WRITING SAMPLE #1

Date: December 29, 2016

To: Board of Registered Nursing

From: [redacted]
Expert Witness

Subject: [redacted]
Case No.: [redacted]
License No.: [redacted]

DOCUMENTS REVIEWED

I reviewed the Division of Investigation Final Report and all attachments (1-8) for Case No. [redacted]

CASE HISTORY

[redacted] RN has been the operator of [redacted] since 1984. She has been a registered nurse practicing in California since 3/31/1981 and her license expired on 6/30/2016. She holds no other licenses in other states. She has no documented disciplinary actions on her California State Registered Nurse license per the investigators report. Contained within the Division of Investigation Final Report are documents indicating that [redacted] participated in continuing education with the San Francisco Department of Public Health Behavioral Health Services in Medication Administration in Community Care Facilities most recently on 4/1/2015 (Attach 8). On 4/29/2016 [redacted] was cited for a type A violation for discontinuing medications and increasing a medication dose without a doctor's order (Attach 3).

Act 1) On multiple instances [redacted] made changes to medications without a physician's order. On 7/7/2015 in the progress note by [redacted] stated that she changed the Depakote dose without a physician's order (Attach 7). On 3/21/ 2016 in the progress note by Dr. [redacted] discontinued the patients Risperidone dose and increased the patients Depakote dose without a physician's order. To augment this change in dose, she utilized medication from another patient's medication supply (Attach 7). From a letter dated on 11/2/2016 [redacted] confirms that she discontinued Risperidone and gave additional medication to the patient without a physician's order (Attach 8). From the interview on 10/20/2016 [redacted] acknowledges that she discontinued the patients Risperidone dose and increased the Depakote dose without a physician's order. Within the interview she states that to increase the clients dose she utilized the overage of medication available. [redacted] stated that when medication is dispensed "it is for 31 days," resulting in this overage. Per the medication records provided, all medications were ordered and dispensed from the pharmacy with a quantity of 30, 60 or 90 tablets (Attach 8).

Act 2) On multiple instances, 6/12/2015, 7/7/2015 and 12/28/2015, the patient's physician [redacted] MD requested that [redacted] RN take the patient to complete laboratory metabolic monitoring. These laboratory tests were not completed until 3/29/2016 (Attach 7).

After the completion of the requested blood lab work significantly abnormal values were noted including a TSH of 6.670 (reference rage of 0.45-4.5), Serum Sodium 129 (reference rage of 134-144, Critical Levels <120 or >160) and Serum Chloride of 94 (reference rage of 97-108). It is unclear how long the patient had been functioning at these abnormal levels due to a lack of consistent completion of the requested laboratory metabolic monitoring.

STANDARDS OF PRACTICE

Act 1) The standard of practice for a registered nurse is to administer medications to the patient under the direction of a physician's order, after being dispensed by a licensed pharmacist. It is within the scope of a practice for a registered nurse to hold a medication if in their clinical assessment the medication is resulting in potentially unsafe side effects. In this instance it is the responsibility of the registered nurse to contact a physician as soon as possible and obtain an order to permanently discontinue the medication. A medication cannot be permanently discontinued without a physician's order. If a registered nurse assesses a patient and believes that a medication dose is inappropriate or requires modification it is their responsibility to discuss this with a physician and obtain an order to change a medication dose. A medication dose cannot be changed without a physician's order. It is outside of the scope of nursing practice to dispense medications, "dispense" or "dispensing" means the interpretation, evaluation, and implementation of a prescription drug order, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to or use by a patient in accordance with applicable State and federal laws and regulations.

Act 2) The standard of practice for a registered nurse regarding completion of ordered laboratory blood work is to do so in a timely manner, prior to the patient's next visit with their physician. This allows a patient's physician to make safe and informed decisions about patient medical care and medication management.

DEPARTURE FROM STANDARDS OF PRACTICE

Act 1) The subject failed to adhere to the standards of practice by working outside of her scope of practice as a registered nurse on multiple occasions in the context of medication management. These instances included 1) discontinuing a medication without a physicians order 2) changing the dose of a patient's medication without a physician's order and 3) dispensing medications ordered for one patient to another patient, in order to modify the dose of a medication without a physician's order.

This departure from the standards of practice is defined as Gross Negligence in that the subject's conduct demonstrate a repeated failure to provide nursing care as required and could have jeopardized the patient's health or life.

Act 2) The subject failed to adhere to the standards of practice on multiple instances by not completing the ordered laboratory blood work requested by the patient's physician. This failure resulted in the delay of care in managing significantly abnormal blood levels.

This departure from the standards of practice is defined as Gross Negligence in that the subject's conduct demonstrate a repeated failure to provide nursing care as required and could have jeopardized the patient's health or life.

HARM TO PATIENT

Act 1) This departure from the standards of practice did not result in physical harm to the patient but could have resulted in potential harm.

Act 2) It is unclear from the documentation provided if the departure from the standards of practice did or did not result in physical harm to the patient, however, it could have resulted in potential harm.

CONCLUSION

It is my opinion that the subject demonstrated Gross Negligence by 1) working outside of her scope of practice as a Registered Nurse on multiple occasions, and 2) failing to complete ordered laboratory bloodwork resulting in a delay of care and potential harm.

Respectfully Submitted,

[redacted]PRN, MSN, PMHNP-BC December 29, 2016
Expert Witness

WRITING SAMPLE #2

SUBJECT: [redacted]
CASE NO.: 4002015006722

Date: March 10, 2017

To: Board of Registered Nursing

From: [redacted] BSN, CCRN, (ACNP in progress)

Subject: **Case No.: 4002015006722**

DOCUMENTS REVIEWED

I reviewed the following emails/documents/files/records:

- Division of Investigation Final Report dated **February 6th, 2017, Case No: 4002015006722** regarding [redacted] **RN.**
- Charges
- Synopsis of Investigation
- Narrative of Investigation
- Document Review
- Interview with:
  - [redacted]N

The material I found to be the most beneficial was the interview with [redacted]RN and the Document Review.

CASE HISTORY

BRIEF SYNOPSIS OF INVESTIGATION:

[redacted]RN was caring for patient [redacted] in the ICU on May 30th, 2012 who was status post a *sip* liver transplant. [redacted]RN claims that during the disconnecting of a completed Albumin infusion, the microclave port on the patient's central venous catheter (CVC) in his right internal jugular (IJ) became inadvertently disconnected and air was introduced into the circulatory system which lead to [redacted] suffering from an air embolism resulting in a left-sided stroke.

STANDARDS OF PRACTICE

Act 1: Intravenous (IV) medications/fluids should be placed on mechanical pumps to maintain patient safety, prevent run-away fluids as well as eliminate the chance for introducing air into the circulatory system on vented IV tubing that must be used with glass transport containers for medications such as Albumin, Nitroglycerine and Mannitol.

Act 2: When accessing a CVC or a peripheral IV catheter, precautions must be maintained for patient safety, sterility and patency when managing, connecting or disconnecting IV therapy modalities. Stabilization devices or manual assistance should be sought for times when safe access maybe compromised due to patient hindrance or interference.

SUBJECT: [redacted]
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DEPARTURE FROM STANDARDS OF PRACTICE

The subject failed to meet the standards of practice in the following ways:

Act 1: [redacted] RN stated in her interview that the Albumin was complete and not on a pump and in fact, in the diagram (attachment #22) reflects no IV pump mechanical device used in the administration of the Albumin. In her interview, she states that she "clamped the line to prevent the flow of Albumin before she proceeded to disconnect the IV line" and "the other side of the tube is connected to a "blue port," or microclave which is connected to the patient's central line" therefore, her statement reflects no use use of an IV pump. In the administration of fluids through glass bottles, vented tubing must be used in order to allow air to displace the fluid so the liquid content can flow. This has the potential to be extremely dangerous if the bottle is gravity fed only, has no dependent loops in the tubing system (i.e. short secondary tubing used) and into a large CVC access point creating sub-atmospheric pressure thus pushing air into the circulatory system when the liquid infusion is complete which would allow air to continue to flow into the circulatory system if not immediately clamped upon fluid completion.

Conclusion: [redacted] RN departed from the standards of care demonstrating gross negligence, incompetence and unprofessional conduct as evidence by failing to exercise ordinary precaution as well as the degree of skill in properly and safely administering Albumin (through a glass bottle with vented tubing off pump) to a patient exposing and conceivably contributing to an air embolism.

Act 2: CVC lines can pose a risk to patients in several ways including but not limited to infection, inadvertent disconnect, air embolism, dislodgment (extravasation), thrombosis, device fracture and phlebitis to name a few. Managing CVC devices requires skill and proficiency in order to perform the function of IV therapy and general care management such as cleaning, clave and dressing changes safely. [redacted] RN stated that the patient was restless and was "moving his head from time to time and touching his central line". [redacted] RN stated that she was going to remove the completed infusion of Albumin from his CVC line, yet stated the patient was restless and moving his head and attempting to touch his CVC line. [redacted] RN should have asked for help with the patient to safely disconnect the IV tubing from the clave in order to prevent the inadvertent dislodgment, disconnect and potential fracture of the CVC due to the patient's restlessness. Irrespective, [redacted] RN claims that she was "holding onto the microclave with one hand and using the other hand to turn the IV tubing counter clockwise" and immediately after "when the IV was free the microclave also disconnected and fell to the floor". Inquisitively, I am perplexed by her statement that if she was holding onto the 'microclave', how it fell to the floor, yet could immediately reconnect the IV to the open CVC hub if she wasn't originally holding the CVC device to begin with and not actually the microclave.

Conclusion: [redacted] RN departed from the standards of care demonstrating gross negligence, incompetence and unprofessional conduct as evidence by failing to exercise ordinary precaution as well as the degree of skill in properly and safely stabilizing and

managing the CVC device with staff assistance contributing to the patient obtaining an air embolism.

HARM TO PATIENT

The patient suffered a left-sided stroke from an air embolism directly related to this event.

CONCLUSION

[redacted] RN was grossly negligent, incompetent and demonstrated unprofessional conduct in her unsafe administration of a medication contained in a glass bottle without utilizing an IV pump to prevent inadvertent air infusion into the circulatory system and in the management of the CVC device on a patient she admittedly stated was restless, moving his head side to side and touching his CVC device which resulted in the patient having a left-sided stroke from an air embolism.

Respectfully,

[redacted] BSN, CCRN, (ACNP in progress)