DOCKET NUMBER 507-18-2455

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT LICENSE	§	
NUMBER 779076,	§	**OF**
ISSUED TO	§	
DON C. LEACH	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: DON C. LEACH
c/o ELIZABETH HIGGINBOTHAM
HIGGINBOTHAM & ASSOCIATES, LLC
1100 NW LOOP 410, SUITE 700
SAN ANTONIO, TX 78213

SHANNON KILGORE
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 24-25, 2019, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

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

The Board, after review and due consideration of the PFD; Staff's recommendations; and the 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

Although the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact or

conclusions of law[1], the Board agrees that the most appropriate sanction in this matter is a probated suspension of the Respondent's license for two years, with probationary stipulations, as set out herein.[2]

The Board finds that the Respondent's conduct collectively warrants a third tier sanction for his violations of §301.452(b)(10) and (b)(13). However, although licensure revocation is authorized for a third tier violation, the Board finds, as was recommended by the ALJ, that a probated suspension is a more appropriate sanction in this matter.

The Respondent's conduct was unprovoked, caused actual harm to the patient, and is serious in nature.[3] However, the Board must consider this conduct in the context of the Respondent's 'otherwise untarnished career'[4]. The Respondent presented evidence of a good work history and several letters of recommendation, attesting to his skill, energy, and compassion.[5] Further, the Respondent had been previously injured by patients several times and two persons had been killed in the hospital.[6] While this cannot justify the Respondent's conduct on this occasion, it may shed some light on the type of environment the Respondent was working in when this event occurred. The Respondent, in his effort to escort the patient from the facility, was attempting to protect other staff from the agitated patient.[7]

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[8] and the Board's rules, including 22 Tex. Admin. Code §213.33, that the most appropriate sanction in this case is a probated suspension for two years.

The Board finds that the stipulations should include the completion of a nursing jurisprudence and ethics course, a critical thinking course, and a professional boundaries course[9]. The Board finds that supervisory requirements are necessary for the duration of the order to ensure safe and effective patient care and to identify any patterns of practice that require further remediation, but the Board finds that indirect supervision for the duration of the Order is sufficient to monitor the Respondent's practice. Employer notifications and quarterly employer reports will be required so that the Board can ensure Respondent is practicing in compliance with the terms of the order. These requirements

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

[2] See pages 17 and 20 of the PFD.

[3] See adopted Findings of Fact Numbers 12-13 and pages 16-17 of the PFD.

[4] See page 17 of the PFD.

[5] See adopted Finding of Fact Number 14.

[6] See adopted Findings of Fact Numbers 15-16.

[7] See adopted Finding of Fact Number 17.

[8] See 22 Tex. Admin. Code §213.33(b).

[9] See **Error! Main Document Only.**22 Tex. Admin. Code §213.33(f), which requires disciplinary orders to include participation in a program of education, including a course in nursing jurisprudence and ethics.

are authorized under 22 Tex. Admin. Code §213.33(e)(6)[10], are supported by the record, and are consistent with the Board's rules and policies.

IT IS THEREFORE ORDERED that Registered Nurse License Number 779076, previously issued to DON C. LEACH, to practice nursing in the State of Texas is/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. 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.

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.

UNDERSTANDING BOARD ORDERS

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[10] See **Error! Main Document Only.**22 Tex. Admin. Code 213.33(e)(6), which provides that a probated suspension may include reasonable probationary stipulations, such as the completion of remedial education courses, limitations of nursing activities, periodic Board review, and supervised practice for a period of at least two years.

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.

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.

C. **The course "Professional Boundaries in Nursing,"** a 3.0 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.*

EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

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

B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Indirect Supervision:** For the duration of the stipulation/probation period, 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 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 eight (8) quarters [two (2) years] of employment as a nurse.

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.

RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, RESPONDENT may be eligible for nurse licensure compact privileges if any.

Entered this 24th day of January, 2019.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-18-2455 (August 8, 2018)

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

August 8, 2018

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

VIA INTERAGENCY

RE: Docket No. 507-18-2455; Texas Board of Nursing v. Don C. Leach

Dear Ms. Thomas:

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

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

Sincerely,

Shannon Kilgore
Administrative Law Judge

SK/tt
Enclosures

xc: John Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA INTERAGENCY**
Kathy A. Hoffman, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA INTERAGENCY**
Elizabeth Higginbotham, Higginbotham & Associates LLC, One Castle Hills, 1100 NW Loop 410, Suite 700, San Antonio, TX 78213 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-18-2455

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
DON C. LEACH, RN, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to sanction Don Leach, RN because he allegedly pushed a patient to the floor. The Administrative Law Judge (ALJ) determines that Mr. Leach is subject to sanction for pushing a patient, and recommends a two-year probated suspension with stipulations.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

The hearing on the merits convened on May 16, 2018, before ALJ Shannon Kilgore at the State Office of Administrative Hearings (SOAH) facilities in Austin, Texas.[1] Assistant General Counsel John Vanderford represented Staff, and attorney Elizabeth Higginbotham represented Mr. Leach. The hearing concluded that day, and the record closed June 26, 2018, with the filing of Staff's written reply argument.

II. STAFF'S FORMAL CHARGE AND APPLICABLE LAW

Staff alleges that on May 26, 2017, in the emergency room (ER) of CHRISTUS Good Shepherd Medical Center in Longview, Texas (Hospital), Mr. Leach shoved a patient to the ground with a force that caused the patient's feet to rise above his head.

[1] At the hearing, Mr. Leach objected that Staff had filed an amended notice of hearing later than 10 days prior to the hearing. The ALJ overruled the objection as to the deletion from Staff's charge of some language in the factual assertions, and Staff withdrew a newly-added citation to an additional subsection of a Board rule.

Pursuant to Texas Occupations Code (Code) § 301.452(b)(10),[2] the Board may discipline a nurse for, among other things, unprofessional conduct likely to deceive, defraud, or injure clients or the public. Board Rule 217.12[3] addresses unprofessional conduct, which includes:

- 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(4): Careless or repetitive conduct that may endanger a client's life, health, or safety (actual injury need not be established);
- Board Rule 217.12(6)(C): Causing or permitting physical, emotional, or verbal abuse or injury or neglect to the client or the public; and
- Board Rule 217.12(6)(F): Threatening or violent behavior in the workplace.

Pursuant to Code § 301.452(b)(13), the Board may also discipline a nurse for failure to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm. Board Rule 217.11[4] discusses minimum acceptable standards of nursing practice, including the following:

- 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; and
- Board Rule 217.11(1)(B): Nurses must implement measures to promote a safe environment for clients and others.[5]

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[2] References to substantive provisions of the law are to the law in effect in May 2017.

[3] 22 Texas Administrative Code § 217.12. For ease of reference, a Board rule found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code is referred to as "Board Rule ____."

[4] 22 Tex. Admin. Code § 217.11.

[5] At the hearing, Staff withdrew a reference in its First Amended Formal Charges to Board Rule 217.11(1)(T).

Board Rule 213.33 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.[6] 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 must prove its allegations by a preponderance of the evidence.[7]

III. EVIDENCE

A. Basic Undisputed Facts

The parties agree that, in the early morning of May 26, 2017, Mr. Leach attempted to escort an uncooperative patient from the Hospital's ER. The situation turned physical, and the patient and Mr. Leach ended up on the floor.

B. Staff's Evidence

Staff introduced a number of exhibits, including hospital records and three security camera video recordings (without audio) related to the alleged incident. Staff's witnesses were:

- Robert Harshaw, a security guard in the Hospital's ER at the time in question;
- Shannon Davis, a nurse in the ER;
- Amy Cockrell, the clinical director of nursing who was on-call at the time of the incident; and
- Kristen Sinay, a nursing consultant for the Board (who testified as an expert, following the presentation of all other evidence by both parties).

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[6] 22 Tex. Admin. Code § 213.33; *see also* Tex. Occ. Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

[7] 1 Tex. Admin. Code § 155.427.

1. Testimony of Robert Harshaw

Mr. Harshaw is a security guard at the Hospital and was at the time of the alleged incident. He testified that he is familiar with the patient involved in this case because the patient is a "frequent flyer" who visits the Hospital for both psychiatric issues and mild medical problems. Mr. Harshaw has seen this patient scream, cuss, and call people the "n-word", but he does not always behave in that manner.

On the evening in question, after the patient had only been in the ER for 15 to 20 minutes, he began to leave. The patient wanted to exit the ER through the ambulance bay doors, but Mr. Leach tried to get him to go through the exit doors. Mr. Harshaw said, as to exiting through the ambulance bay, it is "kind of discretionary as to whether you do or you don't." The patient did not want to move, and Mr. Leach was trying to move the patient down the hallway toward the other doors. Mr. Harshaw was present but did not witness the patient hit Mr. Leach. He stated that the patient was "good at escalating situations" and was "screaming or hollering," but Mr. Harshaw does not know who escalated the situation to the point that both men fell to the floor. Mr. Harshaw agreed that, although he did not see the patient hit Mr. Leach, it could have happened. Mr. Harshaw did not attend a root cause analysis meeting concerning the incident, and no one took a written statement from him about the incident. He was not interviewed by the Longview Police Department.

2. . Testimony of Shannon Davis, RN

Mr. Davis was the charge nurse in the ER at the time in question, and he considers himself a friend of Mr. Leach. Mr. Davis testified that the patient did not have a medical complaint on this occasion, but was brought in by the police and was either going to be in the Hospital or taken to jail. The patient did not seem to have medical issues that evening and was irate. When he arrived at the ER he was placed in a room, but he would not provide anyone with his name or any registration information. He was disruptive, directing racial slurs against Hospital staff. Due to his lack of cooperation, the Hospital could not create a chart for the patient.

Just before the incident, Mr. Davis exited the ER and went to the hallway down which Mr. Leach was trying to escort the patient. They approached the ambulance bay doors. These doors, stated Mr. Davis, need to be used in connection with ambulance arrivals and should not be blocked by people. Although he was unsure if an ambulance was present at the time in question, he said, ambulances arrive quickly and the space needs to be clear. It is a safety issue for the patients in ambulances, and it is not a good idea for someone with a cane, like this patient, to be in the area. Nonetheless, he stated, he would not forcibly prevent someone from using the ambulance bay doors.

Mr. Davis was nearby when the incident occurred. He did not see the whole incident, did not see the patient hit Mr. Leach, and does not know if the patient hit Mr. Leach with the patient's cane. Nor did Mr. Davis see Mr. Leach abuse or assault the patient, and he does not believe Mr. Leach assaulted the patient. It is possible, Mr. Davis stated, that the patient pulled Mr. Leach down. Mr. Davis agreed that not everything is visible on the surveillance video of the incident due to the camera placement. According to Mr. Davis, Mr. Leach has a reputation for truthfulness and is not an aggressive or violent person. His touching of the patient could have been an attempt to guide and calm him. Mr. Davis does not believe that Mr. Leach was forcibly trying to prevent the patient from leaving through the ambulance bay doors.

Mr. Davis testified that, in his years of experience in the ER, nurses have been assaulted by patients on occasions "too many to count." He said that he believes a nurse can protect himself by taking defensive action.

According to Mr. Davis, all ER patients are required to be registered and given a medical screening. This patient did not provide any information, and he was not registered. The medical record for this particular patient was not created until later. There was a "root cause analysis" meeting about this patient that addressed both the failure to register the patient and the events depicted in the surveillance video. Mr. Davis said he had to sign a document acknowledging that ER patients had to be registered. Mr. Leach resigned during the meeting.

3. Testimony of Amy Cockrell, RN

Ms. Cockrell was the clinical director of nursing at the Hospital at the time of the incident. She was on call and was contacted at home by a nurse saying that a police officer wanted to talk to Mr. Leach because of a patient complaint. Ms. Cockrell then spoke to Mr. Leach about what had happened. She saw the surveillance footage during the root cause analysis meeting the following week. She stated that the videos appear to show Mr. Leach pushing the patient. She said that Mr. Leach is the only person who says that the patient hit him. She was not present during the incident and only knows what she has seen in the videos. She does not believe what Mr. Leach did was appropriate.

Ms. Cockrell acknowledged that she once—before the incident—sent a thank-you note to Mr. Leach for being a hardworking nurse.[8] She said she had always found him reliable and is not aware that anyone had ever questioned his credibility or trustworthiness. He was a preceptor and trained other nurses on Hospital polices.

Ms. Cockrell also acknowledged that the medical chart for the patient's ER visit seems to have been created days after the fact and after the root cause meeting.[9] It is a felony, she stated, for a patient to assault ER personnel. Mr. Leach was given an opportunity to file charges against the patient. He had been injured by a patient previous to this incident. Ms. Cockrell signed Mr. Leach's termination of service document,[10] which only states that he resigned during a pending assault investigation and does not reference anything about unsatisfactory performance.

4. Testimony of Kristen Sinay, MSN, RN

Ms. Sinay, a nursing consultant with the Board, provided expert testimony based on her review of the surveillance video. She stated that the surveillance footage seemed to show

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[8] *See* Resp. Ex. 7.

[9] *See* Staff Ex. 6.

[10] *See* Staff Ex. 7 at 35.

Mr. Leach pushing the patient. Ms. Sinay said that is it never acceptable for a nurse to push a patient, even in response to being hit. A nurse must promote safety, not be threatening, and set boundaries with patients. She opined that the patient in this case may have felt threatened, rather than comforted, by Mr. Leach's physical proximity. She stated that a nurse attacked by a patient must step back from the situation, not respond with force.

If Mr. Leach did push the patient, Ms. Sinay said, the action constituted unprofessional conduct sanctionable under Code § 301.452(b)(10), in that Mr. Leach failed to conform to the minimum standards of acceptable nursing practice. According to Ms. Sinay, under the Matrix this was physical abuse that amounts to a third tier offense. Although the specified sanctions for this tier are revocation and emergency suspension, she said that, in this circumstance, revocation would be overly punitive, and Mr. Leach can be remediated through a probated suspension.

Violation of the minimum standards of acceptable nursing practice is also sanctionable under Code § 301.452(b)(13), said Ms. Sinay. She testified that physical abuse, if it did happen, was a third tier offense under this section, for which the specified sanctions are suspension, revocation, or emergency suspension. She further stated that, after consideration of all the applicable mitigating and aggravating factors (which she did not identify), she concluded that a two-year probated suspension is the appropriate sanction here, with one year of direct supervision and one year of indirect supervision. She also recommends that he take courses on ethics, jurisprudence, and boundaries.

Ms. Sinay acknowledged that she has never worked in an ER, encountered this situation, or been trained in de-escalation. She stated the Board's rules are silent as to self-defense by a nurse and agreed that the Board's rules do not require a nurse to maintain a prescribed distance from a hostile patient. She agreed that if the patient, prior to Mr. Leach's involvement, had threatened his originally-assigned nurse with his cane, the patient had therefore engaged in physical aggression.

5. Surveillance Videos

Three brief Hospital surveillance videos are in evidence.[11] Exhibit 9A provides the closest and clearest view of Mr. Leach and the patient. They move off-frame just as they begin to fall to the floor. Exhibit 9B shows them as they interact and fall, and shows what happens just after they fall, but the recording is made from quite a distance and the details of the events leading up to the fall are hard to see. Exhibit 9C shows the aftermath of the incident.

Exhibit 9A begins with a view of the ambulance bay doors from the inside of the Hospital. The patient, carrying a plastic bag and using a cane, walks into view and begins to exit the ambulance bay doors. Mr. Leach walks behind the patient and points further down the hall, to the main entrance. Mr. Davis walks up. Mr. Leach moves to partially block the patient from exiting the ambulance doors; they are talking while Mr. Davis watches. Mr. Harshaw emerges from the ER and watches the conversation. The patient turns back toward the interior of the Hospital, leans against the inside of one of the ambulance bay doors, and crosses one foot over the other.

Mr. Leach moves toward the patient, extending his right arm to put it on the patient's left shoulder, apparently as part of an effort to move him along. At the same moment, the patient notices that something has fallen from his plastic bag onto the floor. He turns back toward Mr. Leach to look down at it, but Mr. Leach, seemingly unaware something has fallen to the floor, continues to urge the patient to turn and go forward. The patient turns and takes two steps forward in the direction Mr. Leach wants him to go, with Mr. Leach's hand on his left shoulder. Mr. Davis turns away at this moment. The patient then stops and partially turns back toward Mr. Leach. At this point, Mr. Leach's right hand is at the patient's arm or shoulder, and he touches the patient's chest with his left hand. Mr. Davis looks back at the two men.

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[11] The video recordings were admitted as Staff Exs. 9A-9C (collectively, Ex. 9). However, the order of the recordings on the disk provided by Staff and admitted is 9A, then 9C, then 9B.

In the next moment, the patient turns fully toward Mr. Leach, and the two men are facing each other and very close. The patient's feet are wide apart, his left foot planted firmly on the floor in front of his body and his right foot behind him, just off-camera. The patient is possibly leaning forward slightly. His right hand is extended behind him and off-camera; this is the hand with the cane, which is not visible. Mr. Leach's right hand is not visible but appears to be along the patient's back, and Mr. Leach plants his left hand squarely on the patient's chest, fingers spread widely apart. Mr. Leach leans forward, both heels off the floor and both knees bent. He pushes the patient in the chest. Mr. Leach and the patient fall out of the frame to the left. The cane is not seen as they begin to go down. They leave the frame before contacting with the floor.

The important part of the encounter—from the point at which the patient turns his back on the ambulance doors and crosses one leg over the other until he and Mr. Leach fall out of sight, consists of only a few seconds. Mr. Harshaw and Mr. Davis watched much of it, but, due to the angles, it is difficult to tell how much each of them could see.

Exhibit 9B begins at about the same point in time as the start of Exhibit 9A, but the camera used for this recording was situated down the hall, nearer the hospital's main entrance, in the direction that Mr. Leach and the patient fell. Therefore, the fall itself is visible, but from a greater distance and with much less detail than in Exhibit 9A. The critical events leading up to the fall of the two men to the floor are so blurry and indistinct as to be scarcely recognizable, and some of the interaction is just off-camera. It is hard to tell, but it appears that the patient's right hand (the one with the cane), as he falls, is behind him. The patient's left hand it extended forward, toward Mr. Leach. The patient hits the floor on his left elbow and back, and his legs fly up in the air. As he hits the floor, his left arm appears to be extended out to the left, away from Mr. Leach. Mr. Leach hits the floor on his knees, right next to the patient. They slide—the patient on his back, Mr. Leach on his knees—a short distance.

Mr. Leach kneels over the patient, with his hand on the patient's chest and his face very close to the patient's face, for about 12 seconds. People come out of doorways to see what

happened. The patient continues to lie on the floor while Mr. Leach and others stand over him. Someone brings a wheelchair, and Mr. Leach helps the patient off the floor and into the chair.

Staff Exhibit 9C shows Mr. Leach wheeling the patient in a wheelchair outside the main entrance of the hospital, followed by a number of others, including security personnel and/or police officers. Mr. Leach returns back inside shortly after.

6. Documentary Evidence

Staff's documentary evidence includes the medical records from the patient's ER visit, which, as reflected in the testimony of Mr. Davis, were not made contemporaneously with the visit. They do not address the incident between Mr. Leach and the patient as he was leaving the Hospital, but do generally state that the patient was uncooperative, angry, profane, and very belligerent to Hospital staff. The patient repeatedly said he was schizophrenic and bipolar.[12]

Some Hospital personnel records for Mr. Leach are also in evidence. In a comprehensive 2016 evaluation, he was rated as "excellent" in nearly all categories, although he received lesser scores and unfavorable comments about his treatment of some patients ("Sometimes I've witnessed [Mr. Leach] being very ugly and rude to patients. He thinks this is funny and tells everyone at nurses station about it later." "He needs to treat all patients equally. If he doesn't like a patient, he treats them horribly.")[13]

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[12] Staff Ex. 6.

[13] Staff Ex. 7. It is unclear whose statements these are, and it appears they may have been anonymous.

C. Mr. Leach's Evidence

1. Testimony of Mr. Leach

Mr. Leach has been an RN since 2009. He worked at the Hospital for eight years. Prior to this incident, he had previously suffered assaults by patients, in the course of which his nose was broken twice, he was choked, and his bicep was torn.

On this occasion, Mr. Leach said, the police brought the patient to the emergency department. He could be heard yelling and cursing. He was irate. The doctor on call asked the police for information about the patient, and the police said that he had called 911 several times. EMS transported him to a different hospital, where he was screened and discharged with instructions to follow up. He then called 911 again from that hospital's grounds. He called 31 more times. The police went to arrest him for 911 abuse, and the police decided to take him to the Hospital for evaluation.

Mr. Leach stated that the assigned nurse went to see the patient, then came out, saying, "I'm done" because the patient was calling names, using racial slurs, and threatening with his cane. According to Mr. Leach, the patient shouted at the doctor profanely and threatened Mr. Harshaw with the patient's cane. The patient said his feet hurt and he wanted a place to rest. At some point, the patient yelled that he would sue and take the nurses' licenses away, and he gathered his things to go. Mr. Leach followed him, not wanting other staffers to get hurt.

According to Mr. Leach, the patient got to the ambulance bay doors and leaned against them, saying he was not leaving. Mr. Leach told him, "C'mon, let's not do this, you don't need to be here." Mr. Leach testified that he put his hands on the patient's shoulders as a calming measure and said, "C'mon, we don't want the police, let's go," at which point the patient hit him in the groin with his cane. Mr. Leach stated he pushed the patient away with his right hand, the patient grabbed Mr. Leach's arm, and they stumbled to the floor. Mr. Leach said he asked the

patient, "Why did you hit me?" and the patient replied, "You won't let me spend the night." Mr. Leach then helped the patient up and into a wheelchair.

At this point, said Mr. Leach, he would have taken the patient back into the ER had he been injured, but the patient said he was fine and refused treatment. The doctor came and said to take the patient outside. The police said that the patient was going to jail, and Mr. Leach went back inside the Hospital. He heard nothing more until the police wanted to speak to him the following day about an allegation that he had assaulted the patient. Ultimately, no charges were brought. Mr. Leach stated he did not press charges against the patient for his attack with the cane.

Mr. Leach stressed that Hospital policy allowed him to defend himself within reason, and his push was not an offensive action. He said that he sees his role as taking care of patients without getting killed himself.

As to the root cause analysis meeting at which he resigned, Mr. Leach said that the focus of the meeting was on the Hospital's failure to register and screen the patient. Mr. Harshaw was not present, nor was the ER doctor. Mr. Leach stated that he was told he was lying and that he should have registered the patient, even though he was not the assigned nurse for the patient or the charge nurse. He realized he was about to be "hammered," and he resigned. He was told he would be re-hireable after a peer review, but the peer review never occurred. The ER doctor quit as well, he said. Further, Mr. Leach stated, the note from Ms. Cockrell was post-marked after the incident but before the root cause analysis meeting. Mr. Leach said no one contacted the state to report patient abuse as a result of this incident.[14]

Mr. Leach testified that he takes his duties as a nurse very seriously, and he does not assault or harm patients, period. He said that he did not assault the patient, but rather reflexively responded to being hit in the groin with the cane. He only defended himself. Placing his hand

[14] In contrast, Respondent Exhibit 8 states that the Texas Department of State Health Services (or, "TxDSHS" in the document) was consulted.

on the patient was a comfort measure. Mr. Leach emphasized that the video has no sound and only partial views, with the assault with the cane occurring just as he and the patient were leaving the frame of Exhibit 9A.

2. Documentary Evidence

Mr. Leach introduced several letters of recommendation. The first is from the doctor who was in the ER at the time of the incident. Justin Morris, DO, wrote that he has known Mr. Leach for seven years and has a tremendous amount of respect for him as a person and a nurse. Dr. Morris further wrote:

> [The Hospital's] attack on Don should be taken in context of the current environment which [the Hospital] has created. Since I began working at [the Hospital] there have been 2 people (1 nurse and 1 patient) killed by a patient's family member. As a response to this [the Hospital] hired off duty officers to provide security, however those officers and their service have been terminated by the administration of [the Hospital]. As a result of this they have created an environment which is not safe to practice. Since the officers have left the [ER], I have been witness to multiple assaults on nurses by psychiatric patients and have been victim to an assault myself. [The Hospital] has not responded responsible to correct this environment. Our current security guards, physicians, and nurses have been instructed by [the Hospital] administration to not place hands on patients, even in defense of our selves. . . . Don's response to this patient was in self defense after being assaulted by the patient with a cane. This particular patient is well known to our [ER] as well as the local police. He has been removed by the police from our [ER] many times due to his behavior.
>
> Because of a long list of events like this, July is my last month with [the Hospital].[15]

Rachel Longacre, RN, BSN, FNP wrote that she worked Mr. Leach for four years in the Hospital's ER. She described Mr. Leach as an "exceptional" nurse with high levels of medical skill and a "kind, compassionate, and caring" demeanor toward his patients, including grieving with devastated families. She stated, "I would feel relieved to see Don as my nurse should I ever

[15] Resp. Ex. 1. The quotation is verbatim.

need emergency care. I know that I would receive the best medical care while being treated with compassion."[16]

Kelli Shipley Harkins, RN praised Mr. Leach's nursing skill and his attention to patients' needs and further wrote:

> Emergency room staff are often verbally, emotionally, and physically threatened and sometimes attacked. Our emergency room is not different. We see a number of patients that make it clear that they do not care what happens to the healthcare worker, they are going to do whatever they want to do to get the outcome they want. [The Hospital] emergency room has seen the decline of twenty-four hour police officer coverage and a decrease in the number of security guards per shift due to administrative decisions. This in turn has created an environment that at times is not conducive to staff or patient safety. I have personally witnessed Don stepping in front of another nurse to keep her from being hit by a disgruntled patient. I have also seen Don spend time attempting to converse and reason with those patients to get the best possible outcome.[17]

Two other RNs, Dana Port and Tirsa Morrison, wrote to speak highly of Mr. Leach's calm professionalism, knowledge, leadership, and empathic concern for his patients.[18]

The Hospital's Apparent Cause Analysis Report concerning the patient encounter indicates that Mr. Leach and Dr. Morris "responded to the patient in a verbally aggressive manner and appeared to want him to leave the [ER]." Further, the report states that Mr. Leach's assertion that he had been hit with the patient's cane and was then pulled down by the patient "does not correlate with the video surveillance views from two angles and with witness statements that did not see the patient . . . strike nurse. . . ." Contributing factors are noted, including the failure of security officers to act and the failure of the charge nurse to help Mr. Leach disengage. The report also discusses the failure to register the patient.[19]

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[16] Resp. Ex. 2.

[17] Resp. Ex. 4.

[18] Resp. Ex. 5-6.

[19] Resp. Ex. 8. Although Staff stated at hearing that this exhibit perhaps should be maintained as confidential, and Staff was invited to brief this issue, Staff's written closing argument did not address it. Therefore, the exhibit is public.

IV. ANALYSIS

The video bears out Mr. Leach's own testimony that he pushed the patient. Mr. Leach testified that he took this action as a defensive measure in response to an attack by the patient. However, the video footage reflects no such attack prior to the push.[20]

Mr. Leach suggests that the shutter speed of the video recordings was insufficient to capture the patient's attack on him and/or that the Hospital tampered with the recordings to remove evidence of such an attack. Neither of these arguments is persuasive.

The shutter speed does not appear to be as fast as in some films. Nonetheless, the time lapse between images is extremely short. For example, when persons are recorded walking, every footfall is visible. The recordings capture the arrival of the patient and Mr. Leach at the ambulance bay doors, their conversation in front of the doors, the movements of Mr. Harshaw and Mr. Davis, the effort by Mr. Leach to get the patient to move toward the front entrance of the Hospital, Mr. Leach's gestures to the main entrance, the item falling from the patient's bag, Mr. Leach's placement of his hand on the patient's chest, Mr. Leach's leaning forward with both heels off the floor and knees bent, and the fall of both men. The cane, in the patient's right hand, remains visible or is extended backward off-camera, behind the patient and away from Mr. Leach, throughout the critical part of the encounter. It is unconvincing to suggest that, before the push, the patient could have brought the cane forward and struck Mr. Leach in the groin and returned the cane to its position behind the patient between camera images and without any sign of this action on the footage.

Further, there is no apparent break in the action to suggest that something has been purposefully deleted. Nor is it clear why the Hospital, after a nurse pushed a patient, would want to tamper with the evidence to remove signs that the patient had first assaulted the nurse. Mr. Leach's argument that he was being discredited or scapegoated in connection with the

[20] Because the latter part of the fall is only visible from the camera positioned farther away, it is not possible to say whether the patient hit or pulled Mr. Leach on the way to the floor, after Mr. Leach pushed him.

Hospital's improper and illegal failure to register the patient[21] is undermined by the fact that the Hospital's Apparent Cause Analysis Report acknowledges the failure and indicates that all involved staff were placed on performance warning (except for Mr. Leach, who resigned).[22] Mr. Leach also emphasized the Hospital's creation of a registration and medical record for this patient after the fact. However, it is not clear that this was improper or amounted to "falsification," as claimed by Mr. Leach. The medical record reflects "late entry." And, that the Hospital belatedly created a record does not mean that it altered its surveillance footage.[23]

That the two persons standing nearby, Mr. Harshaw and Mr. Davis, saw no attack by the patient lends further support to Staff's case. But the most compelling evidence is the surveillance footage. And even if the patient had, earlier in his ER visit, verbally threatened another nurse, there was no need for Mr. Leach to push the patient when he did.

Staff has established by a preponderance of the evidence that Mr. Leach is subject to sanction under Code § 301.452(b)(10) for unprofessional conduct likely to deceive, defraud, or injure clients or the public because he carelessly failed to perform nursing in conformity with the standards of minimum acceptable level of nursing practice (Board Rule 217.12(1)(A)); carelessly failed to conform to generally accepted nursing standards in applicable practice settings (Board Rule 217.12(1)(B)); engaged in careless conduct that may have endangered a client's life, health, or safety (Board Rule 217.12(4)); caused physical abuse to a client (Board Rule 217.12(6)(C)); and engaged in threatening or violent behavior in the workplace (Board Rule 217.12(6)(F)). He is also subject to sanction under Code § 301.452(b)(13) for failing to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that exposed a patient unnecessarily to risk of harm, in that he violated the Board's rules (Board

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[21] *See* Respondent's Closing Argument at 6 ("This is a case about a hospital covering its tail in the face of a clear . . . [legal] violation and using this 'event' as a red herring to avoid the 100k penalty for not screening a psychiatric patient who stated that he was schizophrenic and suicidal.")

[22] Resp. Ex. 8.

[23] In post-hearing argument, Mr. Leach cites to a newspaper article outside the record. *See* Respondent's Closing Argument, footnote 2. The ALJ has not considered the article.

Rule 217.11(1)(A)) and did not implement measures to promote a safe environment for clients and others (Board Rule 217.11(1)(B)).

This one act of pushing, however, occurred in the context of an otherwise untarnished career. The letters of recommendation offered by Mr. Leach were extremely strong, with praise for his skill as well as his energy and compassion. He has previously displayed an ability to work with difficult patients. The push of course cannot be condoned, but the patient involved would have tested the limits of most persons' ability to remain calm. Mr. Leach has already been injured by patients several times in the past, and two persons have been killed in the Hospital. It is clear from his testimony and his letters of support that nerves were raw among the health professionals in this setting, and they were fearful and felt insufficiently protected by the Hospital administration. Mr. Leach, in his effort to escort the patient from the ER, was attempting to protect other Hospital staff.

The ALJ agrees with Ms. Sinay's analysis and recommendation. The conduct sanctionable under Code § 301.452(b)(10) and (13) was physical abuse with a known serious risk of harm; it therefore is a third tier offense, and the appropriate sanction under the Matrix is suspension or revocation. However, in light of the mitigating factors, revocation or an enforced suspension would be too harsh. Rather, Mr. Leach should be subject to a two-year probated suspension, with terms and conditions as deemed appropriate by the Board.

V. FINDINGS OF FACT

1. Don Leach has been a registered nurse licensed by the Texas Board of Nursing (Board) since 2010.

2. On May 26, 2017, Mr. Leach worked in the emergency room (ER) of CHRISTUS Good Shepherd Medical Center in Longview, Texas (Hospital).

3. In the early morning hours, the police brought a patient to the ER.

4. The patient was agitated, profane, and belligerent.

5. The patient refused to cooperate with the Hospital's registration process.

6. The patient walked out of the ER to leave the Hospital.

7. Mr. Leach walked behind the patient down the hall.

8. The patient attempted to leave through the ambulance bay doors.

9. For safety reasons, Mr. Leach told the patient to go farther down the hall and exit the Hospital through the main doors.

10. The patient, who was walking in front of Mr. Leach, turned back toward him, and Mr. Leach pushed him in the chest.

11. Both men fell to the floor.

12. The patient hit the floor with enough force that his feet flew up in the air.

13. Prior to pushing the patient, Mr. Leach had not been physically attacked by the patient.

14. An ER doctor and other nurses wrote extremely strong letters of recommendation for Mr. Leach, praising his skill, his energy and compassion, and his ability to work with difficult patients.

15. Prior to the May 26, 2017 incident, Mr. Leach had been injured by patients several times, and two persons had been killed in the Hospital.

16. Health professionals in the Hospital were fearful and felt insufficiently supported by the Hospital administration.

17. Mr. Leach, in his effort to escort the patient from the ER, was attempting to protect other Hospital staff from an agitated patient.

18. On May 11, 2018, the Board's staff (Staff) sent Mr. Leach a Second Amended Notice of Hearing. The notice 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.

19. The hearing convened at SOAH on May 16, 2018, before Administrative Law Judge (ALJ) Shannon Kilgore. Assistant General Counsel John Vanderford represented Staff, and attorney Elizabeth Higginbotham represented Mr. Leach.

20. At the hearing, Mr. Leach objected that Staff had filed its Second Amended Notice of Hearing later than 10 days prior to the hearing. The ALJ overruled the objection as to the

deletion from Staff's charge of some language in the factual assertions, and Staff withdrew a newly-added citation to an additional subsection of a Board rule.

21. The hearing concluded that day, and the record closed June 26, 2018, with the filing of Staff's written reply argument.

VI. 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. Mr. Leach received adequate and proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.

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

5. Mr. Leach is subject to sanction under Texas Occupations Code § 301.452(b)(10) because he committed unprofessional conduct in that he carelessly failed to perform nursing in conformity with the standards of minimum acceptable level of nursing practice (22 Tex. Admin. Code § 217.12(1)(A)); carelessly failed to conform to generally accepted nursing standards in applicable practice settings (22 Tex. Admin. Code § 217.12(1)(B)); engaged in careless conduct that may have endangered a client's life, health, or safety (22 Tex. Admin. Code § 217.12(4)); caused physical abuse to a client (22 Tex. Admin. Code § 217.12(6)(C)); and engaged in threatening or violent behavior in the workplace (22 Tex. Admin. Code § 217.12(6)(F)).

6. Mr. Leach is also subject to sanction under Texas Occupations Code § 301.452(b)(13) because he failed to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that exposed a patient unnecessarily to risk of harm, in that he violated the Board's rules (22 Tex. Admin. Code § 217.11(1)(A)) and did not implement measures to promote a safe environment for clients and others (22 Tex. Admin. Code § 217.11(1)(B)).

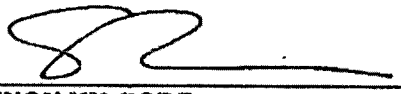
7. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

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 and the Board's Disciplinary Matrix.

VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board impose a two-year probated suspension, with stipulations as the Board deems appropriate, on Mr. Leach's license.

SIGNED August 8, 2018.



SHANNON KILGORE
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS