STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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| DEPARTMENT OF HEALTH, BOARD OF NURSING, | ) | |
| Petitioner, | ) | |
| vs. | ) | Case No. 00-3430PL |
| FANNIE MAE MINSON HUDSON, R.N., | ) | |
| Respondent. | ) | |

RECOMMENDED ORDER

This cause came on for formal hearing on December 7, 2000, in Daytona Beach, Florida, before the Division of Administrative Hearings, by its Administrative Law Judge, Suzanne F. Hood.

APPEARANCES

For Petitioner: John O. Williams, Esquire
Maureen L. Holtz, Esquire
Williams and Holtz, P.A.
211 East Virginia Street
Tallahassee, Florida 32301

For Respondent: Reginald Moore, Esquire
559 Dr. Mary McLeod Bethune Boulevard
Suite 1
Daytona Beach, Florida 32115

STATEMENT OF THE ISSUES

This issues are whether Respondent violated Section 464.018(1)(h), Florida Statutes, and if so, what penalty should be imposed.

## PRELIMINARY STATEMENT

On or about October 4, 1999, Petitioner Department of Health, Board of Nursing (Petitioner), filed an Administrative Complaint against Respondent Fannie Mae Minson Hudson, R.N. (Respondent). Said complaint alleged that Respondent had violated Section 464.018(l)(h), Florida Statutes, by directing a change in medical treatment for two patients without prior approval of a physician.

On November 23, 1999, Respondent requested a formal hearing to contest allegations set forth in the above-referenced complaint. Petitioner referred this request to the Division of Administrative Hearings on August 14, 2000.

The parties filed a Joint Response to Revised Initial Order on August 21, 2000. A Notice of Hearing dated August 21, 2000, scheduled a hearing for October 23 through 24, 2000.

On September 11, 2000, Petitioner filed an unopposed Motion for Continuance and for Rescheduling of Final Hearing. An order dated September 14, 2000, granted this motion and rescheduled the hearing for November 14 through 15, 2000.

On October 25, 2000, Respondent filed an unopposed Motion for Continuance and for Rescheduling of Final Hearing. An order dated October 26, 2000, granted this motion and rescheduled the hearing for December 7 through 8, 2000.

During the hearing, Petitioner presented the testimony of seven witnesses and offered Petitioner's Exhibits P1-P8 and P 11, which were accepted into evidence. After reviewing the record, Petitioner's Exhibits P9 and P10 are hereby accepted into the record.

Respondent testified on her own behalf and presented the testimony of five additional witnesses. Respondent's Exhibits R1-R3 were accepted into evidence.

The Transcript of the proceeding was filed on December 26, 2000. Petitioner filed its Proposed Recommended Order on January 5, 2001. Respondent did not file proposed findings of fact and conclusions of law.

## FINDINGS OF FACT

1. Petitioner is the agency charged with regulating the practice of nursing pursuant to Section 20.43(m), Florida Statutes, and Chapters 455 and 464, Florida Statutes.

2. Respondent is, and at all times material hereto, a licensed registered nurse in the state of Florida. Her license number is RN 1948882.

3. Emory L. Bennet Veterans Nursing Home (the facility) is located in Daytona Beach, Florida. At all times relevant here, the facility employed Respondent as its Executive Director of Nursing.

4. At all times material to this case, the facility had a written policy regarding the recording and implementation of verbal orders given by doctors over the telephone. The policy sets forth the following procedures:

> Verbal orders, including telephone orders, for medications and treatments are taken only by a registered nurse or other licensed or registered healthcare specialists in their own area of specialty and are immediately recorded, dated, and signed by the person receiving the order.
>
> Telephone and verbal orders are written in triplicate:
>
> 1. Original copy to nursing office where it is promptly faxed, mailed or hand carried to physician for signature.
>
> 2. Second copy remains on chart in designated area until signed copy is returned.
>
> 3. Third copy is sent to pharmacy for inclusion in the following months [sic] printed doctor's orders.
>
> *All telephone and verbal orders are to be written on physician's order sheet by person receiving order.
>
> *All telephone and verbal orders by consulting physicians must be countersigned by attending physician.
>
> *After receiving telephone or verbal order, that order is to be noted.
>
> *All telephone and verbal orders are signed by the ordering physician within 48 hours.

5. The facility's telephone/verbal order form, in triplicate, includes space for the following information: (a) facility name and address; (b) patient name, admission number and room number; (c) attending physician name; (d) date and time of order; (e) date order discontinued; (f) order; (g) signature of nurse receiving order; (h) signature of physician; (i) date of physician signature; (j) initials of nurse notating orders on various documents in patient's medical chart, including but not limited to, nurse's notes, patient care plan, doctor's order sheet, and medication administration record; (k) initials of nurse sending copy of order to pharmacy; and (l) date, time and signature of nurse communicating or following through with order.

6. At all times material here, the facility had an "at-risk committee" (committee) that met at least once a week. The purpose of the committee was to review and make recommendations on patient care issues, including but not limited to, weight loss, bedsores, and falls.

7. For patients considered to be "at risk," the committee's recommendations were supposed to be recorded on a "Residents at Risk" form. This form listed the following: (a) patient's room number; (b) patient's name; (c) problem/concern; (d) recommended intervention; (e) person responsible; (f) date; and (g) follow-up.

8. After the committee made a recommendation that required physician approval, the nurse following through with the recommendation was supposed to contact the doctor by telephone or facsimile transmission, seeking his or her approval. Changes in medication could not be implemented without prior approval from the doctor. If the nurse received a physician's approval in a verbal order, the nurse was supposed to fill out and sign a telephone/verbal order form. The nurse would then implement the order herself or delegate that responsibility to a floor nurse. If a second nurse implemented the verbal order, she would add her initials and signature in the appropriate places, indicating the date and time of each action taken. The doctor would sign the telephone/verbal order form on his next visit to the facility.

9. Respondent was the chairperson of the committee at all times relevant here. Other members of the committee included the following: nursing supervisor for the seven a.m. to three p.m. shift, consultant dietitian, food service director, rehabilitative/restorative supervisor and therapist, care plan coordinator, infection control nurse, and social service director. Occasionally, the facility's pharmacist and administrator participated in the committee meetings.

10. Pursuant to the facility's policy, a telephone order form was to be filled out immediately after and not before

receipt of a verbal order from the doctor. Despite this policy, the committee, before and during Respondent's tenure as Executive Director of Nursing, routinely recorded its recommendations for at-risk patients on a telephone/verbal order form as well as the "Residents at Risk" form.

11. On March 23, 1999, Respondent conducted a committee meeting. In addition to Respondent, the following people attended the meeting: (a) Joan Locke, nursing supervisor of the seven a.m. to three p.m. shift; (b) Lee O'Malley, therapist; (c) Sandra F. Law, infection control nurse; (d) Gersom Marchena, social services director; and (e) Debra Weaver, listed as other.

12. During the meeting, Respondent filled out the "Residents at Risk" form for seven patients, including C.K. She did not list W.A. as an at-risk patient.

13. The committee discussed, among other things, standing physician orders for Ativan to be administered to C.K. and for Vistaril to be administered to W.A., both prescriptions on an as needed basis. The committee was concerned due to C.K.'s history of falls and because W.A. appeared to be overly sedated.

14. Ativan and Vistaril are psychotropic medications. Respondent expressed her opinion that the three p.m. to eleven p.m. nursing staff was lazy and using the medicines as chemical restraints for C.K. and W.A. Respondent then directed her subordinate nursing supervisor, Joan Locke, to fill out

telephone/verbal order forms discontinuing Ativan for C.K. and Vistaril for W.A. Respondent knew or should have known that the telephone/verbal order forms should not have been completed until after the doctor verbally approved the committee's recommendations.

15. Following Respondent's instructions, Ms. Locke filled out the telephone/verbal order forms to discontinue the above-reference medicines for C.K. and W.A. She did not sign the forms as having received the orders from the doctor. Instead, Ms. Locke gave the telephone/verbal order forms to her subordinate, Barbara Majors, a licensed practical nurse. Ms. Locke instructed Ms. Majors to follow through with the orders.

16. Ms. Majors incorrectly assumed that a doctor had verbally approved the changes in medication for C.K. and W.A. Ms. Majors then signed the forms on the lines for the signature of the nurse receiving the orders. Ms. Majors proceeded to make the proper notations in the patients' charts, to send copies of the orders to the pharmacy, and to remove the medicines from the patients' respective drawers in the medication cart.

17. When the shift changed at three p.m. on March 23, 1999, the nursing supervisor for the three p.m. to eleven p.m. shift was Mary Lou McMaster, R.N. Ms. McMaster questioned the change in medication for C.K. and W.A. Ms. McMaster was unsuccessful in her attempt to contact Dr. Timothy Johnston, the

facility's medical director, to verify the orders. Because she was unable to contact Dr. Johnston, Ms. McMaster contacted the facility's pharmacist, Rhomell Calara.

18. Later in the evening of March 23, 1999, Mr. Calara contacted Dr. Johnston by telephone. During the conversation, Dr. Johnston made it clear that he had not approved orders to discontinue medicines for C.K. and W.A. and did not intend to do so. As a result of this telephone call, the medicines were not discontinued.

19. The next morning, March 24, 1999, in a meeting of department heads, Mr. Calara questioned Respondent about the telephone/verbal orders. Respondent did not attempt to explain that the telephone/verbal orders were written as the committee's recommendation. Instead, Respondent stated that she was going to have the medications discontinued again because the afternoon shift was using them as chemical restraints and the patients were too sedated during the day.

20. On the morning of March 25, 1999, Dr. Johnston attended the facility's meeting of department heads. During the meeting, Dr. Johnston questioned Respondent regarding the committee's procedures for implementing physician orders. When Dr. Johnston asked Respondent if she had given a direct order to discontinue the medications or a recommendation to discontinue them, Respondent got up and left the meeting. Respondent did

not attempt to explain that the committee's recommendations were written as telephone/verbal orders as a result of miscommunication or other inadvertent mistake.

## CONCLUSIONS OF LAW

21. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding. Sections 120.569, 120.57(1), and 455.621, Florida Statutes.

22. Petitioner has the burden of proving that Respondent violated Section 464.018(1)(h), Florida Statutes, by clear and convincing evidence. Ferris v. Turlington 510 So. 2d 292 (Fla. 1st DCA 1987).

23. Section 464.018, Florida Statutes, provides as follows in pertinent part:

> (1) The following acts shall be grounds for disciplinary action set forth in this section:
>
> * * *
>
> (h) Unprofessional conduct, which shall include, but not be limited to, any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing nursing practice, in which case actual injury need not be established.

24. Nurses may not change a doctor's prescribed medications for patients without the doctor's prior approval.

Writing telephone/verbal orders to discontinue prescriptions without that approval presents a serious risk to patient safety.

25. The nursing profession recognizes the inherent danger in telephone/verbal orders because nurses routinely execute the orders before the doctor signs them. Where one nurse implements a telephone/verbal order written by another nurse, there is no built-in mechanism for the doctor to see the order and prevent the implementing nurse from carrying out an improper and possibly dangerous order. Accordingly, the nursing profession mandates that nurses never write "draft" or "proposed" telephone/verbal orders. In other words, no order should be written until the doctor has spoken.

26. The facility's policy required the nursing staff to secure the attending physician's verbal approval before writing a telephone/verbal order. In light of that policy, it is understandable how a subordinate nurse like Ms. Majors would assume that Dr. Johnson had given his approval before the orders were written and before she began implementing them.

27. There is clear and convincing evidence that Respondent's actions constituted a departure from the minimal standards of acceptable and prevailing nursing practice. Respondent knew or should have known about the facility's policy regarding telephone/verbal orders. She knew or should have known that her direction to Joan Locke to write the orders for

C.K. and W.A. without prior approval from Dr. Johnston was contrary to that policy. As the Executive Director of Nursing, Respondent was responsible for enforcing the facility's written policy and the standards of her profession. This is true regardless of the common practice of the committee before and during Respondent's tenure as chairman of the committee.

28. Rule 64B9-8.006, Florida Administrative Code, sets forth the disciplinary guidelines, including aggravating and mitigating circumstances. The suggested penalty for violation of Section 464.018(1)(h), Florida Statutes, where such violation involves administrative duties such as charting or supervision of others, is as follows: (a) a fine ranging between $250 and $1,000; (b) probation ranging between six months and two years under conditions specified by Petitioner; and (c) required continuing education courses as determined by Petitioner. Rule 64B9-8.006(3)(i), Florida Administrative Code.

29. Rule 64B9-8.006(4)(b), Florida Administrative Codes, states as follows:

> (b) Circumstances which may be considered for purposes of mitigation or aggravation of penalty shall include, but are not limited to, the following:
> 1. The severity of the offense.
> 2. The danger to the public.
> 3. The number of repetitions of offenses.
> 4. Previous disciplinary action against the licensee in this or any other jurisdiction.
> 5. The length of time the licensee has practiced.

6. The actual damage, physical or otherwise, caused by the violation.
7. The deterrent effect of the penalty imposed.
8. Any efforts at rehabilitation.
9. Attempts by the licensee to correct or stop violations, or refusal by the licensee to correct or stop violations.
10. Cost of treatment.
11. Cost of disciplinary proceedings.

30. Respondent's actions created a danger to the public. However, her actions did not cause any actual damage, physical or otherwise.

31. Respondent repeatedly violated Section 464.018(1)(h), Florida Statues. She made no effort to correct the situation when given an opportunity to do so.

32. Respondent has practiced nursing under a Florida license since 1988. She has no prior disciplinary history.

## RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED:

That Petitioner enter a final order fining Respondent $500, placing her on one year's probation with conditions, and requiring her to take appropriate continuing education courses.

DONE AND ENTERED this 17th day of January, 2001, in Tallahassee, Leon County, Florida.

SUZANNE F. HOOD
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of January, 2001.

COPIES FURNISHED:

John O. Williams, Esquire
Maureen L. Holz, Esquire
Williams and Holz, P.A.
211 East Virginia Street
Tallahassee, Florida 32301

Reginald Moore, Esquire
559 Dr. Mary McLeod Bethune Boulevard
Suite 1
Daytona Beach, Florida 32115

Ruth R. Stiehl, Ph.D., R.N., Executive Director
Board of Nursing
Department of Health
4080 Woodcock Drive, Suite 202
Jacksonville, Florida 32207-2714

William W. Large, General Counsel
Department of Health
4052 Bald Cypress Way, Bin A02
Tallahassee, Florida 32399-1701

Theodore M. Henderson, Agency Clerk
Department of Health
4052 Bald Cypress Way, Bin A02
Tallahassee, Florida 32399-1701

Dr. Robert G. Brooks, Secretary
Department of Health
4052 Bald Cypress Way, Bin A00
Tallahassee, Florida 32399-1701

## NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.