the Second Tier. Dr. Benton said she "would not agree that [Respondent's actions] put a patient at immediate risk of death," although there was "harm and risk of harm to patients."[203] Ultimately, it is within the Board's discretion to determine the sanction classification and appropriate disciplinary action.

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[200] Dr. Benton holds bachelor's, master's, and doctoral degrees in nursing. Her qualifications are contained in her *curriculum vitae* (Staff Ex. 11) and are discussed in the transcript at pages 752-63. She was accepted by the ALJ as an expert in the Board's rules and regulations and the application of the Board's Matrix and sanctions. Tr. at 763.

[201] Dr. Benton also testified regarding the aggravating and mitigating factors that are applicable. That testimony, to the extent it was accepted by the ALJ, is incorporated above without citation.

[202] Tr. at 783-84.

[203] Tr. at 785-86.

Within the Second Tier, Dr. Benton recommended Sanction Level I, because she opined there were not "so many aggravating factors that it would warrant a more severe sanction level."[204] The ALJ concurs. Sanction Level II under either Code provision contemplates license denial, suspension, or revocation, and Staff did not contend that level of disciplinary action is required. Sanction Level I proposes a Warning or Reprimand with stipulations.

When there are multiple violations of the Act and/or Board Rules are at issue, as is the case here, the Matrix directs the Board and the ALJ to consider the more severe sanction. Therefore, a Reprimand (a two-year order) is more appropriate than a Warning (a one-year order). With respect to the stipulations accompanying the Reprimand, the ALJ agrees with Dr. Benton's recommendation: classes in medication administration, jurisprudence, physical assessment, documentation, critical thinking, and other subjects the Board deems proper; a requirement that Respondent provide a copy of the Order and Reprimand to his employer(s) and cause the employer(s) to send quarterly performance reviews to the Board; a prohibition on working in home health care and similar autonomous roles; and one year of work with direct supervision by another RN who is on the unit, followed by a year of work with indirect supervision by an RN who is on the premises but not necessarily on the same unit.

In support of the recommended sanction of a Reprimand with stipulations, the ALJ makes the following findings of fact and conclusions of law.

V. FINDINGS OF FACT

1. Terry Douglas Wilmore (Respondent) was issued Registered Nurse (RN) License No. 664853 by the Texas Board of Nursing (Board) in 1999.

2. Between 1999 and 2017, Respondent worked for Texas Children's Hospital in Houston, Texas (TCH) almost exclusively as a flight nurse. He and a respiratory therapist accompanied pilots to reach patients in remote or rural areas, stabilize them, and take them safely back to TCH for treatment.

[204] Tr. at 784-85.

3. Respondent practiced successfully at TCH without any record of discipline for substandard practice.

4. In April 2017, Respondent began a new position as a Staff Nurse in the pediatric intensive care unit (PICU) of Children's Medical Center in Dallas, Texas (Children's).

5. Within the first month of his orientation program, Respondent's preceptor nurses noted that he was making very uneven progress in demonstrating required competencies, with a successful week of shifts followed by a week in which he repeated practice errors that he had previously corrected.

6. In May 2017, Respondent was placed on an orientation action plan focused on improving his ability to perform thorough hourly assessments of patients without being prompted by a preceptor, to complete and enter accurate charting in the electronic medical records system (Epic) without copy-and-paste errors, and to handle routine medication administration and lab collection in a timely manner without prompting.

7. Respondent was released from the orientation action plan on May 23, 2017, but his preceptor nurses continued to identify deficiencies such as charting tasks before completing them and failing to give report thoroughly to the next nurse at a shift change.

8. The orientation action plan was one of several attempts by Children's staff to support Respondent in adjusting to the PICU and succeeding in his position.

9. Respondent believed that from the first day he started orientation at Children's, his preceptor nurses and colleagues had an animus toward him and wanted to harm his career.

10. At the end of June 2017, Respondent was released to handle patients without a preceptor.

11. At approximately 7:00 a.m. on July 9, 2017, Margaret Giddens, RN, took over for Respondent's patients from his night shift, including Patient A, a three-month-old infant.

12. During their shift change report, Ms. Giddens and Respondent together looked up the doctor's orders for Patient A's medications. Ms. Giddens found that the doctor's order was for an intravenous (IV) fentanyl drip set at 1 microgram per kilogram of patient weight per hour (1 mcg/kg/hr) but Respondent had set the pump at 1.33 mcg/kg/hr beginning at 6:22 a.m., if not earlier.

13. At 6:22 a.m., Respondent had started a new syringe of fentanyl for Patient A, but he did not obtain a second nurse's signoff to confirm that the correct dose was being administered at the correct infusion rate.

14. The higher infusion rate of fentanyl increased Patient A's degree of sedation and could have caused a setback in her treatment plan, which included weaning her from fentanyl.

15. When Ms. Giddens advised Respondent he had set the fentanyl pump at the wrong rate, he did not notify a charge nurse or Patient A's doctors so they could make any necessary changes in the plan of care.

16. At 4:33 a.m. on July 9, 2017, during Respondent's shift, Patient A's doctor entered an electronic order for a type-and-screen (T/S) test as well as a stat order to administer packed red blood cells.

17. A T/S test is used to confirms that the blood products ordered for a patient are correctly matched to the patient's blood type. Children's has a neonatal protocol which allows the results of a T/S test taken for an infant under four months of age to be used for administrations of blood until the baby turns four months old or is discharged, whichever occurs first.

18. The neonatal protocol protects very fragile infants from having additional blood drawn for T/S tests. The risks of unnecessary T/S tests include exacerbating anemia, pain, and infection at the injection site, particularly in immunocompromised infants.

19. Children's is a teaching hospital and doctors at various stages of training treat the PICU patients.

20. Nurses at Children's are expected to know the neonatal protocol and serve as a patient advocate by questioning unnecessary T/S blood draws if a valid test result is already on file.

21. Respondent acknowledged the T/S test and stat blood order at 4:57 a.m. He checked Patient A's medical record and found T/S results on file, but he did not consider whether the neonatal protocol applied. Respondent drew the blood for the T/S and sent it to Children's in-house blood bank for analysis.

22. It is a basic nursing skill to recognize that a stat order is urgent and needs to be completed as soon as possible for the patient's health and safety.

23. Respondent did not recognize the urgency of the blood order being marked stat. He was not aware that he needed to check the Epic system for the T/S results, and did not know that the Children's blood bank would not call him. Respondent did not know that the blood bank required a pickup slip to be sent requesting the preparation of the blood products.

24. During the shift change report, Respondent told Ms. Giddens that he had sent blood for a T/S test to the blood bank but had not received the results. He did not advise Ms. Giddens that the blood order was marked stat.

25. Ms. Giddens saw the blood order was marked stat when she logged into Patient A's records. She immediately ordered the blood and advised Patient A's doctors of the delay.

26. Part of Patient A's care plan involved removing her breathing tube to assess her ability to breathe independently. The delay in administering blood impaired her ability to do so.

27. Ms. Giddens documented in the medical records that she reviewed the fentanyl drip rate with Respondent and corrected it to the ordered rate of 1 mcg/kg/hr. The same day, she sent an email to her supervisor and Respondent's team leader to advise them of his fentanyl drip error and the delay in administering the stat blood order.

28. On July 24, 2017, Christa Rogers, RN, took over care for Patient B, an eight-month-old infant, from Respondent, who had cared for the baby overnight.

29. Patient B had an IV in the dorsal vein on his right foot, through which he was receiving Precedex and Versed, which are both sedating medications, and fentanyl for pain.

30. Monitoring of an IV site is required every hour in the PICU. The pedal pulse is checked and assessed on a scale of zero (no pulse) to three-plus, where zero indicates a pulse cannot be detected and two-plus is a normal pulse. Capillary refill rates are checked; less than three seconds is considered a good capillary refill rate for PICU patients. The skin at the IV site is assessed to determine if it is elastic or taut. If an IV is in an extremity, the nurse compares the two extremities to see if one is larger or swollen or has skin that is tauter, or there is a temperature differential.

31. Infiltration results when fluid flows into the surrounding tissue instead of the vein. Versed is a high-risk vesicant that poses a high risk of injury if it infiltrates into the tissues.

32. When Ms. Rogers and Respondent went into Patient B's room for the shift change report, they verified that the IV pump was set correctly for all medications. Respondent told Ms. Rogers the IV site was infusing properly, Patient B's pedal pulse was two-plus, and his capillary refill was less than three seconds.

33. Respondent also advised Ms. Rogers that, in anticipation of Patient B's MRI exam later that morning, he had attached long tubing to the IV site to allow the IV pump to remain outside the MRI room during the procedure.

34. Before Ms. Rogers and Respondent could look at Patient B's IV site together, an alarm for another of Ms. Rogers's patients began sounding and she left to check on the other patient. When Ms. Rogers returned to Patient B's room, Respondent had left the PICU.

35. Ms. Rogers pulled back a blanket that had been covering Patient B's legs and realized his right leg was significantly swollen up to his knee, the right foot was very cold to the touch and was pale compared to the left foot, and the blanket below the foot was wet from fluids seeping out of the IV site. Ms. Rogers could not feel a pulse in the right foot, but was able to hear the pulse with a Doppler device. Patient B's capillary refill was five seconds.

36. At 7:41 a.m., Ms. Rogers clamped Patient B's IV to stop the flow of fluids and called the IV specialist team to assess and treat the infiltrate. She also notified Patient B's care team.

37. Patient B's infiltration was severe, with swelling over 68% of his leg, and there was phlebitis at the IV site.

38. Respondent documented that he performed hourly checks of Patient B's IV throughout the night shift and found the IV infusing properly. He added the long tubing at 5:38 a.m., and checked the IV twice more before shift change.

39. Respondent documented that the skin at the IV site was taut at 6:14 a.m., but he had documented it as elastic for every previous check. Respondent either recorded an erroneous assessment, or he correctly recorded a change in the skin but did not report the change in condition to the treating physician as required.

40. At the rate the IV fluids were infusing, the severe infiltration of Patient B's leg would not have occurred in the time between 6:14 a.m., when Respondent asserted the IV was infusing normally, and 7:41 a.m., when Ms. Rogers discovered the infiltrate and clamped the IV.

41. Respondent was placed on administrative leave by Children's. He was allowed to return to work in August 2017, provided he completed several additional shifts with preceptors. Respondent's preceptors continued to document concerns with his clinical skills and documentation.

42. Children's terminated Respondent's employment verbally on August 26, 2017, and by letter dated September 1, 2017.

43. The evidence does not support Respondent's assertion that he was fired in retaliation for reporting that one of his preceptors was sleeping and online shopping during a shift when she allegedly was not on a break.

44. After he was fired from Children's, Respondent secured employment at Memorial Hermann Health System (MHHS) in the post-anesthesia care unit (PACU) caring for adult surgical post-operative patients. He received an evaluation in 2019 as meeting expectations, and has been commended by his MHHS colleagues for being flexible and helping take assignments as needed.

45. The Staff of the Board opened an investigation of Respondent's conduct during his employment at Children's. On August 14, 2020, Staff sent Respondent a Fourth Amended Notice of Hearing and Formal Charges. Together, these documents 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 either a short, plain statement of the factual matters

asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

46. Administrative Law Judge (ALJ) Pratibha J. Shenoy convened the hearing via the Zoom videoconference service on September 28-30, 2020. Deputy General Counsel Jena Abel represented Staff. Respondent appeared and was represented by attorney Elizabeth Higginbotham. The record closed on December 21, 2020, after submission of written closing arguments.

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 findings of fact and conclusions of law. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

3. Respondent 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, and Respondent had the burden of establishing any mitigating factors. 1 Tex. Admin. Code § 155.427.

5. Respondent committed unprofessional conduct and practiced below minimum standards of nursing care by failing to comply with minimum standards set forth in Board rules; failing to conform to generally accepted nursing standards in applicable practice settings; engaging in careless conduct that endangered a client's life, health, or safety; failing to provide a safe environment for his clients; failing to correctly administer medications and treatments; entering inaccurate information into the medical record and failing to communicate properly with other members of the health care team; and failing to initiate appropriate nursing interventions to stabilize a patient. 22 Tex. Admin. Code §§ 217.12(1)(A), (B), and (4); .11(1)(B), (C), (D), and (M).

6. Respondent's conduct is subject to sanction pursuant to Texas Occupations Code § 301.452(b)(10) and (13).

7. 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).

8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33(c) and the Board's Disciplinary Matrix, 22 Texas Administrative Code § 213.33(b).

9. The Board may consider as aggravating factors in this case: actual or potential harm to clients; actual damage and extent of damage; Respondent's failure to correct or stop his practice deficiencies; multiple violations of the Nursing Practice Act and the Board's rules; the seriousness of the violations; the risk to public safety if the deficiencies are not remediated; patient vulnerability; and the failure to show good professional character with respect to whether Respondent can function autonomously, exercise appropriate judgment in client care, conform to applicable law, and promptly recognize and self-disclose errors and omissions that affect patient health. Tex. Admin. Code § 213.33(b)-(c).

10. The Board may consider as mitigating factors Respondent's prior successful practice as a flight nurse; his current practice as a PACU nurse at MHHS without any known practice deficiencies; and the fact that Respondent has been practicing for over 20 years. 22 Tex. Admin. Code § 213.33(b)-(c).

VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board issue a two-year Order with a Reprimand and stipulations including: classes in medication administration, jurisprudence, physical assessment, documentation, critical thinking, and other subjects the Board deems proper; a requirement that Respondent provide a copy of the Order and Reprimand to his employer(s) and cause the employer(s) to send quarterly performance reviews to the Board; a prohibition on working in home health care and similar autonomous roles; and one year of work with direct supervision by another RN who is on the unit, followed by a year of work with indirect supervision by an RN who is on the premises but not necessarily on the same unit.

SIGNED February 22, 2021.

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS