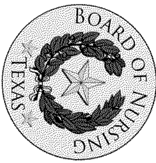


I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

Executive Director of the Board

In the Matter of **Permanent Registered Nurse** **License Number 838497** **Issued to DANIELLE LISA ALSTON,** **Respondent**	§ § § § § § §	**BEFORE THE TEXAS** **BOARD OF NURSING** **ELIGIBILITY AND** **DISCIPLINARY COMMITTEE**

ORDER OF THE BOARD

TO: Danielle Lisa Alston
8510 Trumpet Cir
Converse, Tx 78109

During open meeting held in Austin, Texas, on May 10, 2022, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by

reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN. CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 838497, previously issued to DANIELLE LISA ALSTON to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

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

Entered this 10th day of May, 2022

TEXAS BOARD OF NURSING

BY:

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charges filed January 24, 2022

d17r(2022.03.18)

Re: Permanent Registered Nurse License Number 838497
Issued to DANIELLE LISA ALSTON
DEFAULT ORDER - REVOKE

CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of May, 2022, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested,
Copy Via USPS First Class Mail
Danielle Lisa Alston
8510 Trumpet Cir
Converse, Tx 78109

Copy Via USPS Certified Mail, Return Receipt Requested and USPS First Class Mail
Danielle Lisa Alston
38 Choate Rd.
Park Forest, IL 60466-1851

BY:

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of Permanent Registered Nurse License Number 838497 Issued to DANIELLE LISA ALSTON, Respondent	§ § § § §	BEFORE THE TEXAS BOARD OF NURSING

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, DANIELLE LISA ALSTON, is a Registered Nurse holding license number 838497 which is in current status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about April 23, 2021, Respondent failed to successfully complete a Board-approved course in Texas nursing jurisprudence and ethics, within one (1) year, as required by Section III, Remedial Education Courses, Subsection A, of the Order and Opinion of the Board issued to Respondent April 23, 2020.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1)&(10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

CHARGE II.

On or about April 23, 2021, Respondent failed to successfully complete the course "Sharpening Critical Thinking Skills," within one (1) year, as required by Section III, Remedial Education Courses, Subsection B, of the Order and Opinion of the Board issued to Respondent April 23, 2020.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1)&(10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license(s) and/or privilege(s) to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 TEX. ADMIN. CODE §§ 213.27 - 213.33.

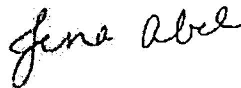
NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, located at 22 TEX. ADMIN. CODE §213.33(b), which can be found under the "Discipline & Complaints; Board Policies & Guidelines" section of the Board's website, www.bon.texas.gov.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is/are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Order(s) of the Board dated April 23, 2020.

Filed this 24th day of January, 2022.

TEXAS BOARD OF NURSING



James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Deputy General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 24036103
Brian L. Miller, Jr., Assistant General Counsel
State Bar No. 24117478
JoAnna Starr, Assistant General Counsel
State Bar No. 24098463
Jacqueline A. Strashun, Assistant General Counsel
State Bar No. 19358600
John Vanderford, Assistant General Counsel
State Bar No. 24086670

333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-8657
F: (512) 305-8101 or (512) 305-7401

Attachment(s): Order(s) of the Board dated April 23, 2020.

D(2022.01.21)

DOCKET NUMBER 507-18-4090

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE NUMBER 838497,	§	OF
ISSUED TO DANIELLE L. ALSTON	§	ADMINISTRATIVE HEARINGS

OPINION AND ORDER OF THE BOARD

TO: DANIELLE L. ALSTON
8510 TRUMPET CIRCLE
CONVERSE, TX 78109

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

At the regularly scheduled public meeting on April 23, 2020, the Texas Board of Nursing (Board), acting through its duly authorized Eligibility and Disciplinary Committee, considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Staff's recommendation to the Board regarding the PFD and order; and Respondent's recommendation to the Board regarding the PFD and order, if any.

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

The Board, after review and due consideration of the PFD; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

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

The Board agrees with the ALJ that the Respondent's conduct warrants a second tier, sanction level I sanction for her violations of §301.452(b)(10) and (13)[1]. The Board further agrees with the ALJ that the most appropriate sanction in this matter is a Warning with Stipulations for one year[2].

There was more than one violation committed by the Respondent, involving two babies[3]. Both babies were vulnerable, and the Respondent's conduct posed a serious risk of harm to Baby A, in that the wrong breastmilk could transmit infection[4]. The Board, however, also recognizes that the ALJ found several mitigating factors. First, although there was a serious risk of harm, no actual harm was shown to either baby[5]. Respondent's practice history does not show any other disciplinary action prior to 2016, and Respondent demonstrated successful employment as a nurse subsequent to these violations[6].

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e)(3), that a Warning with Stipulations for one year is the most appropriate sanction in this matter.

The Board finds that the Respondent should complete remedial education courses in nursing jurisprudence and ethics and critical thinking[7]. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas and to prevent future violations from occurring. The Board further finds that the Respondent's practice should be subject to indirect supervision for the duration of the Order. This supervisory requirement is intended to ensure that any deficiencies in the Respondent's practice can be discovered quickly and remediated appropriately. The employer notification and quarterly reporting requirements are necessary to ensure the Respondent is complying with the terms of the Order and successfully completes the terms of the order. These requirements are authorized by 22 Tex Admin. Code §213.33(e)(3)[8] and are consistent with Board precedent.

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[1] See pages 17-18 of the PFD

[2] See page 18 of the PFD

[3] *Id*

[4] See pages 17-18 of the PFD.

[5] See page 18 of the PFD

[6] *Id*

[7] 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

[8] 22 Tex Admin Code §213 33(e)(3) authorizes reasonable probationary stipulations that may include remedial education courses and practice for a specified period of not less than one year under the direction of a nurse designated by the Board

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

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

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

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

I. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT shall 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. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

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

IV. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

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

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

the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Indirect Supervision:** For the second year [four (4) quarters] of employment as a Nurse under this order, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, **who is on the premises.** The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

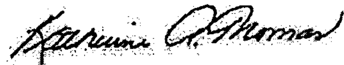
D. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports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

V. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) 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 23rd day of April, 2020..

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; Docket No. 507-18-4090 (January 22, 2020)

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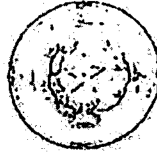


State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

January 22, 2020

VIA INTERAGENCY

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

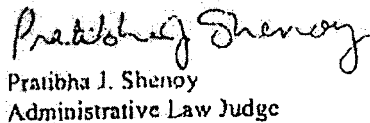
RE: Docket No. 507-18-4090; Texas Board of Nursing v. Danielle Lisa Alston

Dear Ms. Thomas:

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

Exceptions and replies may be filed by any party in accordance with 1 Tex Admin. Code § 155.507, a SOAH rule which may be found at www.soah.texas.gov.

Sincerely,



Pratibha J. Shenoy
Administrative Law Judge

PS/tt
Enclosures

xc: John Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – VIA INTERAGENCY
Elizabeth Tschudi, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 (with 1-CD of Hearing on the Merits) – VIA INTERAGENCY
Danielle L Alston, 8510 Trumpet Circle, Converse, TX 78109 – VIA REGULAR MAIL

300 W. 15th Street, Suite 504, Austin, Texas 78701/ P.O. Box 13025, Austin, Texas 78711-3025
512 475 4993 (Main) 512 475 3445 (Docketing) 512 475 4994 (Fax)
www.soah.texas.gov

SOAH DOCKET NO. 507-18-4090

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
	§	
v.	§	OF
	§	
DANIELLE LISA ALSTON, RN LICENSE NO. 838497, Respondent	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to impose disciplinary action against the Registered Nurse (RN) license held by Danielle Lisa Alston (Respondent) because she allegedly failed to verify breastmilk before dispensing it for a neonatal patient; falsely documented care that she did not provide; and pre-documented a record with inaccurate information. The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove its allegations by a preponderance of the evidence, and recommends that the Board issue a warning with stipulations.

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 Pratibha J. Shenoy convened the hearing on the merits at the State Office of Administrative Hearings (SOAH) facility in Austin, Texas, on December 11, 2019. Assistant General Counsel John Vanderford represented Staff. Respondent appeared and represented herself. The record closed at the conclusion of the hearing that day.

II. STAFF'S FORMAL CHARGES AND APPLICABLE LAW

In 2016, Respondent was a neonatal intensive care unit (NICU) nurse at Baptist Health System (Baptist) in San Antonio, Texas. Staff's Charge I alleges that on March 31, 2016, Respondent dispensed a bottle of breastmilk to the mother of a patient, Baby A, without having a second nurse verify that the correct milk was being given. Charge II asserts that Respondent falsely documented that she changed Baby A's diaper and took vital signs during the shift. Charge III alleges that on April 3, 2016, Respondent pre-documented a feeding for Baby B and entered incorrect information in the medical record. Respondent countered that, even if she made some

errors, she met the standard of care for her patients. She added that she faced bullying and harassment at Baptist and suggested her supervisors were looking for a reason to fire her.

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, unprofessional conduct (pursuant to Code § 301.452(b)(10)) or failure to conform to minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm (pursuant to Code § 301.452(b)(13)).[1] Staff asserts that Respondent's conduct is grounds for disciplinary action under both Code provisions, as well as pursuant to a number of Board rules.[2] Board Rule 217.12[3] discusses unprofessional conduct and Staff alleged Respondent is subject to sanction under six provisions of that rule:

- **Board Rule 217.12(1)(A)**: Carelessly failing, repeatedly failing, or exhibiting an inability to perform 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)**: Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;
- **Board Rule 217.12(1)(C)**: Improper management of client records;
- **Board Rule 217.12(4)**: Careless or repetitive conduct that may endanger a client's life, health, or safety, without requiring a showing of actual harm;
- **Board Rule 217.12(6)(A)**: Falsifying reports, client documentation, agency records or other documents; and
- **Board Rule 217.12(6)(H)**: Providing information which was false, deceptive, or misleading in connection with the practice of nursing.

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[1] Code § 301.452(b) was amended effective September 1, 2017. This Proposal for Decision (PFD) cites the substantive law in effect at the time of the allegations (March-April 2016) and cites the current version of procedural provisions.

[2] For ease of reference, the Board's rules, found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code, may be referred to in this PFD as "Board Rule ____."

[3] 22 Texas Administrative Code § 217.12 was revised effective February 25, 2018, and October 7, 2019. This PFD cites the rule in effect in March-April 2016, when the alleged conduct occurred.

Board Rule 217.11[4] discusses minimum acceptable standards of nursing practice, seven of which Staff alleged were not met by Respondent. Specifically, nurses must:

- **Board Rule 217.11(1)(A)**: 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)**: Implement measures to promote a safe environment for clients and others;
- **Board Rule 217.11(1)(C)**: Know the rationale for and the effects of medications and treatments and correctly administer the same;
- **Board Rule 217.11(1)(D)**: Accurately and completely report and document client status, care rendered, doctors' orders, medication and treatment administration, client response, and contacts with the health care team regarding significant events;
- **Board Rule 217.11(1)(M)**: Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications;
- **Board Rule 217.11(1)(P)**: Collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care; and
- **Board Rule 217.11(3)(A)**: Provide (in the case of registered nurses) individualized, goal-directed nursing care in assessments, nursing diagnoses, developing and implementing a plan of care, and evaluating the client's response to interventions.

Board Rule 213.33(b) sets out a disciplinary matrix (Matrix) that is intended to match the severity of the sanction imposed to the nature of the violation at issue, taking into account mitigating and aggravating factors.[5] The Matrix classifies offenses by tier and sanction level, and must be consulted by the ALJ and the Board in determining the appropriate sanction. Additional mitigating and aggravating factors are listed in Board Rule 213.33(c).

Staff had the burden of proving its allegations by a preponderance of the evidence.[6]

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[4] 22 Tex. Admin. Code § 217.11.

[5] 22 Tex. Admin. Code § 213.33; *see also* Tex. Occ. Code § 301.4531.

[6] 1 Tex. Admin. Code § 155.427.

III. DISCUSSION

Staff offered a total of 18 exhibits, all of which were admitted, and called as witnesses three of Respondent's former colleagues, the mother of Baby A, and a Board expert on nursing practice and Board rules. Respondent testified on her own behalf.

A. Fact Witnesses

1. Donna Wilcox, RN

Ms. Wilcox obtained her RN license in 1982 and has been the Director of the Baptist NICU for the last five years. She said that mothers of infants in the NICU often express breastmilk for later use. The mother attaches a label (pre-printed with the mother's admission wristband number) to each bottle and writes the date and time and the baby's name. The milk is stored until it is retrieved by a nurse Ms. Wilcox explained that breastmilk, as a bodily fluid, can transmit HIV, hepatitis, and other infectious diseases. NICU babies are particularly vulnerable. Given the risks, Baptist policy is that all breastmilk administered to infants in care must be "checked by two licensed nursing staff members and documented in the patient's medical record."[7]

On April 1, 2016, Baby A was discharged after spending nearly two months in the NICU to address complications from her premature birth. An environmental services (EVS) worker who was cleaning Baby A's room found a bottle of breastmilk left in the mini-fridge and alerted Ms. Wilcox and the NICU Clinical Director, Jeanne Vranes, RN, who both realized that the baby listed on the bottle label was not Baby A.

The possibility that Baby A was fed the wrong breastmilk was of immediate and grave concern, Ms. Wilcox said. She notified the hospital's risk management department and contacted Baby A's mother (Mother A) to advise her that the "donor mother" (whose milk might have been given to Baby A) would be asked to come in for tests to determine whether she had any infections that could have been transmitted. Ms. Wilcox testified that, after four years, she does not remember

[7] Staff Ex 5 at 9

some details, but she prepared an Employee Performance Improvement Plan (PIP) for Respondent in the days immediately following the incident with Baby A. Ms. Wilcox said the PIP is an accurate record of the investigations for both Baby A and Baby B (discussed below).

Per the PIP,[8] Mother A reported that Respondent had given her a bottle of breastmilk before taking the family to the private room where they spent the night. When she was contacted by Ms. Wilcox, Respondent said she took Baby A and her family to the private room at 8:00 p.m. and did not see them again until around 5:00 a.m. However, Baby A's records included an entry by Respondent for a 12:30 a.m. diaper change and check of vital signs. Furthermore, the NICU Daily Flowsheet for Baby A did not document that the breastmilk had been verified by Respondent and a second nurse prior to it being given to Mother A.

Ms. Wilcox stated that, when questioned about the verification, Respondent said another nurse, Kelsey Stanush, verified the milk but had not signed the chart. However, Ms. Stanush told Ms. Wilcox she did not remember speaking to Respondent at all during the March 31, 2016 overnight shift. Ms. Wilcox and Ms. Vranes decided that they needed to document the incident and have a Human Resources representative join them for a meeting with Respondent.

Ms. Wilcox denied that she had a vendetta against Respondent or any motive to find fault with Respondent's practice. Although Respondent said other nurses bullied her after she got an exemption from the flu shot (discussed below), Ms. Wilcox said many nurses had exemptions and it was not an issue. Ms. Wilcox added that she had hired Respondent and wanted her to succeed as a nurse. Also, the PIP that Ms. Wilcox drafted proposed a two-day suspension, not termination of Respondent's employment. Because Respondent did not come to the meeting that Ms. Vranes and Ms. Wilcox scheduled, the PIP was never finalized. Respondent's employment was documented as ending in an involuntary termination.[9]

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[8] Ms. Wilcox referred to the PIP when testifying about the matters discussed in this paragraph.

[9] Staff Ex. 7 at 3

2. Mother A

Mother A testified that she was highly satisfied with the care she and her family received at Baptist, with the exception of the breastmilk mix-up. It took a week or two to get the test results back showing the donor mother was negative for infections, and during that time, Mother A experienced anxiety and fear that Baby A would get sick and have to return to the hospital.

During Baby A's two-month stay at the hospital, Mother A became very familiar with the process of storing and retrieving her breastmilk. She said that after a while, she would just hold out her wrist and wait for the nurses to match the bottle label to her wristband, without looking at the bottle herself. Mother A sometimes saw a second nurse double-verify the milk bottle, and believed that other times it was done at the nurses' station. She testified she had no reason to doubt that, if the nurses documented the double-verification, it had been done.

The night of March 31, 2016, is the only time Mother A recalls having Respondent as the nurse assigned to Baby A. Respondent met with Mother A and her husband and explained the "rooming-in" process, which is a "trial run" for parents to make sure they are ready to care for their baby at home. Instead of being in a "pod" with a few other NICU babies, a baby being prepared for discharge spends the rooming-in night in a private room where parents can ask for help from nurses if needed, but the baby is no longer on any continuous monitors.

At the hearing, Mother A testified that she remembered Respondent gave her a bottle of breastmilk before taking the family to the private room. However, Mother A did not recall whether she was the one who put the bottle in the mini-fridge. During the night, Mother A "grabbed a bottle from the fridge and fed the baby." Mother A could not say with certainty whether the fridge held more than one bottle. She said it was possible that Respondent gave her more than one bottle.

3. Jeanne Vranes, RN

Ms. Vranes has worked at Baptist for 10 years and was Respondent's supervisor. She concurred with Ms. Wilcox's testimony that: an EVS worker found a bottle of breastmilk (labeled for a different baby) in Baby A's room immediately after Baby A was discharged; Respondent told

Ms. Wilcox and Ms. Vranes that Ms. Stanush verified the milk before it was given to Mother A, but Ms. Stanush could not confirm Respondent's account; and Respondent said she did not enter Baby A's room between 8:00 p.m. and 5:00 a.m., even though there was a 12:30 a.m. visit documented in the record. Ms. Vranes testified that it was highly unlikely a bottle of breastmilk from the prior occupant was mistakenly left in the mini-fridge when Baby A's family was taken to the room. She is unaware of any such mistake being made in her decade working at Baptist.

On the night of April 3, 2016, Ms. Vranes was on call for the NICU. She received a call from the hospital's night supervisor (the House Officer) between 4:30 and 5:00 a.m., advising her that Respondent was "nervous and in a lot of pain" and wanted to "go home to take Norco." The House Officer also said she offered "Mylanta and Tums" to Respondent but Respondent refused. Ms. Vranes "immediately got dressed and headed to the hospital" because Respondent was caring for four infants and the other nurses could not absorb her assignments.

Ms. Vranes recalled arriving at Baptist around 5:45 a.m. and going straight to Respondent's pod. What happened next is in dispute (Respondent's account is discussed below). According to Ms. Vranes, Respondent was "frantic" and "uneasy" and did not want to leave even though she appeared ill. Respondent said she was "fine" but Ms. Vranes told her to go home since she had already come in to take over the shift. Respondent had just started a bottle feeding for Baby B and handed the baby to Ms. Vranes while giving a verbal report on all four babies under her care. Respondent then said she "needed to finish her charting" and left the room where Ms. Vranes was feeding Baby B. Ms. Vranes did not see Respondent after that.

The doctor's order for Baby B was for 48 milliliters (ml) of milk per feeding. Ms. Vranes said she fed Baby B around 22 ml by bottle before the baby fell asleep. Ms. Vranes administered the remaining amount—which she estimated as 23 ml—through Baby B's nasogastric (NG) tube. Ms. Vranes retrieved Baby B's NICU Daily Flowsheet to document the feeding, and saw that Respondent had already made an entry stating that Baby B had been given 48 ml of milk by mouth. Ms. Vranes added her own entry to indicate that Baby B took 22 ml by mouth and 23 ml by NG tube. She testified that, until she reviewed the record at the hearing, she did not realize that the total she documented (45 ml) was less than the amount ordered (48 ml). Ms. Vranes speculated

that the difference could be due to what Baby B drank when Respondent started the bottle before handing the baby to Ms. Vranes. Or, a small amount of fluid could have been lost in the NG tubing.

Regardless of the reason for the 45 ml/48 ml discrepancy, Ms. Vranes said the biggest issue was Respondent's "pre-documentation." Ms. Vranes explained that one consideration when a baby is evaluated for discharge is whether the baby can tolerate feedings by mouth. A baby who is partly dependent on an NG tube is less likely to be deemed ready to go home. Based on Respondent's documentation, Ms. Vranes said, another health care provider might be led to believe Baby B was making progress in taking feedings by mouth, when that was not accurate.

Ms. Vranes said she called Respondent and arranged a meeting that Ms. Wilcox and a Human Resources representative would also attend. The meeting was rescheduled to a different time on the same date at Respondent's request. However, according to Ms. Vranes, Respondent failed to appear. Ms. Vranes texted Respondent to advise that she could not work again before having a face-to-face meeting with herself and Ms. Wilcox. Respondent did not return to Baptist.

4. Kelsey Stanush, RN

Ms. Stanush has been a nurse for four years, and has worked at Baptist since she obtained her nursing license. She testified that, before Baptist transitioned to electronic medical records, the paper medical file for a patient was not always readily available for a nurse to initial verification of breastmilk. It was not uncommon for nurses to visually verify the milk labels for each other and then initial the records at the end of the shift.

Nonetheless, Ms. Stanush stood by her statement from the internal investigation, namely that she did not recall verifying breastmilk for Respondent during the March 31, 2016 overnight shift, whether for Baby A or another baby Ms. Stanush also disputed Respondent's statement (discussed below) that a baby could be "discharged from vital signs" such that vital signs did not need to be taken during the rooming-in night. As long as a patient is in care, Ms. Stanush said, vital signs should be taken at least every eight hours. Her practice with rooming-in babies is to check and record vital signs at least once during each shift

5. **Respondent**

Respondent began her health care career as a certified nursing assistant and worked as a phlebotomist before completing nursing school in 2013 and obtaining her RN license. She said her dream had always been to work in the NICU, so she was excited to be hired at Baptist in September 2015. Respondent "faced some issues" during her orientation because her preceptor was "not enthusiastic." At Respondent's request, Ms. Wilcox assigned her to a new preceptor. The new preceptor was helpful, had "good feedback," and recommended Respondent be released from orientation and allowed to work without requiring further training or monitoring.

Once her orientation was over, Respondent said, things went well until she asked for an exemption from getting a flu shot. Respondent explained that she had a very bad reaction to a flu shot a few years earlier, and she did not want to risk her health again. Although her supervisors at Baptist gave her "barely one hour" to provide an exemption letter from her doctor, Respondent made sure she obtained and submitted the letter. She also agreed that during flu season she would wear a mask over her nose and mouth when she was within six feet of infants in the NICU. Respondent then noticed that other nurses began "bullying" her.

The harassment took various forms. Respondent said nurses moved the bins of breastmilk for her patients so she had a hard time finding them, and some nurses would not cooperate with her to double-verify breastmilk. Others refused to help Respondent with physical tasks that require two nurses. Respondent felt she was frequently "called in" to Ms. Wilcox's office and asked to respond to "frivolous charges" from other nurses, but the complaining nurses were not required to explain their role or to document the alleged basis for the complaints.

During the hearing, Respondent asserted that the hospital's double-verification policy requires only two adults to match the labels, not two nurses. She discussed the following excerpts from Baptist's policies:

Policy: "Preparation of Formula"

III. GENERAL GUIDELINES

...

F. General Formula Preparation and Handling

...

5. All Breast milk and fortified formula will be checked by two licensed nursing staff members and documented in the patient's medical record.[10]

Policy: "Lactation: Guidelines for the Collection, Storage and Handling of Human Milk in the Hospital"

III. Guidelines

...

H. Feeding Breast milk

1. At the patient's bedside, two nurses will complete the Breastmilk verification process of comparing the patient admission band to the label on the feeding device and document in the patient's medical record.[11]

Respondent pointed out that the first policy—cited by Ms. Wilcox in her testimony—pertains to the preparation of formula or fortified breastmilk, not to dispensing milk. Similarly, Respondent said, the second policy relates to feedings administered by nursing staff, not to dispensing of milk to a patient's mother. Respondent added that the second policy is labeled "Guidelines," indicating it is not mandatory.

In a situation where another nurse is unavailable, Respondent said, the nurse can verify breastmilk labels with the mother or another adult. According to Respondent, she and Mother A both verified the label on the bottle of milk that Mother A took to the rooming-in room. Respondent denied telling Ms. Wilcox that Ms. Stanush verified the milk for Baby A. Respondent also stated that she gave Mother A only one bottle of milk, so if Mother A recalled multiple bottles being in the mini-fridge, milk from another patient must have been left behind.

As for the notation of a 12:30 a.m. diaper change and check of vital signs for Baby A, Respondent conceded the entry was an error. She noted that rooming-in babies do not require

[10] Staff Ex. 6 at 9

[11] Staff Ex. 6 at 18

monitoring and Baby A's doctor "discharged the baby from vital signs." Therefore, Respondent explained, no harm was done if Baby A's vital signs were not measured during the shift.

With respect to the April 3, 2016 shift involving Ms. Vranes, Respondent contended she had not "pre-documented" anything in Baby B's feeding record. Respondent recounted that, around 3:00 a.m., she got a severe migraine and started experiencing dizziness and blurred vision. She asked the charge nurse and later the House Officer if she could go to the hospital's own emergency department, but her requests were denied Respondent said that by the time Ms. Vranes got to the NICU, it was close to 6:00 a.m. and "almost the end of the shift" so it was of little help. After giving Ms. Vranes a report on the four babies in her care, Respondent told Ms. Vranes that she would finish her charts before going home.

Respondent testified that she did not start a bottle for Baby B and Ms. Vranes handled the entire feeding. While Ms. Vranes fed Baby B, Respondent was at a nurses' station completing her charts. She could see Ms. Vranes through a window, and, when the feeding was over, Respondent wrote down "48 ml" and checked the box for feeding by mouth. Thus, Respondent explained, there was no "pre-documentation." She asserted that Ms. Vranes's additional note (22 ml by bottle and 23 ml by NG tube) was something Ms. Vranes "added to substantiate her claim of pre-documentation" and it demonstrated NICU management's desire to force Respondent out.

In Respondent's opinion, the method of feeding is not relevant because Baby B received the total amount of nutrition ordered by the doctor (or almost the full amount, if Ms. Vranes's entry of 45 ml was correct). Respondent added that the "outcome to the child [Baby B] is more important than who wrote what, and when," and contended that Baby B was unharmed.

Respondent deemed Ms. Wilcox's investigation timeline "suspicious." For example, Respondent remembered Ms. Wilcox called about a "breastmilk mix-up" when Respondent had "just pulled into the driveway" on the morning of April 1, 2016. However, Ms. Wilcox said the EVS worker found the bottle of breastmilk in Baby A's room after Baby A was discharged, which was not until the afternoon of April 1, 2016. Inconsistencies were also evident in the testimonies

of other witnesses, Respondent said. She also questioned why the House Officer would report offering "Mylanta and Tums" when those medications would not help a migraine headache.

Respondent agreed with Ms. Vranes that she did not work at Baptist after April 4, 2016, and she did not attend a final meeting with Ms. Vranes, Ms. Wilcox, and Human Resources. However, Respondent denied that her employment was involuntarily terminated. She explained that she texted Ms. Vranes to state that she would not be coming back to work because of how poorly she had been treated by supervisors and other nurses. Respondent contended her former colleagues were retaliating against her by sending this matter to the Board, and noted that since she left Baptist, she has continued to work as a nurse without any issues for nearly four years.

B. Staff's Expert Witness Jolene Zych, PhD, RN, WHNP-BC

Dr. Zych[12] is a nursing consultant for the Board. In addition to bachelor's and master's degrees in nursing, she has a PhD in public policy and administration. Her duties include answering questions from the public, legislators, nurses, and others regarding a broad range of nursing practice topics. Although she most often consults on advanced practice nursing cases, she is familiar with the Board's policies with respect to all levels of nursing.

Dr. Zych testified that dispensing breastmilk requires the same type of precautions as administering blood, because of the risk of transmitting infections via bodily fluids. She said the standard of care requires two nurses or health care professionals to verify the correct milk is given to the correct patient. She added that documenting the verification in the medical record is important because "if it isn't documented, it wasn't done." Dr. Zych noted that a nurse cares for a patient but also must consider the patient's significant others. The wrong breastmilk being given to an infant can cause "stress, panic, and anxiety" for parents and family.

Regarding Respondent's incorrect documentation of a vital signs check and diaper change at 12:30 a.m., Dr. Zych said she has never seen a doctor's order directing that a patient's vitals do not need to be checked at least once every 8 hours. Even when a baby in the NICU is taken off of

[12] The ALJ refers to Dr. Zych as "Dr." because she has a PhD. She is not a medical doctor.

continuous monitoring (as is done prior to rooming-in), the baby is still a hospital patient and the standard of care requires a nurse to be aware of her patients' status. Thus, Respondent should have checked Baby A's vital signs at least once during the overnight shift. Dr. Zych added that the incorrect entry could cause another health care provider reviewing the record to have a false sense of security, thinking Baby A was being properly monitored.

Dr. Zych opined that the same issue—a false sense of security—could be caused by the discrepant documentation for Baby B. She said that pre-term infants are generally on a strict intake schedule because they need to gain weight, and the ability to regularly take feedings by mouth is an indication of a baby's likelihood to thrive. A healthcare professional looking at Respondent's entry of 48 ml by mouth would "be relying on faulty knowledge" in Dr. Zych's view. The wrong information could affect care decisions, which are already challenging for pre-term infants.

C. ALJ's Analysis

1. Charge I (Dispensing Breastmilk to Mother A without Verification)

All three of Respondent's former colleagues confirmed that the policy at Baptist required a second nurse to verify that the label on a breastmilk bottle matched the infant's wristband (or the mother's wristband, if the milk was being given to the mother to administer). Dr. Zych testified that for a bodily fluid like breastmilk, it is the standard of care for two nurses or two healthcare professionals to verify that the correct milk is going to be dispensed.

Respondent argued that the two Baptist policies discussed at the hearing were inapplicable because one pertained to preparation of formula or fortified breastmilk, and one related to feedings by nursing staff, and not (in Respondent's view) to the dispensing of milk to a patient's mother. However, the policies were sufficiently clear that all of Respondent's colleagues, as well as Staff's expert witness, testified that a two-nurse check was required by hospital policy and by the standard of care. The risks of infection from a bodily fluid are serious and it stands to reason that healthcare professionals should be responsible for ensuring patient safety. In this case—even if it was acceptable to verify milk with a patient's mother—Mother A said she had grown accustomed to

holding out her wrist to be checked, and she was not paying attention to the verification process. Moreover, no verification by *any* person was documented in Baby A's medical record.

Staff established Respondent committed unprofessional conduct prohibited by Code § 301.452(b)(10), because her behavior could endanger a client's health or safety.[13] The ALJ does not find violations of other Board rules related to unprofessional conduct if those rules overlap with minimum practice standards governed by Code § 301.452(b)(13).[14]

With respect to Code § 301.452(b)(13), Staff proved by a preponderance of the evidence that Respondent failed to conform to minimum nursing standards because she did not implement measures to promote a safe environment for her patient[15] and failed to correctly administer a treatment.[16] Respondent also did not properly collaborate with the patient's significant others (here, Baby A's family) in the interests of Baby A's care because she improperly transferred a nursing responsibility to Mother A.[17] The ALJ does not find distinct violations were clearly established for the other Board rules on practice standards cited by Staff.[18]

2. Charge II (Incorrect Documentation of Care for Baby A)

Respondent acknowledged that she erroneously entered in Baby A's record that she changed the baby's diaper and checked vital signs at 12:30 a.m. during her March 31, 2016 shift. Although Respondent asserted that Baby A had been "discharged from vital signs," Dr. Zych credibly and logically testified that, as long as a patient is in a facility's care, vital signs should be

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[13] 22 Tex. Admin. Code § 217.12(4).

[14] Staff alleged violations of Board Rule 217.12(1), subsections (A) (failure or inability to perform nursing in conformity with minimum standards set out in Board Rule 217.11) and (B) (failure to conform to generally accepted nursing standards in applicable practice settings). Board Rule 217.12(1)(A) and (B) are general provisions; the specific nursing practice standards that Respondent failed to meet are covered in the discussion of Code § 301.452(b)(13) and Board Rule 217.11. Staff did not plead that Board Rule 217.12(1)(A) or (B) addresses an independent violation or gives rise to a different disciplinary action. Therefore, the ALJ does not address these provisions separately.

[15] 22 Tex. Admin. Code § 217.11(1)(B).

[16] 22 Tex. Admin. Code § 217.11(1)(C).

[17] 22 Tex. Admin. Code § 217.11(1)(P).

[18] The ALJ does not find a separate violation was established for Board Rules 217.11(1)(A) (general failure to know and comply with applicable law and rules); 217.11(1)(M) (failure to institute appropriate interventions), or 217.11(3)(A) (failure to provide individualized nursing care).

monitored every 8 hours at a minimum. Staff proved that Respondent failed to perform the required minimum check to ensure Baby A's safety. In addition, Respondent's incorrect entry had the potential to mislead a subsequent health care provider.

The ALJ finds Respondent's behavior could substantiate violations of Board rules related to unprofessional conduct under Code § 301.452(b)(10).[19] However, as noted in the discussion of Charge I, above, there is considerable overlap among the various Board rules on unprofessional conduct as well as between the unprofessional conduct and minimum standards rules. In this case, the ALJ finds the conduct demonstrated is best addressed by nursing practice standard rules under Code § 301.452(b)(13). Specifically, Staff proved by a preponderance of the evidence that Respondent failed to conform to minimum nursing standards because she did not promote a safe environment for her patient by taking vital signs at least once during a shift.[20] Staff also proved Respondent failed to accurately and completely document Baby A's status and care rendered.[21]

3. Charge III ("Pre-Documentation" and Inaccurate Record for Baby B)[22]

Respondent contended that the method of feeding she recorded was unimportant because Baby B received the full amount (or very close to the full amount) ordered by the doctor. Ms. Vranes and Dr. Zych disagreed, and both persuasively testified that it is important to know how well a baby is tolerating oral feedings as a measure of the baby's readiness to be discharged. Also, Respondent's own entries from earlier in the same shift reflect that Baby B took 22 ml by mouth/26 ml by NG tube at 9:00 p.m. and 10 ml by mouth/38 ml by NG tube at 1:00 a.m., indicating Respondent understood the relevance of tracking the feeding route.[23] The inaccuracy of Respondent's entry could be misleading to another provider assessing Baby B's progress.

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[19] For example, Respondent arguably engaged in improper management of client records, which is proscribed by Board Rule 217.12(1)(C)

[20] 22 Tex. Admin. Code § 217.11(1)(B)

[21] 22 Tex. Admin. Code § 217.11(1)(D).

[22] The ALJ notes that Charge III in Staff's Second Amended Formal Charges contains an allegation that Respondent's record for Baby B did not include documentation that she "double checked the breast milk." However, at the hearing, Staff clarified that only the pre-documentation and inaccuracy of the record were at issue in Baby B's case

[23] Staff Ex. 10 at 152

Respondent said she did not start the feeding for Baby B and Ms. Vranes handled the entire feeding. However, the only narrative entry regarding the feeding is by Ms. Vranes, and it states that Ms. Vranes "took over po [by mouth] feeding for the remainder." That entry was made contemporaneously and is more likely to be accurate than Respondent's recollection, especially because Respondent was suffering from a serious migraine at the time. Despite Respondent's charges of harassment, the evidence does not indicate Ms. Vranes had motive to falsely claim that Respondent started the bottle.

According to Respondent, she witnessed Ms. Vranes's feeding of Baby B and made her entry (48 ml by mouth) only after Ms. Vranes was finished. However, the credible evidence indicates that Respondent made the entry before the feeding was over. If Respondent in fact had a line of sight to Ms. Vranes, it would have been obvious that part of the feeding was by NG tube. And, if Respondent had consulted with Ms. Vranes when the feeding was complete, it is likely the two of them would have recognized that Ms. Vranes's total did not add up to 48 ml.

Staff established that Respondent committed unprofessional conduct prohibited by Code § 301.452(b)(10) because her premature, inaccurate entry was misleading information that she provided in connection with the practice of nursing.[24] Staff also demonstrated a failure to meet minimum nursing practice standards under Code § 301.452(b)(13), because Respondent failed to accurately and completely document Baby A's status and care rendered (or not rendered).[25]

D. Sanction Analysis

This discussion focuses on Respondent's actions related to Baby A. Though Respondent's conduct with respect to Baby B could have caused harm if a subsequent provider was misled as to Baby B's progress, the risk to Baby A was greater because ingestion of breastmilk from a donor other than Mother A could expose Baby A to potentially life-threatening infections. The ALJ therefore considers the sanction that would be applicable to the more serious conduct.

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[24] 22 Tex. Admin. Code § 217.12(6)(H).

[25] 22 Tex. Admin. Code § 217.11(1)(D)(i)-(ii)

Dr. Zych testified that, whether analyzed under Code § 301.452(b)(10) or (13), a Second Tier, Level I categorization would be appropriate, and recommended that the sanction be a warning with stipulations. For the reasons discussed below, the ALJ agrees

A First Tier offense under Code § 301.452(b)(10) is an isolated failure to comply with Board rules without adverse patient effects, or involving minor, unethical conduct where no patient safety is at risk.[26] A Third Tier offense is a failure to comply with a substantive Board rule regarding unprofessional conduct resulting in "serious patient harm," repeated acts of unethical behavior, or unethical behavior that results in harm to the patient or public. Here, Respondent's actions fit best in the Second Tier. There was a serious risk to Baby A that the wrong breastmilk could transmit infection, taking the conduct out of the First Tier, but actual harm was not shown to result, making the Third Tier inappropriate. The Second Tier covers unprofessional conduct "resulting in serious risk to patient or public safety," and matches the facts of this case.

Within the Second Tier, Sanction Level II calls for denial or suspension of licensure, which Dr. Zych opined would be more severe than required in this case. The ALJ concurs. Notably, Respondent's own employer planned to suspend her for two days and believed she could safely continue working in the NICU with some practice improvements. The ALJ also endorses the stipulations Dr. Zych proposed, which are discussed further below.

Pursuant to the Matrix, the Second Tier is also the most appropriate classification of Respondent's conduct under Code § 301.452(b)(13). A First Tier offense is practice below the minimum standard with "a low risk of patient harm," and a Third Tier offense is practice below the minimum standard with "a serious risk of harm or death that is known or should be known." The Second Tier covers practice below the minimum standard with "patient harm or risk of patient harm." Respondent's actions posed a serious risk of harm to Baby A and could be classified in the Third Tier. However, whether a Third Tier offense is classified as Sanction Level I or Sanction Level II, the minimum sanctions listed in the Matrix that are applicable to Respondent are license suspension or revocation. As noted above, Respondent's conduct does not rise to the level of

[26] As previously mentioned, sanction tiers and levels are listed in the Matrix. 22 Tex. Admin. Code § 217.33(b)

requiring such severe sanctions. For these reasons, the ALJ recommends the Second Tier, and recommends Sanction Level I within that tier.[27]

For both Code § 301.452(b)(10) and (13), aggravating factors from the Matrix that the Board may consider include the number of events (considering both Baby A and Baby B), and patient vulnerability. As listed in Board Rule 213.33(c), the Board may also consider as mitigating factors the lack of evidence of actual harm to Baby A and Baby B; Respondent's practice history, which does not show any other disciplinary actions before 2016; and Respondent's apparently successful employment as a nurse for nearly four years after she left Baptist.

A course in nursing jurisprudence and ethics is required as a component of all Board orders, pursuant to Board Rule 213.33(f). Dr. Zych proposed the Board also require Respondent to complete courses in critical thinking and documentation. In addition, Dr. Zych recommended that Respondent be required to notify her employer(s) of the Board order and have her employer(s) make quarterly reports to the Board for one year, during which time Respondent would be required to have another nurse available for indirect supervision on each shift. The ALJ agrees with the recommended stipulations. In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. Danielle Lisa Alston (Respondent) was issued Registered Nurse (RN) License No. 838497 by the Texas Board of Nursing (Board) on June 24, 2013.

2. In March 2016, Respondent was employed as a neonatal intensive care unit (NICU) nurse at Baptist Health System (Baptist) in San Antonio, Texas.

3. Breastmilk is a bodily fluid and as such is capable of transmitting infectious diseases such as hepatitis and HIV. NICU babies are particularly vulnerable.

4. It is the policy at Baptist that all breastmilk dispensed for or administered to infants in care must be verified by two licensed nursing staff members and documented in the patient's medical record to ensure that the correct infant receives the correct breastmilk.

[27] Sanction Level II in the Second Tier is similar to Sanction Level I in the Third Tier, listing license denial, suspension, revocation, and voluntary surrender as possible options. As discussed above, the ALJ finds those sanctions unsuitable to Respondent, who appears capable of remediating her practice issues.

5 On the night of March 31, 2016, Respondent dispensed a bottle of breastmilk to the mother of a patient (Baby A) without first having a second nurse verify that the label on the bottle matched the identifying information on the mother's wristband.

6. Respondent did not document any verification of the breastmilk in Baby A's medical record.

7. Respondent did not check Baby A's vital signs at least once every 8 hours.

8. On the night of April 3, 2016, Respondent was caring for four infants when she got a migraine headache causing dizziness and blurred vision.

9. Jeanne Vranes, the NICU Clinical Director, was on call and came to the NICU to relieve Respondent for the remainder of her shift.

10. Respondent had started feeding a bottle of milk to Baby B, and handed the baby to Ms. Vranes to complete the feeding.

11. Ms. Vranes fed Baby B approximately 22 milliliters (ml) by mouth until the baby fell asleep. Ms. Vranes then administered approximately 23 ml of milk through Baby B's nasogastric (NG) tube.

12. Before Ms. Vranes had finished feeding Baby B, Respondent made an entry in Baby B's medical record indicating that Baby B had taken the entire feeding by mouth. Ms. Vranes added an entry to correctly reflect the portion of the feeding that was by NG tube.

13. Whether a baby in the NICU is making progress in regularly taking feedings by mouth is a factor considered in determining the baby's readiness to be discharged.

14. Shortly after the incidents with Baby A and Baby B, Respondent's supervisors set a meeting to discuss performance issues with Respondent. Respondent did not attend the meeting and her employment was involuntarily terminated by Baptist.

15. Respondent has no prior licensure or disciplinary interactions with the Board.

16. After her employment with Baptist ended, Respondent has continued to work as a nurse with no known practice complaints.

17 There is no indication that Respondent cannot continue practicing nursing if she undergoes additional education and a period of indirect supervision.

18. After an investigation of the events related to Baby A and Baby B, the staff (Staff) of the Board filed formal charges against Respondent and docketed this case at the State Office of Administrative Hearings (SOAH) in Austin, Texas, for assignment of an Administrative Law Judge (ALJ).

19. On May 16, 2019, Staff sent Respondent a Fourth Amended Notice of Hearing and Second Amended Formal Charges. The notice and formal charges 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.

20. On December 11, 2019, ALJ Pratibha J. Shenoy convened the hearing on the merits. Assistant General Counsel John Vanderford represented Staff. Respondent appeared and represented herself. The hearing concluded and the record closed that day.

V. CONCLUSIONS OF LAW

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

2. SOAH 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, .458; Tex. Gov't Code §§ 2001.051-.052.

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

5. Respondent is subject to sanction because she committed unprofessional conduct by failing to promote a safe environment for her patient and providing information that was misleading in connection with the practice of nursing. Tex. Occ. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(4), (6)(11).

6. Respondent is also subject to sanction because her conduct failed to meet minimum practice standards that require nurses to implement measures to promote a safe environment for clients and others; to know the rationale for and the effects of medications and treatments and correctly administer the same; to accurately and completely document patient status and care rendered; and to collaborate with a patient's significant others in the interests of the patient's care Tex. Occ. Code § 301.452(b)(13); 22 Tex. Admin. Code § 217.11(1)(B), (C), (D), (P).

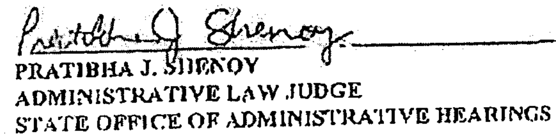
7. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license, and which may include assessment of a fine. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e)

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(c)). In this case, the Board may consider aggravating factors such as the number of events and patient vulnerability. The Board may also consider as mitigating factors the lack of evidence of actual harm to Baby A and Baby B; Respondent's practice history showing no other disciplinary actions before 2016; and Respondent's successful employment as a nurse after she left Baptist in April 2016.

VI. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board sanction Respondent with a one-year order of a warning with stipulations including: (1) courses in (A) nursing jurisprudence and ethics, (B) critical thinking, and (C) documentation; (2) disclosure of the order to Respondent's employers, and quarterly performance reports to the Board from such employers for the duration of the order; (3) indirect supervision on each shift for the duration of the order; and (4) such other provisions as the Board sees fit.

SIGNED January 22, 2020.



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