DOCKET NUMBER 507-20-3794

IN THE MATTER OF PERMANENT CERTIFICATE NUMBERS AP121858 & 816595, ISSUED TO AMBER KAY WALKINGTON	**§**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: AMBER KAY WALKINGTON
C/O KIMBERLY L. CORMIER, ATTORNEY
BEARD KULTGEN BROPHY BOSTWICK & DICKSON, PLLC
15150 PRESTON RD., SUITE 230
DALLAS, TX 75248

SRINIVAS BEHARA
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on July 22, 2021, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Respondent's exceptions to the PFD; Staff's response to Respondent's exceptions to the PFD; the ALJ's final letter ruling dated May 6, 2021; 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. Respondent filed exceptions to the PFD on April 15, 2021. Staff filed a response to Respondent's exceptions to the PFD on April 21, 2021. On May 6, 2021, the ALJ issued a final letter ruling, in which he corrected a technical error and made changes to the proposed findings of fact and conclusions of law, but did not make any changes to the proposed sanction.

The Board, after review and due consideration of the PFD; Respondent's exceptions to the PFD; Staff's response to Respondent's exceptions to the PFD; the ALJ's final letter ruling dated May 6, 2021; 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, including the corrected technical error and the amended proposed findings of fact and conclusions of law contained in the ALJ's letter ruling of

May 6, 2021. 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[1].

The ALJ found that the Respondent's conduct warrants a third tier, sanction level I sanction for her violation of §301.452(b)(13)[2]. Either licensure suspension or licensure revocation is authorized by the Board's Disciplinary Matrix for a third tier, sanction level I sanction for §301.452(b)(13)[3]. Because the patient sustained serious harm in this case, the Board finds the Respondent's conduct warrants a third tier, sanction level I sanction for her violation of §301.452(b)(10)[4]. Licensure revocation is authorized by the Board's Disciplinary Matrix for a third tier, sanction level I sanction for §301.452(b)(10)[5]. The Board agrees with the ALJ that, collectively, a probated suspension is the most appropriate sanction in this case based upon the aggravating and mitigating factors. The Board further finds that stipulations consistent with the ALJ's recommendation and analysis should be included in the Board's order.

The Respondent's conduct created a serious risk of harm for the patient, including cardiac arrhythmias, and the patient suffered actual harm as a result, including seizures, cancellation of his scheduled surgery, and transfer to a higher level of care[6]. The Respondent was not a new nurse and had been practicing for a significant period of time when the error occurred[7]. The patient was elderly and particularly vulnerable, as medications were being administered directly into his spine[8]. The severity of the error is also an aggravating factor[9].

The ALJ found several mitigating factors as well. The Respondent has no prior disciplinary history and received positive recommendations from co-workers and her supervising anesthesiologist[10]. Further, the Respondent reported the error to her supervising anesthesiologist and attempted to administer additional medications to

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[1] See Tex. Occ. Code. §301.459 (a-1), and page 30 of the PFD.

[2] See pages 22; 27; and 29-30 of the PFD. The ALJ declined to analyze the Respondent's violation of §301.452(b)(10) under the Board's Disciplinary Matrix, finding instead that an analysis under §301.452(b)(13) was more appropriate.

[3] See §213.33(b).

[4] See *id.*

[5] See *id.*

[6] See pages 22-24 of the PFD and adopted Findings of Fact Numbers 21, 24, and 25.

[7] See page 24 of the PFD.

[8] See page 26 of the PFD.

[9] See *id.*

[10] See page 24 of the PFD.

mitigate the potential harm caused by her error[11]. The Respondent also testified that she had changed her practice to ensure she follows the five rights of medication administration[12]. The ALJ also found the Respondent to have good professional character[13].

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 probated suspension is the most appropriate sanction in this case. The Board finds that stipulations consistent with the ALJ's recommendation and analysis are necessary to include in the Order.

Consistent with the ALJ's recommendation, the Board finds that the Respondent should be required to complete a nursing jurisprudence and ethics course, a medication administration course, and a critical thinking course[14]. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas, to reiterate the rights of medication administration that apply to all nursing levels, and to prevent future violations from occurring. Additionally, the Board finds that the Respondent's practice should be, at a minimum, indirectly supervised for the duration of the order. While the Board appreciates that the Respondent produced positive recommendations from her co-workers and supervising anesthesiologist, and acknowledges her error was not intentional, disregarding the basic rights of medication administration in the context of nurse anesthesia is particularly risky. Consistent with the ALJ's recognition that the full time supervision of Respondent's practice by an anesthesiologist provides sufficient safeguards to keep the Respondent's practice safe, the Board notes that Respondent's practice setting could change at any time, and such supervision might not be available. Indirect supervision of the Respondent's practice ensures she continues to incorporate the rights of mediation administration into her practice without placing unnecessary limitations on her practice. Indirect supervision also ensures that any deficiencies in the Respondent's practice can be discovered quickly and prevent harm to patients. The Board finds that the Respondent should also be required to inform her employers/practice sites of this order and to submit quarterly employer reports to the Board so the Board can monitor the Respondent's progress and compliance with the order. The Board also notes that these supervisory and monitoring stipulations are consistent with its precedent involving probated suspension orders. Further, these additional stipulations are consistent with 22 Tex. Admin. Code §213.33(e)(6)[15].

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[11] See page 25 of the PFD.

[12] See *id.*

[13] See page 29 of the PFD.

[14] 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.

[15] 22 Tex. Admin. Code §213.33(e)(6), 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.

IT IS THEREFORE ORDERED that Advanced Practice Registered Nurse License Number AP121858 and Registered Nurse License Number 816595, previously issued to AMBER KAY WALKINGTON, to practice nursing in the State of Texas are hereby **SUSPENDED** and said suspension is **STAYED** and RESPONDENT is hereby placed on **PROBATION** for a minimum of two (2) years **AND** until RESPONDENT fulfills the additional requirements of this Order.

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

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

C. Until successfully completed, RESPONDENT may not practice nursing in the State of Texas except in accordance with the terms of this Order.

D. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

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)

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. **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. APRN EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as an advanced practice registered 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 an advanced practice registered nurse have elapsed. Periods of unemployment or of employment that do not require the use of an advanced practice registered nurse (APRN) license will not apply to this period and will not count towards completion of this requirement. Further, Respondent may not work as a registered nurse (RN) or a vocational nurse (LVN) license, as applicable, while under the terms of this Order.

A. **Notifying Present and Future Employers, Practice Sites and Credentialing Agencies:** RESPONDENT SHALL notify each present employer, practice site and/or credentialing agency in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer, practice site and/or credentialing agency in nursing within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers, practice sites and/or credentialing agencies in nursing and present a complete copy of this Order, including all attachments, if any, to each future employer, practice site and/or credentialing agency in nursing prior to accepting an offer of employment and/or assignment.

B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer, practice site and/or credentialing agency in nursing to submit the Board's "Notification of Employment" form, which is provided to the RESPONDENT by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer, practice site and/or credentialing agency in nursing to submit the Board's "Notification of Employment" form, which is provided to the RESPONDENT by the Board, to the Board's office within five (5) days of employment as a nurse.

C. **Indirect Supervision:** RESPONDENT SHALL be supervised by an Advanced Practice Registered Nurse or Physician who is on the premises. The supervising Advanced Practice Registered Nurse or Physician 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 Advanced Practice Registered

Nurse or Physician shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. If being supervised by an Advanced Practice Registered Nurse, the supervising APRN must be in the same advanced role and population focus area as RESPONDENT. 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.

D. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each supervising Advanced Practice Registered Nurse or Physician 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 Advanced Practice Registered Nurse or Physician who supervises the RESPONDENT and these reports shall be submitted by the supervising Advanced Practice Registered Nurse or Physician 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.

VI. FURTHER COMPLAINTS

If, during the period of probation, an additional allegation, accusation, or petition is reported or filed against RESPONDENT'S license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

VII. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) and/or privilege(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 July, 2021.

TEXAS BOARD OF NURSING

Katherine A. Thomas

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

Attachment: Proposal for Decision; 507-20-3794 (March 31, 2021)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

March 31, 2021

VIA EFILE TEXAS

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

RE: Docket No. 507-20-3794; Texas Board of Nursing v. Amber Walkington

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.

/s/ Srinivas Behara
Administrative Law Judge
STATE OFFICE OF ADMINISTRATIVE HEARINGS

SVB/jh

cc: 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**
Kimberly Land Cormier, Beard Kultgen Brophy, Bostwick & Dickenson, PLLC, 15150 Preston Rd., Ste. 230, Dallas, TX 75248 – **VIA EFILE TEXAS**

SOAH DOCKET NO. 507-20-3794

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
AMBER WALKINGTON, AP21858 and RN 816595, Respondent	§	ADMINISTRATIVE HEARINGS

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SOAH DOCKET NO. 507-20-3794

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
AMBER WALKINGTON, AP21858 and RN 816595, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) filed one formal charge against Amber Walkington (Respondent), a Certified Registered Nurse Anesthetist (CRNA), seeking to revoke her registered nursing (RN) and advanced practice registered nursing (APRN) licenses. Staff alleges Respondent violated the minimum acceptable standards of nursing practice and engaged in unprofessional conduct when she failed to perform final verification of a spinal block medication, which resulted in the administration of an incorrect medication to the patient. The Administrative Law Judge (ALJ) concludes that Staff established some but not all of the disciplinary grounds alleged and recommends that the Board impose a probated suspension of Respondent's licenses for two years.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Notice and jurisdiction were undisputed and are set out in the Findings of Fact and Conclusions of Law without further discussion here.

ALJ Srinivas Behara of the State Office of Administrative Hearings (SOAH) convened the hearing on the merits through the Zoom government videoconferencing platform on October 26-28, 2020. Deputy General Counsel Jena Abel represented Staff. Respondent appeared and was represented by attorneys Kimberly Land Cormier and Courtney Boes Huber. The record closed on February 1, 2021, after receiving Staff's written rebuttal closing argument.

II. BACKGROUND/UNDISPUTED FACTS

United States Anesthesia Partners (USAP) has employed Respondent as a CRNA since 2011. Respondent was working for USAP on February 22, 2019, at a hospital called Medical City Frisco. Around 7 a.m., an 81-year-old male patient (Patient) arrived for a scheduled total knee replacement surgery. As part of the care team model, Respondent was assigned to provide anesthesia care to Patient during the procedure, specifically a spinal block. Respondent and her supervising anesthesiologist, Dr. LeBlanc, both assessed Patient pre-operatively.

Prior to taking Patient to the operating room (OR), Respondent reviewed Patient's records, introduced herself to Patient, and asked Patient a few questions. Respondent then checked the OR to confirm she had the equipment and medications she needed for the procedure. Respondent then accessed the hospital's central medication dispensing system (Pyxis) to pull two medications that were unavailable in the OR: (1) .5% bupivacaine for the spinal block, which is a local anesthetic/nerve blocker also referred to as its brand name, Marcaine; and (2) tranexamic acid (TXA), an antifibrinolytic medication that helps slow clots postoperatively and allows the surgeon to give patients less blood products. Sometime between when Patient entered the OR around 9:08 a.m. and 9:25 a.m., a medication error occurred during Respondent's placement of the spinal block.

Respondent, the anesthesia technician, and the circulating nurse were the only personnel in the OR with Patient at the time of the error. The circulating nurse felt ill that day and asked the anesthesia technician for assistance with the procedure. A sterile field must be maintained to perform a spinal block—meaning Respondent could not herself touch the vial to draw up the .5% Marcaine—so she requested the anesthesia technician's assistance to hold the medication for the spinal block. Respondent passed the .5% Marcaine to the anesthesia technician, gloved in, and then asked the anesthesia technician for the medication. As Respondent drew the medication into the syringe, she did not perform a final check to read the label on the vial of medication the anesthesia technician was holding, and she did not ask the anesthesia technician to read the label out loud before drawing it. Respondent was unable to place the spinal block at the first level that she tried, but she achieved successful cerebral spinal flow at the second level and administered

what she believed to be 3 mL of .5% Marcaine intrathecally (i.e., into Patient's spinal canal). Patient complained of burning and itching around the buttock region. Respondent began cleaning up and when she looked around the spinal tray, she discovered the .5% Marcaine vial unused. Respondent looked at the vial she drew from and realized she had inadvertently administered 3 mL of TXA intrathecally into Patient. TXA is not approved to be administered intrathecally by the United States Food and Drug Administration.

Respondent immediately texted Dr. LeBlanc. Before Dr. LeBlanc returned to the OR, Respondent decided to perform the correct spinal block with .5% Marcaine, which Respondent completed successfully. Dr. LeBlanc entered the room and after some discussion and research into intrathecal injection of TXA, he decided to cancel the surgery. Patient's vital signs were stable and he was transferred to the post-anesthesia care unit (PACU). Around 10:15 a.m., Patient began involuntary jerking, and he transferred to the intensive care unit (ICU) at Medical City Frisco, where he was intubated. Later that day Patient transferred to a sister hospital, Medical City Plano. Patient remained in the ICU at Medical City Plano for about five days before transferring to University of Texas (UT) Southwestern Medical Center for another five weeks. Patient eventually transferred to a skilled nursing facility for an additional month before discharge to his home.

III. APPLICABLE LAW

The Texas Nursing Practice Act, found in chapter 301 of title 3, subtitle E of the Texas Occupations Code (Code), empowers the Board to discipline licensees, for, among other things, engaging in unprofessional conduct (Code § 301.452(b)(10)) or failing to meet minimum standards of nursing practice (Code § 301.452(b)(13)). Staff asserts that Respondent's conduct described above is grounds for disciplinary action under the two Code provisions above, as well as pursuant to Board Rules 217.11 and 217.12, described below.[1]

[1] For ease of reference, the Board's rules, found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code, shall be referred to as "Board Rule ____." Unless stated otherwise, this Proposal for Decision cites the rules in effect when the alleged conduct occurred.

Board Rule 217.11 discusses minimum acceptable standards of nursing practice, four of which Staff alleged were not met by Respondent:

- **Board Rule 217.11(1)(A)**: Nurses must know and conform to the Texas Nursing Practice Act, the Board's rules and regulations, and federal, state, or local laws, rules, or regulations affecting the nurse's current area of nursing practice;
- **Board Rule 217.11(1)(B)**: Nurses must implement measures to promote a safe environment for clients and others;
- **Board Rule 217.11(1)(C)**: Nurses must know the rationale for and the effects of medications and treatments and shall correctly administer the same; and
- **Board Rule 217.11(1)(M)**: Nurses must institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.

Staff also alleges Respondent violated three provisions of Board Rule 217.12, which addresses unprofessional conduct:

- **Board Rule 217.12(1)(A)**: Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;
- **Board Rule 217.12(1)(B)**: Failing to conform to generally accepted nursing standards in applicable practice settings;
- **Board Rule 217.12(4)**: Engaging in conduct that may endanger a client's life, health, or safety;

Finally, Staff alleges Respondent's conduct implicated three Board rules specific to advanced practice nursing. Board Rule 221.12 states that an APRN may perform only those functions which are within that scope of practice and which are consistent with the Nursing Practice Act, Board rules, and other laws and regulations of the State of Texas. Board Rule 221.13 provides that an APRN shall know and conform to the Nursing Practice Act; current Board rules, regulations, and standards of professional nursing; and all federal, state, and local laws, rules, and regulations affecting the advanced role and specialty area. Board Rule 221.15(a) pertinently states in a licensed hospital or ambulatory surgical center, consistent with facility policy or medical staff bylaws, a CRNA may select, obtain, and administer drugs in maintaining the patient in sound physiologic

status pursuant to a physician's order for anesthesia or an anesthesia-related service, and this order need not be drug specific, dosage specific, or administration-technique specific.

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 at issue, taking into account mitigating and aggravating factors.[2] The Matrix classifies offenses by tier and sanction level, and must be consulted by the ALJ and the Board in determining the appropriate sanction.

Staff had the burden of proving its allegations by a preponderance of the evidence.[3]

IV. DISCUSSION

A. Summary of Dispute

There were only two witnesses at the hearing who were also in the OR when Respondent injected Patient intrathecally with TXA: the anesthesia technician and Respondent. Although their versions of events differ slightly from one another, the parties agree that the salient question is whether Respondent violated the standard of care. The parties further agree that, although there is no Board rule specifically addressing how to administer medications, a basic principle of nursing is the "Five Rights" of medication administration: the nurse shall confirm that he or she has the right patient, the right medication, the right dose, the right time, and the right route. All nurses, including CRNAs, are required to utilize the Five Rights when administering medication to a patient. Finally, the parties agree that a nurse may not delegate his or her duty of medication administration to an unlicensed person and that the duty to follow the Five Rights remains with the nurse.

Staff alleges that Respondent violated the standard of care because she did not follow one of the Five Rights—confirming the right medication. According to Staff, for Respondent to ensure

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[2] Board Rule 213.33; *see also* Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

[3] 1 Tex. Admin. Code § 155.427.

that the medication was correct and not expired, Respondent was required to ask the anesthesia technician to read the medication label aloud, or have the anesthesia technician show the vial to Respondent as she prepared to draw up the medication so that she could read the label herself. Respondent, on the other hand, counters that she followed the Five Rights and it was sufficient to check the medication vial right before she handed it off to the anesthesia technician, specifically because Respondent was expecting to receive the medication back immediately from the anesthesia technician. In other words, Respondent argues that based on the circumstances, there was no reason to think that the anesthesia technician would set the medication down or swap out the medication with an incorrect one.

B. Evidence

Staff offered 17 exhibits that were admitted and the testimony of the following eight witnesses: (1) Barbara Fox, Patient's wife; (2) Lei Wang, Patient's neurologist at Medical City Plano; (3) Aaron (Mike) Hart, the anesthesia technician; (4) Respondent;[4] (5) Kirk LeBlanc, Patient's anesthesiologist at Medical City Frisco; (6) James Walker, Staff's expert witnesses on CRNA practice; (7) Jonathan Dru Riddle, Staff's expert witness on CRNA practice; and (8) Jolene Zych, Staff's expert witness on the Board's statute and rules.

Respondent offered six exhibits that were admitted and offered the testimony of the following three witnesses: (1) Respondent; (2) Catherine Keen, Respondent's expert witness on CRNA practice; and (3) Jordyn Feldmann, Respondent's expert on CRNA practice.

1. Staff's Evidence

a. Testimony of Barbara Fox

Ms. Fox testified about her husband's lifestyle and health prior to and after the medication error at issue. The following is a summary of her testimony:

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[4] Although Respondent testified in both parties' case-in-chief, her testimony is summarized in this Proposal for Decision in Respondent's evidence section.

Patient was active husband and grandfather who enjoyed playing golf and cards with his friends. He was active in a men's prayer breakfast and enjoyed going to the horse race track. Although Patient had diabetes, it was well-controlled, and he had no issues with memory loss. Patient's surgeon, Dr. Toulson, evaluated Patient on February 14, 2019, one week prior to the scheduled surgery, and found him healthy enough to undergo the knee surgery.

After the medication error, Patient was intubated. Patient's jerking activity would not stop, so he had to be transferred via ambulance to the Medical City Plano ICU, where he spent five days. At Medical City Plano, Patient was given a large amount of barbiturate or anti-seizure medication. He was not able to move his body at that time, but by the time he was moved to the neurology wing at Medical City Plano, he could move or squeeze his fingers and no longer required intubation, although he still required supplemental oxygen. Patient still had not regained consciousness, and he was then transferred to UT Southwestern.

After approximately 10 days, Patient regained consciousness, and he spent a week on the neurology floor before moving to the rehabilitation floor where he stayed for an additional month. It was at UT Southwestern that Ms. Fox first learned that her husband suffered an anoxic brain injury at Medical City Plano. After some recovery, Patient was then transferred to a rehabilitation facility for an additional month, where he received physical and speech therapy and assistance with his mobility. Patient was finally discharged on May 20, 2019, but he continued to have short-term memory issues after returning home. Ms. Fox noted that based on neurological condition, Patient walked with the assistance of a walker, and eventually a cane, and he could never drive a car again because of his memory loss and loss of reflexes. Ms. Fox had to manage her husband's diabetes or else he would have forgotten to do it himself. Patient received in home therapy for six weeks, after which time, he received physical and speech therapy at UT Southwestern. Ms. Fox's husband passed away on April 21, 2020.

b. Testimony of Lei Wang, M.D.

Dr. Wang, a neurologist at Medical City Plano, testified about her treatment of Patient. Dr. Wang's testimony is summarized below:

On her first observation of Patient after his transfer, Patient was in the ICU, intubated, and experiencing violent jerking activities that had not subsided, despite being on several medications intended to stop the seizing activity. Dr. Wang ordered an EEG to determine the effect the seizing activity was having on Patient's brain as she had never had a patient who had been suffering from seizures after receiving TXA intrathecally.

Dr. Wang reviewed medical literature and concluded that the constant jerking activity posed a risk of brain damage to the patient. Dr. Wang testified that Patient did not receive sodium thiopental, a short-acting medication recommended by the literature, because the hospital did not have it. Instead, Dr. Wang prescribed Pentobar, an analog medication that has chemical and therapeutic similarities. Dr. Wang acknowledged that Patient received Pentobar at levels that were above the therapeutic range, but she denied that the levels were toxic. Patient was kept in a pharmacologically-induced coma in an effort to stop his seizing activity. According to Dr. Wang, if the seizing activity could not be stopped, Patient could not return to normal mental status and would not be able to regain consciousness.

Over the period of time that Patient remained at Medical City Plano, Patient's bodily seizure activity slowed and then stopped. Although patient's brain seizures continued, by the time he was transferred to UT Southwestern, his brain seizures had ceased as well. At one point during his treatment, however, the attending physician diagnosed Patient with pneumonia. Dr. Wang could not testify to what extent the seizures affected the patient's mental status, as he was transferred to UT Southwestern before he recovered enough to be evaluated.

Based on her research, Dr. Wang opined that the injection of the TXA into the Patient's spinal column caused irritation to the spinal cord/nerve root, and once it circulated into Patient's brain, caused irritation, ischemic changes, lack of blood circulation, and the seizures.

c. Testimony of Aaron (Mike) Hart

At the time of the event, Mr. Hart was the lead anesthesia technician at the Medical City Frisco and had worked there for two years. Mr. Hart described that anesthesia technicians at

Medical City Frisco primarily assist and are supervised by anesthesiologists during surgical procedures. Mr. Hart does not hold any licenses or certifications in Texas. According to Mr. Hart, anesthesia technicians are not permitted to pull medications from the hospital's central or operating room Pyxis, and anesthesia technicians do not receive any specialized training about medications used during surgical procedures, the appropriate routes of administrations, or contraindications. Anesthesia technicians are also not permitted to choose the medications used in the surgical procedures or administer medications to patients during surgical procedures. Anesthesia technicians are, however, permitted to hold medications for an anesthesiologist or CRNA so the anesthesiologist or CRNA could draw up the medication. In those situations, Mr. Hart testified, he would typically show the name of the medication to the anesthesia provider, who would then read back the name of the medication and the expiration date to ensure the medication was correct and not outdated. Mr. Hart testified that this verification procedure was not unique to him, and was commonly utilized in the operating rooms with anesthesiologists. At the time of the event, Mr. Hart had utilized this verification procedure with anesthesiologists at Medical City Frisco, but not with any of the CRNAs. Mr. Hart noted there were typically not many CRNAs practicing at the hospital except for about four times that he could remember.

Mr. Hart testified as follows about his arrival in the OR:

- Mr. Hart was not originally scheduled to be in Patient's operating room, but he was asked to come into Patient's operating room to assist with holding the patient, who was relatively big, because the assigned nurse was feeling ill that day.
- When Mr. Hart arrived in the OR, Patient was awake and sitting up, and Respondent was behind the patient with her gloves on, preparing the spinal block. Mr. Hart could not remember for certain but he felt that the spinal block had already begun, or at least that Respondent had prepped Patient, because according to Mr. Hart, the spinal tray was already opened.
- Mr. Hart relieved the ill nurse and he got in front of Patient with Patient's legs hanging off the table and body facing him. Mr. Hart had his hands on both of Patient's shoulders to keep him from falling back or forward off the table.
- Respondent needed Patient to bend his back and poke it out, and Patient had his head on Mr. Hart's shoulder while talking into Patient's ear about some topic he could not recall. Mr. Hart recalled that Patient joked with him, asking Mr. Hart if Respondent "had ever done this before," referring to the spinal block procedure.

Mr. Hart recalled the following about the medication error:

- Respondent asked loudly for the medication with the "green top." Mr. Hart thought Respondent was asking the nurse and no one spoke back or did anything. Respondent repeated her request and asked Mr. Hart, by name, to hand her the medication with the green top sitting on top of the anesthesia machine.
- Mr. Hart held Patient with one hand, obtained the medication from the anesthesia machine with his other hand, and asked Respondent if the medication vial was the correct medication she was requesting. Respondent was not looking at the vial when Mr. Hart asked her if it was correct vial, so he asked Respondent again if the medication he was holding was the medication Respondent wanted.
- Mr. Hart held up the medication vial with two fingers allowing the label to face Respondent so that it was visible, expecting her to look at the medication so she and Mr. Hart could verify the medication name and expiration date together. However, Respondent did not read the name of the medication or expiration date. Instead, Respondent seemed to respond angrily, or like she was in a rush, and told Mr. Hart, "Yes, Mike, that one," indicating to him that the vial he was holding was the correct medication.
- Mr. Hart then popped off the top of the medication, and Respondent drew up the medication into the syringe and completed the spinal block.
- Patient complained about a burning or itching, and Mr. Hart helped lay down Patient on the bed while Respondent began cleaning up after the procedure. Respondent walked near the anesthesia machine and rushed back and asked Mr. Hart to sit Patient back up. Respondent asked Mr. Hart to pull another spinal tray but he was holding Patient, so he asked the scrub technician to get a new spinal tray.
- Mr. Hart noticed a medication vial with a blue top sitting on top of the anesthesia machine.
- Mr. Hart repositioned Patient, who was still complaining of burning and itching. Patient was difficult to keep still.
- The scrub technician brought in spinal tray. Respondent did not ask Mr. Hart to draw up any medication this time. Respondent opened the spinal tray and administered a second medication into Patient's spine.

Mr. Hart testified he could not recall if he ever stated that it was "my fault" after the wrong medication was administered. According to Mr. Hart, as soon as he left the OR, he checked his phone to search what can happen when the wrong medication is injected during a spinal block.

Mr. Hart then discussed the situation with his supervisor, and his supervisor alerted Dr. LeBlanc. He denied speaking with Dr. LeBlanc before exiting the OR. Mr. Hart testified that had he been aware of any potential danger, or if he were asked to do something that he knew would cause harm to a patient, he would have notified someone. Mr. Hart did not receive any employment discipline relating to the incident and continues to work at Medical City Plano. However, Mr. Hart sends a different anesthesia technician to assist with Respondent's procedures.

d. Testimony of Kirk LeBlanc, M.D.

Dr. LeBlanc described that he has been Respondent's supervising anesthesiologist for about eight years, and he has observed her perform thousands of procedures, including about 150 spinal blocks a year. Dr. LeBlanc opined that Respondent's clinical skills are among the top 3 of the 70 to 80 CRNAs he has supervised over his career. The following is a summary of Dr. LeBlanc's testimony about the incident:

- Not long after performing a preoperative assessment of Patient, Dr. LeBlanc stepped back into the OR and observed Respondent prepping Patient for the spinal block, with draping around Patient's back and Mr. Hart holding up Patient. A nurse technician was in the corner of the room near a desk.

- Dr. LeBlanc walked to another operating room about 20 yards away to observe a different patient scheduled for a procedure. Dr. LeBlanc could not recall how long he was in that room but he remembered receiving a text message from Respondent to go back into the OR. Dr. LeBlanc returned to the OR within about 10 seconds of seeing the text and observed Patient laying down on the bed with Mr. Hart near the bed.

- Respondent then told Dr. LeBlanc what happened and Dr. LeBlanc overheard Mr. Hart say it was "my fault." Dr. LeBlanc determined that Patient was stable, and he informed Respondent to go ahead and finish preparing Patient for the surgical procedure while he researched the effects of TXA, if any.

- Dr. LeBlanc did not have experience with the intrathecal administration of TXA and he decided to consult with the primary surgeon to determine the next steps. Dr. LeBlanc spoke with his partners, who also did not have any knowledge regarding the effect of intrathecal injection of TXA for a patient.

- After conducting some research, Dr. LeBlanc found case reports indicating that patients could succumb very quickly to cardiac arrhythmias as a result of intrathecal

administration of TXA, specifically ventricular tachycardia (fast, abnormal heart beat) or ventricular fibrillation (severely abnormal heart rhythm). One case report from a neurologist suggested a few medications, including mannitol (for cerebral edema), kepra (for seizures), and decadron (an anti-inflammatory drug).

- Within about 10 minutes of finishing his research and speaking with the surgeon, Dr. LeBlanc returned to the OR. Patient's vital signs were still stable and Patient was asleep as he had been sedated from propofol. Dr. LeBlanc informed Respondent that Patient's knee replacement procedure was cancelled; he ordered mannitol, kepra, and decadron for Patient; and he ordered Patient to be moved to the PACU.

Dr. LeBlanc testified that Patient's condition was generally fine in the PACU. Dr. LeBlanc was optimistic about Patient's recovery because Patient did not exhibit any signs of cardiac arrhythmias. According to Dr. LeBlanc, Patient was having seizures but he was not as concerned with the seizures because, unlike the possible heart issues, seizures will not often result in death. After Patient was transferred out of Medical City Frisco, Dr. LeBlanc visited Patient the first three or four weeks about every other day at the other hospitals. Dr. LeBlanc testified that he was later informed that Patient had aspirated a significant amount of fluid out of his lungs and he had to be re-intubated in the ICU.

Dr. LeBlanc stated that he did not instruct Respondent to perform the spinal block after the misadministration of TXA, and it would not have been his choice, but he did not have any concerns with Respondent's decision to do so. Dr. LeBlanc noted that when he instructed Respondent to continue prepping Patient for the procedure, he understood that preparation would include intravenous administration of TXA. Dr. LeBlanc stated that he did not have any concern with Respondent's abilities to practice safely and he continues to work with her on anesthesia procedures.

e. Testimony of James Walker, Ph.D., CRNA

Dr. Walker[5] has been a licensed CRNA for over 20 years. The entirety of his employment in the field of nursing anesthesia has been through the Baylor College of Medicine, where he is

[5] The title "Dr." for this witness refers to a doctorate degree in nursing.

presently the Director of the Nurse Anesthetist Program. Dr. Walker testified that he has not been in the OR for the last three years, and that he has not been in the full-time practice of providing clinical CRNA services for about 10 years. Dr. Walker described that the Five Rights are designed for nurses to avoid medication errors and to ensure patient safety. According to Dr. Walker, a CRNA cannot rely on an unlicensed person to ensure the correct medication is being given to a patient. Dr. Walker further testified that the use of anesthesia technicians in operating rooms is not uncommon, and in some cases, is required for anesthesia providers to administer necessary anesthetic medications to patients in a sterile manner. In such situations, anesthesia technicians are often asked to hold medication vials for the anesthesia provider to draw from and then administer. Unlicensed individuals, such as anesthesia technicians, however, have not been educated about the drugs themselves, even though they may work around them, and they are not tasked with understanding what the drugs are used for, or knowing their indications or contraindications. In contrast, CRNAs are educationally prepared to choose the particular anesthetic medications used during surgical procedures, as well as understanding medication interactions, contraindications, and their pharmacological effect. CRNAs are also educationally prepared, and required, to know the proper routes of administration of the medications they administer.

Dr. Walker testified that he has made medication errors as a CRNA, and he opined that because everyone is capable of making mistakes, like picking up the wrong vial of medication, the nurse should make the final check of the medication before drawing it. Dr. Walker testified that the following standard of care taught in CRNA educational programs is no different than the standard of care applicable in real world settings:

- The nurse should read the label of the medication to confirm the correct medication and concentration.
- If a nurse is asking a person to assist in drawing a medication, regardless of who is assisting, the nurse must request that person show the vial so that the nurse can read it to his or herself.
- After determining the medication is correctly identified and the dosage is correct, the nurse should ensure that the medication is not expired, and then ask the person assisting to invert the vial to allow the syringe to draw the medication.

According to Dr. Walker, this method of verification has been taught for over 20 years, and he uses the method in his own clinical practice. Dr. Walker further noted that CRNAs have been providing anesthesia services for over two centuries, and it has always been the standard of care that nurses administer the correct medications to patients.

f. Testimony of Jonathan Dru Riddle, Ph.D., CRNA

Dr. Riddle[6] testified as an expert on the standard of care for medication administration. He is employed as an associate professor in the nurse anesthesia training program at Texas Christian University in Fort Worth, Texas. When Dr. Riddle was in full-time practice, he performed over 100 cases per month. Dr. Riddle's opinions largely mirrored those of Dr. Walker—the CRNA's final check of the correct medication and correct concentration has to come when he or she withdraws the medication from the vial, regardless of how many times the CRNA has checked it before. Dr. Riddle noted that the CRNA can ask the person holding the vial to position it in such a way that the label can be read, specifically to move their hand or turn the vial so that the label is visible.

Dr. Riddle further testified that if using a medication that is not contained in the spinal kit, the nurse must place the medication somewhere outside of the sterile field, typically on some sort of anesthesia cart, in close proximity where the CRNA can keep an eye on it. In addition, if there are several medications that the CRNA intends to use, a CRNA should place the medication that the CRNA does not intend to immediately use away in a drawer so it is not out and readily available to be inadvertently confused or picked up when it is not intended for administration yet.

According to Dr. Riddle, he has made at least one medication error as a CRNA. Dr. Riddle testified that one instance was similar to the allegations in this case when he intended to draw a local anesthetic to give a patient for a Cesarean delivery but mistakenly administered epinephrine. Because of the mistake, the patient had to be put under general anesthesia for the delivery, but otherwise there was no harm to the patient or the baby. Dr. Riddle noted that, although his error

[6] The title "Dr." for this witness refers to a doctorate degree in nursing.

occurred in a different jurisdiction than Texas, he did not receive any significant discipline as a result and went on to have a successful career.

g. Testimony of Jolene Zych, Ph.D, RN, APRN

Dr. Zych[7] is a nursing consultant for the Board, and her duties include answering questions from the public, legislators, nurses, and others regarding a broad range of nursing practice topics. Dr. Zych is familiar with the Board's policies with respect to all levels of nursing, including CRNAs. According to Dr. Zych, Respondent would have violated the Code if the conduct alleged in the single formal charge is found to be proven by a preponderance of the evidence. She discussed each Board Rule that Respondent allegedly violated, her use of the Disciplinary Matrix to recommend an appropriate sanction, and any applicable mitigating and aggravating factors.

If the charge was proven, under either Code § 301.452(b)(10) or Code § 301.452(b)(13), Dr. Zych opined that the conduct would fall under Tier 3, Sanction Level 1. Dr. Zych further testified that although the conduct was isolated, there was more than a risk of harm. This conclusion was based primarily on Patient's seizures and the subsequent transfer to a higher level of care, which according to Dr. Zych was evidence of actual, serious harm to Patient that was known or should have been known. She also noted that the serious risk of harm at a minimum included potential cardiac arrhythmias. Dr. Zych also referred to the fact that Patient lost the ability to have the knee replacement procedure. Mitigating factors in favor of Respondent were that Respondent did not have any prior Board history or issues with prior practice, and Dr. Zych further credited Dr. LeBlanc's professional character testimony in favor of Respondent. Another mitigating factor was Respondent's prompt, full disclosure to Dr. LeBlanc of the error.

Dr. Zych opined that Respondent's omission in failing to verify the medication before administering it demonstrated incompetence to a level that Respondent should not practice without remediation and subsequent demonstration of competency. Part of Dr. Zych's testimony focused on Respondent's reluctance to take full responsibility or ownership of the medication error, which

[7] Dr. Zych has bachelor's and master's degrees in nursing. The title "Dr." refers to her doctorate degree in public policy and administration.

according to Dr. Zych, affected Respondent's trustworthiness. Dr. Zych questioned whether Respondent has the ability to practice safely in what is a fairly autonomous role of a CRNA. Dr. Zych also raised concerns about the administration of additional drugs, such as the spinal block, after the TXA was administered incorrectly.

Finally, Dr. Zych testified that in her view, if more than one section of Code is implicated in a case like here, the Disciplinary Matrix requires that the highest level of sanction be considered. Although the Disciplinary Matrix allows for suspension of a nurse's license under Code § 301.452(b)(13), the applicable discipline under Code § 301.452(b)(10) is revocation. Accordingly, Dr. Zych recommended revocation of Respondent's nursing licenses.

2. Respondent's Evidence

a. Testimony of Respondent Amber Walkington, CRNA

Respondent has 18 years' experience of patient care. She practiced in Michigan for several years before moving to Texas in 2012, when she received her RN and APRN licenses from the Board. As a CRNA, Respondent has performed thousands of spinal blocks and epidurals. Respondent primarily provides anesthesia services at Medical City McKinney but rotates at several other facilities, including Medical City Frisco. At the time of the incident, Respondent had only worked at Medical City Frisco no more than five times. The following is a summary of Respondent's testimony about the incident:

Respondent pulled .5% Marcaine and TXA from the central Pyxis prior to Patient's procedure. Respondent did not recall what color tops were on the vials of the TXA or .5% Marcaine. The spinal tray contained .75% Marcaine, but Respondent did not intend to use it because unlike the .5% Marcaine, which lasts three to four hours, it only lasts two or three hours. Respondent could not recall exactly where she placed the medications in the OR but thought she placed the TXA either on a back table or on the anesthesia cart. Respondent recalled placing the .5% Marcaine next to the spinal tray and gloves. She believed she also had placed propofol and

1% lidocaine, which were already drawn into syringes, either on the anesthesia cart or in a locked drawer of the anesthesia cart. Respondent then left to bring Patient into the OR.

Patient had not been medicated yet, had his faculties, and was sitting on the side of the bed alone with his legs dangling off the bed. Generally for spinal blocks, patients need to curl their shoulders and look at the belly button to arch the back so that the spaces in the spine are open and more accessible. Another nurse or the anesthesia technician will help stabilize the patient, who is bending forward, so it is a standard position for whoever is assisting to be in front of the patient, while the anesthesia provider is behind the patient. Since the nurse was not feeling well and someone needed to help stabilize Patient, who was about 5'11" and 220 pounds, Mr. Hart assisted. Respondent affixed monitors to Patient for blood pressure and pulse oximetry, and she then grabbed the anesthesia spinal tray, the .5% Marcaine, and her gloves. Respondent moved from the anesthesia cart area to the back of the bed, and she simultaneously handed the anesthesia tray and the .5% percent Marcaine to Mr. Hart. Respondent asked Mr. Hart to open the spinal tray. Respondent did not hand him any other medication, and she never saw Mr. Hart touch any other medication. Respondent was not sure if Mr. Hart set the medication down so he could open the spinal tray. Respondent then palpated Patient's pelvis area to help find landmarks for the spinal block, which took 5 to 10 seconds, and she then placed on her gloves sterilely.

Respondent prepared Patient for the spinal block with the contents of the spinal tray. She opened up the iodine cleansing solution, poured it in a tray, dipped sponge sticks into the iodine, and then cleansed Patient's back at the level she anticipated doing the spinal block. She repeated the steps three times to cleanse the area. Respondent placed a clear drape on Patient by peeling the sticker on the top portion and opening up the drape widely, affixing it to Patient's upper back. Respondent applied the lidocaine and was ready for the spinal block.

Respondent then asked Mr. Hart to hand her the .5% Marcaine, either by referring to it as bupivacaine or "the local." Respondent disagreed with Mr. Hart's recollection that he asked her two times about which medication Respondent was requesting. Respondent stated that she did not ask for the medication by the color of its top because that is not how she was trained to call for medications. Respondent admitted she did not ask Mr. Hart to show her the label of the medication

or read the label of the medication to her at the time she drew up the medication. Respondent also did not read the label simultaneously while drawing up the medication or ask Mr. Hart to show her the label immediately before or after she drew up the medication. Respondent placed the syringe on the spinal tray and, after missing the first placement of the spinal needle, injected the syringe into the patient's spine.

Respondent began cleaning up and noticed that the .5% Marcaine was underneath the drape of the spinal tray but it was unused. Patient was also complaining of itching around his buttocks area. Respondent returned to the head of the bed and picked up an open vial of TXA and read the label. She asked Mr. Hart if it was the bottle that he held up for her when she asked for the local and he said yes. Respondent then sent a text message to Dr. LeBlanc asking him to return to Patient's room. Respondent requested an additional spinal tray, and Mr. Hart initially brought an epidural tray before returning with another spinal tray. According to Respondent, she was hoping that if the TXA was not beneficial it was at least neutral, possibly not attaching to any receptor sites. In the worst case scenario, the TXA could be detrimental and Respondent thought that, based on pharmacodynamics and her training, the spinal block could block the receptor sites and dilute the concentration of any medication, in this case TXA, that would have a negative effect. After placement of the second spinal block, Patient's burning or itching sensation went away. Respondent did not witness any seizure activity from Patient after the TXA was administered. Respondent testified that she was performing the spinal block with the .5% Marcaine as Dr. LeBlanc returned to the room to evaluate the situation.

Dr. LeBlanc researched intrathecal administration of TXA and eventually informed everyone that the knee replacement surgery was canceled. Respondent pushed patient to PACU on a stretcher, hooked him up to monitors in recovery, stayed with Patient in PACU during the course of his stay, and only left for brief moments to grab medications. It was not until Patient was taken to PACU when the first jerking was observed. The Medical City Frisco ICU only has 20 beds and no neurological ICU, while Medical City Plano was a Level 1 trauma center with more specialized ICU units, so Patient was eventually transferred to Medial City Plano.

Respondent testified that the medical literature suggests the rate of improper intrathecal administration of TXA has escalated due to the medication being used more in practice settings. According to Respondent, she felt there were several contributory factors to consider with the medication error, including the lack of fully-staffed operating room and Mr. Hart handing over a different medication than the one she handed to him. Respondent expressed that the incident has caused significant distress and grief in her personal life and in her professional life, she has made adjustments to her practice to make a final analysis of the vial when drawing up the medication.

b. Testimony of Catherine Keen, CRNA

Ms. Keen testified as an expert in CRNA standard of care. She has been a CRNA for almost 12 years and is also employed with USAP. Based on her experience working with and observing Respondent, Ms. Keen described Respondent as vigilant, professional, conscientious, thorough, and well-respected. Ms. Keen opined that Respondent complied with the standard of care, specifically the Five Rights. Ms. Keen based her opinion primarily on two facts: (1) Respondent confirmed she handed .5% Marcaine to Mr. Hart; and (2) Respondent expected to immediately receive the .5% Marcaine back as soon as she gloved in. According to Ms. Keen, no reasonably prudent nurse would expect that the anesthesia technician would have set the medication down and changed it, or swapped the medication before handing it to Respondent. Ms. Keen noted that she has worked with Mr. Hart before and further noted that the vials for Marcaine and TXA are similar in size.

c. Testimony of Jordyn Feldmann, CRNA

Ms. Feldman has been a CRNA for about five years and works for Garland Anesthesia Consultants. Ms. Feldman offered opinions on the standard of care, Respondent's conduct after the medication error, and mitigating circumstances. Like Ms. Keen, Ms. Feldman opined that Respondent met the standard of care by confirming the mediation before passing it to Mr. Hart because Respondent expected it immediately back. Based on her review of anesthesia record and medical literature provided by Staff and Respondent, Ms. Feldman opined that a CRNA would not have known what to do if TXA is inadvertently injected intrathecally.

Ms. Feldman further testified that Patient appeared to remain hemodynamically stable throughout what was documented. According to Ms. Feldman, Respondent's conduct after the error demonstrated sound judgment in that Respondent checked the vial of TXA to ensure it was preservative-free, and Respondent came up with a supported plan repeat the spinal with the .5% Marcaine in an effort to dilute the TXA. Ms. Feldman further opined that the main takeaway from this case is the totality of the circumstances should be considered, that medication errors are multifactorial, and there are rarely medications errors that arise from one single misstep or mishap.

D. Analysis

1. Conduct Established

Staff proved by a preponderance of the evidence that Respondent failed to meet the minimum standards of nursing practice in this case. Although Mr. Hart's recollection differed from Respondent's, the undisputed facts demonstrate that Respondent failed to perform a final verification that the medication she was administering to Patient was the correct medication. Prior to Patient's procedure, Respondent pulled TXA and .5% Marcaine from the central Pyxis. Respondent placed some medications, including propofol and lidocaine, in a locked drawer of the anesthesia cart. However, Respondent did not place TXA or the .5% Marcaine in the locked drawer of the anesthesia cart. Respondent was uncertain where she placed the TXA, which could have been on a back table or on the anesthesia cart. Accordingly, TXA was unaccounted for in that the Respondent could not identify where it was at the time of the procedure.

Although the Respondent asserts she verified the .5% Marcaine when she picked it up and handed it to Mr. Hart contemporaneously with the spinal tray, the preponderant evidence demonstrated that Mr. Hart would have likely placed the medication down somewhere to open up the spinal tray and/or stabilize Patient. Mr. Hart did not have access to any medication other than those that had been placed on the anesthesia cart by Respondent or handed to him by Respondent. Respondent also did not suggest that she had her eyes on the .5% Marcaine vial the entire time even after handing it to Mr. Hart. Accordingly, the undisputed facts demonstrate that, at the point when Respondent asked for the medication to begin the spinal block, Mr. Hart could have handed

back the following medications to Respondent: (1) the .5% Marcaine, as Respondent had expected; (2) the .75% Marcaine in the spinal tray, which Respondent did not intend to use; or (3) the unaccounted-for TXA, which was possibly on the anesthesia cart and/or near the spinal tray.

As Ms. Keen testified, the Marcaine and TXA vials look similar in size, and Mr. Hart was not trained, expected, nor licensed to determine which medication was correct. The parties agree that Respondent, as the licensed individual, is the only one responsible for accounting for the medications. Given that the TXA was not accounted for in the OR, the evidence supports Staff's assertion that the minimum standards of nursing practice required Respondent to at least perform one of the following acts before administering the medication: ask that Mr. Hart read the name of the medication aloud to confirm the medication; or ask Mr. Hart hold the medication vial closer and/or reposition his hands so that Respondent could verify its contents by reading the label of the medication herself. Respondent did neither. In other words, at the time Respondent drew up her syringe from the medication vial Mr. Hart was holding up for her, she assumed, but did not know for certain, what vial Mr. Hart was holding up.

By failing to follow the Five Rights, specifically Respondent's failure to verify the correct medication before administering it to Patient, Staff proved that Respondent's conduct supports disciplinary action under the following Code provisions and Board Rules: Code § 301.452(b)(10), (13); and Board Rules 217.11(1)(A), (B), (C) and 217.12(1)(A), (B), (4). The same conduct demonstrates that Respondent failed to practice in conformity with the following standards required for APRNs and those specific to CRNAs in a surgical center: Code § 301.452(b)(13); Board Rules 221.13, .15. Staff did not demonstrate that Respondent acted outside her scope of practice as an APRN. Accordingly, Board Rule 221.12 is not implicated by Respondent's conduct. Staff also did not demonstrate by a preponderance of the evidence that Respondent failed to institute appropriate nursing interventions. Instead, the evidence suggested that Respondent acted appropriately when the error was discovered. Accordingly, Board Rule 217.11(1)(M) is not implicated by Respondent's conduct as stated in the formal charge.

2. Sanction Analysis

Staff sufficiently proved most of the allegations in the formal charge against Respondent, thereby warranting the imposition of sanctions against her. Pursuant to Board Rule 213.33(a), the Board and SOAH are required to utilize the Matrix in all disciplinary matters to determine the appropriate sanction. For a violation of Code § 301.452(b)(10) or (b)(13), the Matrix lists possible sanction tiers and levels. Whether Respondent's conduct is analyzed as unprofessional conduct prohibited by Code § 301.452(b)(10) or as a failure to meet the minimum practice standards set out in Code § 301.452(b)(13), Staff argues a Third Tier, Sanction Level I classification is appropriate under the Matrix. As discussed below, Respondent's conduct is most appropriately analyzed as a violation of Code § 301.452(b)(13), as it involved a failure to meet the minimum standards of nursing practice, specifically the Five Rights, rather than what is typically considered unprofessional conduct that could deceive, defraud, or injure a patient. Further, Respondent's violation falls under the Third Tier. Based on the aggravating and mitigating factors in this case, a Sanction Level I classification is appropriate, and a two-year probated suspension would adequately protect the health, safety, and welfare of the public.

a. Third Tier Sanction

The First Tier of the Matrix for either Code section 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)). Although Respondent's conduct was isolated, the preponderant evidence showed adverse effects and more than a low risk of harm to Patient.

The Second Tier under Code § 301.452(b)(10) addresses a serious risk to a patient, and the Third Tier encompasses unprofessional behavior that results in serious harm to a patient or the public. The Second Tier under Code § 301.452(b)(13) addresses patient harm or risk of patient harm, and the Third Tier 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 preponderant evidence demonstrated that Respondent's conduct resulted in serious harm or a

serious risk of harm. The evidence was too attenuated to demonstrate that Respondent's conduct caused any of Patient's complications that occurred well after Respondent's error, such as Patient's respiratory arrest, brain injury, memory loss, or that it led to his death. In other words, there were genuine issues of fact whether subsequent care at Medical City Plano made Patient's condition worse. The evidence, however, demonstrated that, more likely than not, Respondent's intrathecal administration of TXA caused Patient's seizures and required Patient's transfer to a higher level of care from the PACU to the ICU. Staff also showed that a minimum, there was a serious risk of harm of potential cardiac arrhythmias from the intrathecal administration of TXA.

At the hearing, Respondent argued that analysis of harm alone as the main factor in determining a sanction level is arbitrary. Generally, given the nature of CRNA practice and anesthesia services specifically, a medication administration-related violation will likely carry a serious risk of harm, which will result in a more severe sanction Tier against a CRNA than for other nursing practices. The Matrix and the Board's Rules, however, do not distinguish or make exceptions for a particular type of nursing practice, and a serious risk of harm was present in the case.

b. Sanction Level I

Within a given Tier, the Sanction Level is determined by reference to aggravating and mitigating factors. The Board has also included in Board Rule 213.33(c) a list of factors that the Board and SOAH shall consider in conjunction with the Matrix. Staff argues that Sanction Level I under Code § 301.452(b)(13) is appropriate, which carries discipline of a either suspension or revocation of Respondent's license. The following is a discussion of applicable factors under Board Rule 213.33(c) and additional Matrix factors that should be considered based on the evidence in this case.

i. Actual Harm to Patient [Board Rule 213.33(c)(1)]

As noted above, Staff presented sufficient evidence of actual harm to Patient, which is an aggravating factor under Board Rule 213.33(c)(1). TXA is not approved for intrathecal

administration. In those patients that have received TXA intrathecally, the side effects included myoclonic jerking and seizing activity. Other significant risks of harm included cardiac arrhythmias.

ii. Lack of Truthfulness or Trustworthiness [Board Rule 213.33(c)(2)]

Staff argues that evidence showed Respondent lacks truthfulness or trustworthiness under Board Rule 213.33(c)(2), primarily based on the premise that, from Staff's perspective, Respondent refused to accept responsibility for her medication error and blamed the error on several other factors, including Mr. Hart. Although it is true that Respondent defended her own conduct and presented evidence of multiple other factors that could have contributed to her error, disagreement with a theory of the case or presenting a defense in a contested case is not evidence of a lack of truthfulness or trustworthiness. Instead, Respondent's testimony was clear and free from contradiction. She was candid about the events in question and acknowledged when she could not recollect or was unsure of important facts, such as where exactly she placed the TXA before the spinal block. Ms. Keen credibly opined that Respondent is conscientious and well-respected. Dr. LeBlanc has also continued to work with Respondent and relied on her for numerous procedures since the incident with Patient, which demonstrates Respondent's trustworthiness. In sum, the lack of truthfulness or trustworthiness is not an aggravating factor in this case.

iii. Factors under Board Rule 213.33(c)(3)-(8)

Staff did not present evidence of any misrepresentation under Board Rule 213.33(c)(3). Respondent's practice history under Board Rule 213.33(c)(4) is in her favor, as she has been a successful CRNA for over 10 years. Dr. LeBlanc testified that she was among the top five CRNAs that he has observed, and Ms. Keen described Respondent as a model CRNA. Under Board Rule 213.33(c)(5), Staff did not question Respondent's present fitness to practice. Respondent has no previous disciplinary history by the Board under Board Rule 213.33(c)(6), which is a mitigating factor. The length of time of practice under Board Rule 213.33(c)(7) is not a mitigating factor as Respondent was not a new nurse and had been practicing for a significant period of time when the error occurred. Staff also presented sufficient evidence of actual damages under Board Rule

213.33(c)(8). As Dr. Zych noted, Patient's knee surgery was canceled and he was transferred to the ICU at Medical City Frisco, which more likely than not resulted in additional, unanticipated healthcare costs.

iv. Deterrent Effect of Penalty [Board Rules 213.33(c)(9)]

The deterrent effect of the penalty imposed under Board Rule 213.33(c)(9) is not an aggravating factor. Staff argues that revocation would serve as a deterrent because Respondent demonstrated an inability or refusal to accept full responsibility for her medication error, and any hope of remediation is dependent upon the Respondent fully owning her mistake and learning from it. Revocation, however, would serve a punitive purpose rather than deter Respondent from making another medication error. Moreover, Respondent credibly testified that after the error in question, she has adjusted her practice to always confirm she is drawing the correct medication immediately prior to administration by either reading it herself or asking the individual holding the medication to read it out loud. Respondent also testified that she takes steps to ensure she does not lose control of TXA. Staff questions Respondent's motivation for changing her practice, but whether Respondent has adjusted her practice to avoid future Board discipline or to prevent errors is not material—Respondent now ensures she fully complies with the Five Rights, so revocation would not serve any deterrent purpose.

v. Attempt to Stop or Correct the Violation [Board Rule 213.33(c)(10)]

It was undisputed that Respondent immediately reported the medication error to her supervising anesthesiologist, Dr. LeBlanc. As Staff correctly notes, Respondent did not wait for Dr. LeBlanc to respond before she administered the second spinal block with the .5% Marcaine, but there was no evidence that Respondent committed an additional error by doing so. Instead, Respondent presented sufficient evidence that she used her clinical judgment, based on her training and knowledge of pharmacodynamics, to determine administration of the second block was prudent under the circumstances. Respondent credibly testified that she intended to block the receptor sites and dilute the concentration of any medication that would have a negative effect. Dr. LeBlanc also did not dispute Respondent's judgment to administer the spinal block.

Accordingly, the effort to stop or correct the violation is a mitigating factor.

vi. Matrix Aggravating and Mitigating Factors [Board Rule 213.33(c)(11)]; Systems Dynamics [Board Rule 213.33(c)(12)]

The following Matrix aggravating factors under § 301.452(b)(13) are inapplicable: the number of events; impairment at time of incident; prior complaints or discipline for similar conduct; and failure to demonstrate competent nursing practice consistently during nursing career. As described above, actual harm is an aggravating factor. Severity of the harm is also an aggravating factor, as Patient was transferred to the ICU and the evidence demonstrated significant seizure activity. Staff also presented evidence of patient vulnerability. Although almost all patients preparing for surgery are in a vulnerable position, Patient was elderly and medications were being administered directly into his spinal column.

The following Matrix mitigating factors are inapplicable: outcome not a result of care and participation in established or approved remediation or rehabilitation program. Respondent presented evidence of her competency through her own testimony and testimony of Dr. LeBlanc and Ms. Keen. Respondent's competency as a nurse is a mitigating factor.

The Matrix identifies systems issues as a mitigating factor, and Rule 213(c)(12) also references the extent to which system dynamics in the practice setting contributed to the problem. Respondent argued that Medical City Frisco's Pyxis contained TXA in a vial rather than a bag as in other facilities, and further noted that the nurse technician was sick so the anesthesia technician provided assistance for the procedure. The evidence did not support the inference that any of the purported systems issues affected Respondent's conduct. In other words, regardless of any outside factors, Respondent should have verified the medication at the time she was drawing it into the syringe and/or immediately prior to administration. Accordingly, system dynamics are not a mitigating factor.

vii. Multiple Violations of Code [Board Rule 231.33(c)(13)]

Board Rule 213.33(d) states that "[e]ach specific act or instance of conduct may be treated as a separate violation." Staff brought one formal charge and proved one act or omission in this case, and therefore there are no separate violations. However, in its closing, Staff argues that Respondent committed multiple violations of the Code and Board Rules. Citing to Code § 301.4531(c), Staff further argues that the Board is thus "required to consider taking a more severe action, including revocation of the person's license." The distinction with regard to the sanction is significant here because the Matrix provides that under the Third Tier, Sanction Level I of Code § 301.452(b)(10), revocation is appropriate. On the other hand, a Third Tier, Sanction Level I violation of Code § 301.452(b)(13) under the Matrix carries a sanction of either revocation *or* suspension of Respondent's licenses.

A reasonable construction of the governing statute and Board's rules demonstrates that "multiple" violations contemplates different conduct and/or different statutory provisions, and thus requires more than citation to the numerous subparts of Board Rule 217.11 (for § 301.452(b)(13)) or Board Rule 217.12 (for Code § 301.452(b)(10)) that could be said to apply. Here, the same act or omission does not constitute a violation of distinct statutory or regulatory provisions because each provision required proof of the same facts. In other words, Staff did not prove that any specific provision required proof of a fact which a different provision did not.[8] For example, Dr. Zych testified that if any other Board Rule is violated, then Board Rule 217.11(1)(a) is also violated. Likewise, failure to comply with the minimum standards of acceptable level of nursing practice set out in Board Rule 217.11 will necessarily implicate the cross-reference to the unprofessional conduct rules, specifically Board Rule 217.11217.12(1)(A). In sum, Respondent's conduct is not any less or more serious simply because her conduct implicated multiple Board Rules or Code provisions. Accordingly, the ALJ concludes that whether multiple violations existed is not an applicable aggravating factor in this case.

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[8] *See, e.g., Blockburger v. United States*, 284 U.S. 299, 304 (1932) (discussing principles of double jeopardy in criminal cases and announcing rule "where the same act or transaction constitutes a violation of two distinct statutory provisions, the test to be applied to determine whether there are two offenses or only one, is whether each provision requires proof of a fact which the other does not.").

viii. Factors under Board Rule 231.33(c)(14)-(17)

The evidence suggests that Respondent did not strictly comply with the Five Rights, which under any circumstance is serious based on the potential for patient harm. Accordingly, Staff demonstrated the seriousness of the violation as an aggravating factor under Board Rule 213.33(c)(14).

Staff contends that Respondent is a threat to public safety, which is an aggravating factor under Board Rule 231.33(c)(15). Like Staff's argument regarding lack of trustworthiness or truthfulness under Board Rule 213.33(c)(2), Staff emphasizes that Respondent continues to assert a standard of care that is contrary to that required by the minimum standards of nursing practice, and refuses to accept responsibility for her actions. Staff argues that Respondent's continued practice poses a continuing threat to the public, and will continue to do so, until she understands the required standard of care, accepts it, and incorporates it into her own practice in an effort to protect the safety of her patients. However, as noted in the discussion of the deterrent effect of the proposed discipline (revocation), Respondent has incorporated the required minimum standard of care into her practice—she performs the final verification process before or while drawing up the medication. The evidence in the record demonstrates that Respondent is held in high regard by her colleagues for her ability to practice competently and safely. Therefore, the possibility of a threat to public safety is not an aggravating factor.

Regarding good professional character under Board Rule 213.33(c)(16), relevant factors from Board Rule 213.27 include: (1) whether the individual will be able to practice nursing in an autonomous role with patients/clients, their families, significant others, healthcare professionals, and members of the public who are or who may become physically, emotionally, or financially vulnerable; (3) whether the individual will be able to make appropriate judgments and decisions that could affect patients/clients and/or the public; (4) whether the individual has exhibited an inability to conform his/her behavior to the requirements of the Code, Board rules and regulations, including Board Rule 217.11 and 217.12, and (5) whether Respondent will be able to promptly and fully self-disclose facts, circumstances, events, errors, and omissions, when such disclosure could enhance the health status of patients/clients or the public and/or could protect patients/clients

or the public from an unnecessary risk of harm. Dr. LeBlanc persuasively testified about Respondent's continued ability to practice in an autonomous role. It was also undisputed that Respondent promptly and fully disclosed the medication error. Moreover, Respondent credibly testified that she now incorporates that correct standard of care into her practice through a true final verification and has performed hundreds of procedures since the medication error without any incident. Regardless of Respondent's purported reasoning for changing her practice, the evidence demonstrates that Respondent has learned from the error and made the appropriate adjustments to her practice to ensure a similar error will not occur in the future, which weighs in favor of a finding that she is able to conform to the requirements of the Code and Board Rules. In sum, the evidence demonstrates that Respondent's good professional character is a mitigating factor and not an aggravating factor.

Board Rule 213.33(c)(17) regarding continuing education is not applicable to this case.

ix. Any Other Matter that Justice May Require [Board Rule 231.33(c)(18)]

As Respondent notes, both of Staff's experts admitted having committed medication errors in their own practices. Dr. Riddle testified that in his past, although not in Texas, he made a serious error that was similar to Respondent's error when he also failed to comply with the Five Rights by making a true final verification of the medication prior to administration. Both expert witnesses testified that they did not receive any significant discipline for the errors and both went on to become leaders and teachers in CRNA practice. The evidence suggests that Respondent should be treated like other similarly situated CRNAs who have committed a single medical error without evidence of intent or recklessness. Accordingly, any other matter that justice may require weighs in favor of Respondent as a mitigating factor.

c. Summary of Probated Suspension Recommendation

Staff sufficiently proved that Respondent committed a Third Tier, Sanction Level I violation under Code § 301.452(b)(13), which carries an applicable sanction of either suspension

or revocation. While the ALJ may recommend a sanction, the Board remains the ultimate arbiter of the disciplinary action taken in this case.

Respondent proved that she is a competent CRNA with excellent clinical skills. Although Staff correctly notes that Respondent attempted to argue that other factors, such as system dynamics, played a role in the error, the evidence demonstrated that Respondent immediately took the appropriate steps to disclose and mitigate the medication error. Respondent sufficiently acknowledged that she is ultimately responsible for the medication error, and she demonstrated remorse for it. There was also no dispute that Respondent has subsequently adopted measures, including compliance with the required standard of care, to ensure the error will not occur in the future. Respondent also continues to work in a care team with full-time supervision by an anesthesiologist, which provides more than sufficient safeguards for her CRNA practice.

The ALJ concludes that an enforced suspension or revocation for a single medical error, which occurred without intent or recklessness, would not advance patient safety. A probated suspension, on the other hand, would sufficiently provide for a heightened level of disciplinary action to recognize the seriousness of the violation, particularly as it would be made public and would negatively impact Respondent's reputation, even if she complies with all of the demands of the probated suspension and her licenses are fully restored. Because the primary objective of sanctions is to ensure the protection of the health, safety, and welfare of the public, taking all the facts and mitigating/aggravating circumstances into account, the ALJ finds an appropriate sanction is a probated suspension for two years. In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law.

V. FINDINGS OF FACT

1. Amber Walkington (Respondent) was issued Registered Nurse (RN) License No. 816595 and Advanced Practiced Registered Nurse (APRN) License No. 121858 by the Texas Board of Nursing (Board) in 2012.

2. Respondent is a Certified Registered Nurse Anesthetist (CRNA) and has been employed by United States Anesthesia Partners (USAP) as a CRNA since 2011.

3. Respondent was working for USAP on February 22, 2019, at a hospital called Medical City Frisco in Frisco, Texas, when an 81-year-old male patient (Patient) arrived at Medical City Frisco for a scheduled total knee replacement surgery.

4. As part of the care team model, Respondent was assigned to provide anesthesia care, specifically a spinal block, to Patient during the procedure.

5. Respondent and her supervising anesthesiologist, Dr. Kirk LeBlanc, both assessed Patient pre-operatively.

6. Respondent accessed the hospital's central medication dispensing system (Pyxis) to pull two medications that were unavailable in the operating room (OR): (1) .5% bupivacaine for the spinal block, which is a local anesthetic/nerve blocker also referred to as its brand name, Marcaine; and (2) tranexamic acid (TXA), an antifibrinolytic medication that helps slow clots postoperatively and allows the surgeon to give patients less blood products.

7. Prior to Patient's procedure, Respondent placed some medications, including propofol and lidocaine, in a locked drawer of the anesthesia cart in the OR. However, Respondent did not place the TXA or the .5% Marcaine in the locked drawer of the anesthesia cart. Respondent was uncertain where she placed the TXA, which could have been on a back table or on the anesthesia cart in the OR.

8. The TXA was unaccounted for in that Respondent could not identify where it was at the time of the procedure.

9. The circulating nurse felt ill that day and asked the anesthesia technician for assistance with the procedure.

10. Anesthesia technicians do not receive any specialized training about medications used during surgical procedures, the appropriate routes of administrations, or contraindications. Anesthesia technicians are also not permitted to choose the medications used in the surgical procedures or administer medications to patients during surgical procedures.

11. A sterile field must be maintained to perform a spinal block—meaning Respondent could not herself touch the vial to draw up the .5% Marcaine—so Respondent requested the anesthesia technician's assistance to hold the medication for the spinal block.

12. Respondent passed the .5% Marcaine to the anesthesia technician, gloved in, and then asked the anesthesia technician for the .5% Marcaine, either by referring to it as bupivacaine or "the local."

13. The anesthesia technician did not have access to any medication other than those that had been placed on the anesthesia cart by Respondent or handed to him by Respondent.

14. As Respondent drew the medication into the syringe, she did not perform a final check to read the label on the vial of medication the anesthesia technician was holding, and she did not ask the anesthesia technician to read the label out loud before drawing it.

15. Respondent was unable to place the spinal block at the first level that she tried, but she achieved successful cerebral spinal flow at the second level and administered what she believed to be 3 mL of .5% Marcaine intrathecally (i.e., into Patient's spinal canal).

16. Patient complained of burning and itching around the buttock region.

17. Respondent began cleaning up and when she looked around the spinal tray, she discovered the .5% Marcaine vial unused.

18. Respondent looked at the vial she drew from and realized she had inadvertently administered 3 mL of TXA intrathecally into Patient.

19. TXA is not approved to be administered intrathecally by the United States Food and Drug Administration.

20. Respondent immediately texted Dr. LeBlanc. Before Dr. LeBlanc returned to the OR, based on pharmacodynamics and her training, Respondent decided to perform the correct spinal block with .5% Marcaine to block the receptor sites and dilute the concentration of the TXA.

21. Intrathecal administration of TXA may result in a serious patient harm. Specifically, a patient may succumb very quickly to cardiac arrhythmias such as ventricular tachycardia (fast, abnormal heart beat) or ventricular fibrillation (severely abnormal heart rhythm).

22. Dr. LeBlanc entered the room and after some discussion and research into intrathecal injection of TXA, the surgery was cancelled.

23. Patient's vital signs were stable and he was transferred to the post-anesthesia care unit.

24. Around 10:15 a.m., Patient began involuntary jerking, and he transferred to the intensive care unit (ICU) at Medical City Frisco, where he was intubated.

25. The injection of the TXA into the Patient's spinal column caused irritation to the spinal cord/nerve root and caused Patient to exhibit seizures.

26. On May 26, 2020, Staff filed one formal charge against Respondent and docketed this case at the State Office of Administrative Hearings (SOAH) for assignment of an Administrative Law Judge (ALJ).

27. On September 3, 2020, Staff sent Respondent Staff's Fourth Amended Notice of Hearing. 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.

28. ALJ Srinivas Behara convened the hearing on the merits through the Zoom government videoconferencing platform on October 26-28, 2020. Deputy General Counsel Jena Abel represented Staff. Respondent appeared and was represented by attorneys Kimberly Land Cormier and Courtney Boes Huber. The record closed on February 1, 2021, after receiving Staff's written rebuttal closing argument.

29. Aggravating factors related to Respondent's conduct include: actual, severe patient harm of myoclonic jerking and seizing activity; a significant risk of cardiac arrhythmias; patient vulnerability as an elderly, surgical patient; and actual damages relating to cancellation of the Patient's knee surgery and transfer to the a higher level of care and ICU at Medical City Frisco.

30. Mitigating factors relating to Respondent's conduct include: Respondent's lack of previous disciplinary history by the Board; Respondent's effort to stop or correct the medication administration error; prompt disclosure of the error; Respondent's competency level as a CRNA; and Respondent's good professional character.

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 is subject to sanction because she committed unprofessional conduct and practiced below minimum standards of nursing care by conduct described in the Findings of Fact, specifically for failure to verify she was administering the correct medication to Patient.

6. Respondent's conduct is subject to sanction pursuant to Texas Occupations Code § 301.452(b)(10) and (13), and 22 Texas Administrative Code §§ 217.11(1)(A), (B), (C), 217.12(1)(A), (B), (4), and 221.13, .15.

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).

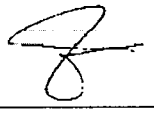
8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33(c) and the Board's Disciplinary Matrix, 22 Texas Administrative Code § 213.33(b).

9. The Board may also consider any aggravating and mitigating circumstances set forth in the findings of fact above. 22 Tex. Admin. Code § 213.33.

VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board sanction Respondent by imposing a probated suspension of Respondent's RN and APRN licenses for a period of two years, with any additional educational requirements the Board sees fit to include.

SIGNED March 31, 2021.



SRINIVAS BEHARA
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

SOAH DOCKET NO. 507-20-3794

TEXAS BOARD OF NURSING,	§	**BEFORE THE STATE OFFICE**
	§	
Petitioner	§	
	§	
v.	§	**OF**
	§	
AMBER KAY WALKINGTON, AP21858 and RN 816595	§	
	§	
Respondent.	§	**ADMINISTRATIVE HEARINGS**

RESPONDENT AMBER KAY WALKINGTON, C.R.N.A.'S EXCEPTIONS TO PROPOSAL FOR DECISION

Respondent, through her attorneys of record, submits the following Exceptions to the ALJ's proposal for decision (PFD) pursuant to Tex. Gov't. Code § 2001.062 and 1 Tex. Admin. Code § 155.507(b):

CONCLUSION OF LAW NO. 5

Conclusion of Law No. 5 is not supported by the Findings of Fact. The ALJ found:

> *5. Respondent is subject to sanction because she committed unprofessional conduct and practiced below minimum standards of nursing care by conduct described in the Findings of Fact, specifically for failure to verify she was administering the correct medication to Patient.*

However, the Findings of Fact do not identify the standard of care as it applies to Respondent's conduct, nor do they establish a standard of care regarding how a Certified Registered Nurse Anesthetist (CRNA) should properly verify the CRNA is administering the correct medication to a patient.

In failing to make Findings of Fact regarding the standard of care as established by the expert testimony, the PFD prejudices the substantial rights of Respondent because Conclusion of Law No. 5 is not reasonably supported by substantial evidence considering the reliable and

probative evidence in the record as a whole. Further, in making Conclusion of Law No. 5 without supporting Findings of Fact, the PFD is arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. Tex. Gov't. Code § 2001.174. Tex. Occ. Code § 301.459 (providing that the APA governs the Board's formal hearing procedures).

CONCLUSIONS OF LAW NOS. 6, 7, 8, AND 9

Likewise, Conclusion of Law No. 6 is not supported by the Findings of Fact. In failing to identify or establish the standard of care, the Findings of Fact do not support a conclusion of law that Respondent's conduct is subject to sanction pursuant to Tex. Occ. Code § 301.452(b)(10) and (13), and 22 Tex. Admin Code §§ 217.11(1)(A), (B), (C), 217.12(1)(A), (B), (4), and 221.13, .15.

- For Tex. Occ. Code § 301.452(b)(13), the Findings of Fact fail to identify the minimum standards of nursing practice Respondent failed to meet.
- For Board Rule 217.11(1)(A), the Findings of Fact fail to establish Respondent did not know or conform to the Texas Nursing Practice Act, the Board's rules and regulations, and federal, state, or local laws, rules, or regulations affecting the nurse's current area of nursing practice.
- For Board Rule 217.11(1)(B), the Findings of Fact fail to identify the measures Respondent failed to implement to promote a safe environment for clients and others.
- For Board Rule 217.11(1)(C), the Findings of Fact fail to establish Respondent failed to know the rationale for and the effects of medications and treatments and failed to correctly administer the same.
- For Tex. Occ. Code § 301.452(b)(10), the Findings of Fact fail to establish Respondent engaged in unprofessional conduct.

- For Board Rule 217.12(1)(A), the Findings of Fact fail to establish Respondent carelessly failed, repeatedly failed, or exhibited an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11.
- For Board Rule 217.12(1)(B), the Findings of Fact fail to establish Respondent failed to conform to generally accepted nursing standards in applicable practice settings.
- For Board Rule 217.12(4), the Findings of Fact fail to establish Respondent engaged in conduct that may endanger a client's life, health, or safety.
- For Board Rule 221.13, the Findings of Fact fail to establish Respondent failed to know and conform to the Nursing Practice Act; current Board rules, regulations, and standards of professional nursing; and all federal, state, and local laws, rules, and regulations affecting the advanced role and specialty area.
- For Board Rule 221.15, the Findings of Fact fail to establish sufficient facts to show what, if any, portion of this rule was violated by Respondent.

In failing to make Findings of Fact to support Conclusion of Law No. 5, the PFD prejudices the substantial rights of Respondent because Conclusion of Law No. 6 is also not reasonably supported by substantial evidence considering the reliable and probative evidence in the record as a whole. Further, in making Conclusion of Law No. 6 without Findings of Fact to support Conclusion of Law No. 5, the PFD is arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. Tex. Gov't. Code § 2001.174. Tex. Occ. Code § 301.459 (providing that the APA governs the Board's formal hearing procedures). Further, without Findings of Fact to support the conclusion that Respondent's conduct is subject to sanction, the

Board may not impose a disciplinary sanction, and has no need to consider the aggravating and mitigating circumstances set forth by Tex. Admin. Code § 213.33.

FINDING OF FACT NO. 8

A preponderance of the evidence does not support Finding of Fact No. 8. The finding of fact reads:

> *8. The TXA was unaccounted for in that Respondent could not identify where it was at the time of the procedure.*

In the ALJ's analysis, he writes:

> *...the undisputed facts demonstrate that, at the point when Respondent asked for the medication to begin the spinal block, Mr. Hart could have handed back the following medications to Respondent: (1) the .5% Marcaine, as Respondent had expected; (2) the .75% Marcaine in the spinal tray, which Respondent did not intend to use; or (3) the unaccounted-for TXA, which was possibly on the anesthesia cart and/or near the spinal tray.*

Respondent initially placed the spinal tray, a vial of .5% bupivacaine, and her gloves on the anesthesia cart. (T.T. Vol. 3, pg. 657, lines 3-5). Respondent handed the anesthesia technician the spinal tray and the vial of .5% bupivacaine simultaneously, and he subsequently set it down on the bed next to the patient. (T.T. Vol. 1, pg. 250, lines 10-11; T.T. Vol. 3, pg. 637, lines 8-9; Respondent's Exhibit 12).

Both Respondent and the anesthesia technician testified at hearing that the TXA was located on the anesthesia cart during the procedure. This is consistent with Finding of Fact No. 13, which states, "The anesthesia technician did not have access to any medication other than those that had been placed on the anesthesia cart by Respondent or handed to him by Respondent."

Further, neither party proffered testimony that the TXA had been placed on the bed. Therefore, the only place the TXA could have been located is on the anesthesia cart.

While Respondent testified at one point that she could not specifically recall where she placed the TXA, a preponderance of the evidence demonstrates it was on the anesthesia cart. Accordingly, Finding of Fact No. 8 prejudices Respondent's substantial rights because is not reasonably supported by substantial evidence considering the reliable and probative evidence in the record as a whole. Tex. Gov't. Code § 2001.174.

POINT OF CLARIFICATION

Kirk LeBlanc, M.D. did not testify as part of Board Staff's case. He is Respondent's witness and was taken out of order in the record.

PRAYER

Based on the foregoing exceptions, Respondent respectfully requests that the ALJ revise the Proposal for Decision such that her substantial rights are not prejudiced, and such that the technical error is corrected.

Respectfully submitted,

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ATTORNEYS FOR RESPONDENT
AMBER KAY WALKINGTON, C.R.N.A.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing instrument was served on counsel of record this **15th** day of **April, 2021** by the method indicated below:

VIA E-FILE
docketing@soah.texas.gov
Docket Clerk
State Office of Administrative Hearings
William B. Clements Bldg.
300 West 15th #504
Austin, TX 78701

VIA E-MAIL & E-SERVE
Jena Abel, Deputy General Counsel Jena.Abel@bon.texas.gov
Texas Board of Nursing
333 Guadalupe Street, Ste. 3-460
Austin, TX 78701

/s/ Kimberly L. Cormier
Kimberly Land Cormier

Texas Board of Nursing

333 Guadalupe Street, Ste. 3-460, Austin, Texas 78701
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Katherine A. Thomas, MN, RN, FAAN
Executive Director

April 21, 2021

Srinivas Behara, Administrative Law Judge
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

via Electronic Filing

Re: In the Matter of Permanent Certificate Nos. **AP121858 and RN 816595**
Issued to: **AMBER KAY WALKINGTON**
Docket No. **507-20-3794**

Dear Judge Behara:

Enclosed is ***Staff's Response to Respondent's Exceptions to the PFD.***

Sincerely,

Jena Abel

Jena Abel
Deputy General Counsel

Electronically Signed as Authorized by
Tex. Bus. & Comm. Code §322.007

JA/man
Enclosure

FILED
507-20-3794
4/21/2021 10:56 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Carol Hale, CLERK

ACCEPTED
507-20-3794
04/21/2021 11:28 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Carol Hale, CLERK

DOCKET NO. 507-20-3794

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBERS AP121858 and	§	OF
RN 816595 ISSUED TO	§	
AMBER KAY WALKINGTON	§	ADMINISTRATIVE HEARINGS

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

COMES NOW, Staff of the Texas Board of Nursing (hereinafter "Staff" or "Board"), and files this, its response to Respondent's Exceptions to the PFD.

Summary

Respondent states that proposed Conclusion of Law Number 5 is not supported by the proposed findings of fact because they do not identify the standard of care as it applies to Respondent's conduct.

Respondent further states that proposed Conclusions of Law Numbers 6, 7, 8, and 9 are not supported by the proposed findings of fact.

Respondent further states that a preponderance of the evidence does not support proposed Finding of Fact Number 8.

Staff disagrees.

Proposed Conclusion of Law Number 5

Proposed Conclusion of Law Number 5 is supported by the proposed Findings of Fact, specifically proposed Findings of Fact Numbers 14 and 18. Further, Conclusion of Law 5 also states the violated standard, "...failure to verify she was administering the correct medication to the patient". However, Staff suggests adding the following findings of fact to the PFD for additional clarity:

1. A basic principle of nursing is the "Five Rights" of medication administration: the nurse shall confirm that he or she has the right patient, the right medication, the right dose, the right time, and the right route. See page 5 of the PFD.

2. All nurses, including CRNAs, are required to utilize the Five Rights when administering medication to a patient. See page 5 of the PFD.

3. A nurse may not delegate his or her duty of medication administration to an unlicensed person and that the duty to follow the Five Rights remains with the nurse. See page 5 of the PFD.

4. The Respondent, as the licensed individual, is the only one responsible for accounting for the medications. See page 21 of the PFD.

5. Given that the TXA was not accounted for in the OR, the minimum standards of nursing practice required Respondent to at least perform one of the following acts before administering the medication: ask that Mr. Hart read the name of the medication aloud to confirm the medication; or ask Mr. Hart hold the medication vial closer and/or reposition his hands so that Respondent could verify its contents by reading the label of the medication herself. Respondent did neither. See page 21 of the PFD.

6. At the time Respondent drew up her syringe from the medication vial Mr. Hart was holding up for her, she assumed, but did not know for certain, what vial Mr. Hart was holding up. See page 21 of the PFD.

7. Board Rule 217.11(1)(C) requires all nurses to know the rationale for and the effects of medications and treatments and shall correctly administer the same. When the Respondent failed to follow the Five Rights, she violated this minimum standard of nursing practice.

Proposed Conclusion of Law Numbers 6-9

It appears Respondent's primary argument regarding proposed Conclusions of Law Numbers 6-9 hinges on the sufficiency of proposed Conclusion of Law Number 5. Staff has proposed additional findings of fact that would eliminate any argument Respondent may have that proposed Conclusion of Law Number 5 is not based on sufficient findings of fact, and urges the ALJ to amend the PFD to include those additional findings of fact for additional clarity. Further, proposed Conclusions of Law Numbers 7-9 are proper statements of law, are correctly written, and do not depend on the sufficiency of proposed Conclusions of Law Numbers 5 or 6. Staff does not see any reason to change them.

Proposed Finding of Fact Number 8

Proposed Finding of Fact Number 8 is based on the credible preponderance of the evidence as determined by the ALJ.

Respectfully submitted,

TEXAS BOARD OF NURSING

Jena Abel

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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing ***Staff's Response to Respondent's Exceptions to the PFD,*** was sent this the 21st day of April, 2021, to:

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Jena Abel

Jena Abel, Deputy General Counsel

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

May 6, 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. 507-20-3794; Texas Board of Nursing v. Amber Walkington

Dear Ms. Thomas:

On March 31, 2021, a Proposal for Decision (PFD) was issued in the above-captioned and styled matter. Counsel for Respondent, Amber Walkington AP121858 and RN 816595, timely filed exceptions to the PFD on April 15, 2021. Staff for the Texas Board of Nursing responded to Respondent's exceptions on April 21, 2021. The following addresses Respondent's exceptions:

1. **Technical Error Regarding Testifying Witness**

Respondent correctly notes that witness Kirk LeBlanc, MD, was called out of order at the hearing and that Staff did not call the witness to testify as part of Staff's case. Accordingly, pages 6 and 11-12 of the PFD should reflect Dr. LeBlanc as Respondent's witness at the hearing.

2. **Conclusion of Law No. 5**

Respondent contends that her substantial rights are prejudiced because proposed Conclusion of Law No. 5 is not supported by the proposed findings of fact. Specifically, Respondent argues that the findings of fact do not identify the standard of care as it applies to Respondent's conduct. Conclusion of Law No. 5 specifically references the sanctionable conduct—"failure to verify [Respondent] was administering the correct medication to Patient"—and Finding of Fact No. 14 identifies with sufficient detail the

facts supporting Respondent's failure to verify. The evidentiary record also contains substantial evidence of the applicable standard of care and Respondent's violation of the same. In an effort to add clarity to the findings of fact, however, Staff suggests adding to the PFD certain findings of fact, taken directly from the PFD's analysis section. Staff's suggestion is well-taken. Accordingly, the PFD should be amended to add the following Findings of Fact (identified in bold and italics), which would most appropriately follow Finding of Fact No. 13:

14. ***A basic principle of nursing is the "Five Rights" of medication administration: the nurse shall confirm that he or she has the right patient, the right medication, the right dose, the right time, and the right route.***

15. ***All nurses, including CRNAs, are required to utilize the Five Rights when administering medication to a patient.***

16. ***A nurse may not delegate his or her duty of medication administration to an unlicensed person and that the duty to follow the Five Rights remains with the nurse.***

17. ***The Respondent, as the licensed individual, is the only one responsible for accounting for the medications.***

18. ***At the time Respondent drew up her syringe from the medication vial Mr. Hart was holding up for her, she assumed, but did not know for certain, what vial Mr. Hart was holding up.***

19. [Previously Finding of Fact No. 14]: ~~As Respondent drew the medication into the syringe, she did not perform a final check to read the label on the vial of medication the anesthesia technician was holding, and she did not ask the anesthesia technician to read the label out loud before drawing it.~~ ***Given that the TXA was not accounted for in the OR, the minimum standards of nursing practice required Respondent to at least perform one of the following acts before administering the medication: ask that Mr. Hart read the name of the medication aloud to confirm the medication; or ask Mr. Hart hold the medication vial closer and/or reposition his hands so that Respondent could verify its contents by reading the label of the medication herself. Respondent did neither. By failing to perform either action, Respondent failed to follow the Five Rights, which resulted in a violation of the minimum standard of nursing practice.***

3. Conclusions of Law Nos. 6-9

Respondent contends that proposed Conclusion of Law Nos. 6-9 are not supported by the proposed Findings of Fact. The proposed amendments to the Findings of Fact identified above in Paragraph 2 sufficiently clarify the Findings of Fact based on the evidence in the record, which also support Conclusion of Law Nos. 5-6. Regarding Conclusion of Law Nos. 7-9, the conclusions are correct statements of law. Accordingly, Respondent's exceptions to Conclusions of Law 6-9 are overruled.

4. Finding of Fact No. 8

Respondent argues that a preponderance of the evidence does not support proposed Finding of Fact No. 8. Finding of Fact No. 8 is based on the credible preponderance of the evidence. *See, e.g.*, PFD at 16-17, 20-21. Accordingly, the exception to Finding of Fact No. 8 is overruled.

With the suggested revisions above outlined in Paragraphs 1 and 2 and the remaining exceptions overruled, the PFD is ready to be presented to the Board for a final decision.

Best regards,

/s/ Srinivas Behara
Administrative Law Judge
STATE OFFICE OF ADMINISTRATIVE HEARINGS

SVB/tl

cc: Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD) – **VIA EFILE TEXAS**
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