STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING, Petitioner, vs. DONNA M. CAMERON CONNOLLY, R.N., C.R.N.A., Respondent.	)	Case No. 05-3268PL

RECOMMENDED ORDER

Notice was provided and on October 18, 2005, a formal hearing was held in this case. Authority for conducting the hearing is set forth in Sections 120.569 and 120.57(1), Florida Statutes (2005). The hearing commenced at 10:00 a.m. at the Lake County Judicial Center, Suite 12, Second Floor, 550 West Main Street, Tavares, Florida. The hearing was conducted by Charles C. Adams, Administrative Law Judge.

APPEARANCES

For Petitioner: Irving Levine
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STATEMENT OF THE ISSUE

Should discipline be imposed against Respondent based upon the allegation that she failed to meet minimal standards of acceptable and prevailing nursing practice in violation of Section 464.018(1)(n), Florida Statutes (2002)?

PRELIMINARY STATEMENT

On June 21, 2005, by an Administrative Complaint in Case No. 2004-34970, before the State of Florida, Department of Health, the Department, as Petitioner, accused Respondent of the aforementioned statutory violation. Material facts in that Administrative Complaint concern the care Respondent provided Patient M.M., who underwent a colonoscopy in which Respondent provided anesthesia. Respondent is accused of failing to meet minimal standards of acceptable and prevailing nursing practice in one or more of the following ways:

a. By leaving an unstable patient in the Post Anesthesia Care Unit (PACU);

b. By failing to verify patient's vital signs upon admission to PACU;

c. By failing to stay with a patient in PACU long enough to ensure that the patient was stable;

d. By disregarding the patient's unstable vital signs when leaving the patient in PACU;

e. By failing to provide oxygen via a bag-valve mask or through intubation immediately;

f. By failing to ensure that proper equipment for intubation was readily available in the PACU;

g. By failing to utilize the intubation equipment in a timely fashion as necessary to restore breathing in an emergency; and

h. By choosing to utilize mouth-to-mouth resuscitation as her first intervention.

Having been served with the Administrative Complaint, Respondent was noticed of her rights in accordance with Sections 120.569 and 120.57, Florida Statutes. She chose the option to contest certain allegations within the Administrative Complaint as to facts. As a consequence, the case was referred to the Division of Administrative Hearings (DOAH) in the person of Robert S. Cohen as Director and Chief Judge. The case was assigned the DOAH reference number, and the undersigned became responsible for the case, after it was first assigned to Susan B. Harrell, Administrative Law Judge.

Following notice of the hearing date, the hearing took place on the date described.

Cenon Erwin Velvis, C.R.N.A., testified for Petitioner. Petitioner's Composite Exhibit numbered one and Exhibit numbered 2 were admitted. Respondent testified in her own behalf and presented Michael A. Binford, M.D., as her witness.

Respondent's Exhibits numbered one and three were admitted. Respondent's Exhibit numbered two was denied admission. Both the exhibits that were admitted and the exhibit denied admission are being transmitted with this Recommended Order.

In accordance with a pre-hearing stipulation, the parties agreed to certain facts. Those stipulated facts are reported in the fact finding to this Recommended Order.

On November 1, 2005, a hearing transcript was filed with DOAH. The parties submitted proposed recommended orders which have been considered in preparing the Recommended Order.

At the conclusion of the Petitioner's case-in-chief, Respondent moved for a directed verdict. That motion was denied for reasons stated in the transcript.

FINDINGS OF FACT

STIPULATED FACTS:

1. Petitioner is the state department charged with regulating the practice of nursing pursuant to Section 20.43, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 464, Florida Statutes.

2. At all times material to the Complaint, Respondent was licensed to practice as a certified registered nurse anesthetist ("C.R.N.A.") within the State of Florida.

3. Respondent's address of record is 4409 Hoffner Avenue, Suite 328, Orlando, Florida 32812.

4. On or about March 13, 2003, Patient M.M. presented to Endosurg Outpatient Center (Endosurg) for a colonoscopy.

5. The colonoscopy began at or about 7:16 a.m.

6. According to the Respondent's Anesthesia Record, Patient M.M. had a blood pressure of 120/70 at 7:30 a.m., and a blood pressure of 140/84 and an oxygen saturation of 96 percent "at the end of case."

7. Respondent began mouth-to-mouth resuscitation and CPR at or about 7:46 a.m., then provided oxygen via a bag-valve mask at or about 7:48 a.m., and then provided oxygen by intubation at or about 7:50 a.m.

8. Section 464.018(1)(n), Florida Statutes (2002), subjects a licensed nurse anesthetist to discipline for failing to meet minimal standards of acceptable and prevailing nursing practice.

ADDITIONAL FACTS:

9. The indications for the endoscopic procedure performed on Patient M.M. were in relation to bright red blood per rectum and anemia. The endoscopic diagnosis confirmed by the procedure was diverticulosis and internal hemorrhoids.

10. According to Patient M.M., this was the first colonoscopy she had ever had.

11. In the history reported by Patient M.M. prior to the procedure, there was no report of chest pain, indigestion, heart burn, or nausea. The patient did report rectal bleeding. Patient M.M. provided a history of bronchitis, but it was noted that there were no recent problems with the bronchitis. In the recount of her past medical history, she made no reference to congestive heart failure, coronary artery disease, diabetes, atrial fibrillation, angina, heart murmur, heart valve problems, or irregular heart. She did have a history in her family of heart disease; the family member was her father. By history, the patient suffered from high blood pressure. At the time the patient was seen at Endosurg she was 67 years old, 5 feet 5 inches tall, and weighed 215 pounds.

12. Respondent has practiced for 30 years in numerous settings. Respondent was an independent contractor recently employed at Endosurg. Over time she has met her obligations in relation to continuing education for her profession.

13. When Respondent first saw Patient M.M. on the date in question, the patient was in the holding area adjacent to the procedure room. Respondent introduced herself to the patient and checked the intravenous access. The line had been placed and Respondent checked to make certain that the line was patent. Respondent explained to the patient that the patient would be given sedation. In particular, Respondent told the patient that

she would be placed under conscious-sedation during the procedure. The patient responded that her son had had post-operative nausea and vomiting, having undergone sedation, but that the patient had experienced no problems with anesthesia in the past. Respondent listened to the patient's chest. The heart was regular, in that there were no audible sounds of irregularity or murmur at that time. The patient's chest was clear. No signs of wheezing or bronchi or rales were present that would indicate upper-respiratory difficulties. Respondent was aware that the patient suffered from hypertension.

14. Before the procedure Respondent did not observe anything in the patient's demeanor which suggested that the patient was overly anxious.

15. As the anesthesia record reflects, the administration of anesthesia by Respondent commenced at 7:15 a.m. and ended at 7:26 a.m. The procedure commenced at 7:16 a.m. and concluded at 7:25 a.m. Before providing the anesthesia, Respondent placed a blood pressure cuff on the patient, a pulse oximeter, an EKG monitor, and a pre-cordial stethoscope.

16. The patient was anxious and Respondent administered a total of 2 mg of Versed. The Versed was administered twice. After waiting to see the reaction to the first administration, a second administration was provided. During the administration

of this medication, Respondent discussed its subjective influence with the patient.

17. Two other persons were in the procedure room with Respondent. They were the physician gastro-endrologist, who was performing that procedure, and an anesthesia technician. The doctor involved was Dr. Nehme Gebrayel.

18. When the scope used to perform the procedure was inserted the patient winced. In response to those circumstances Respondent provided Fentanyl, an ultra-short acting narcotic in an amount considered appropriate to the circumstances.

19. When the scope reached the area within the colon where the scope needed to be turned, the patient grasped the arm of the technician and dug her nails into his forearm. The physician called upon Respondent to provide other sedation to allow him to continue the procedure while providing some comfort to the patient. In response Respondent gave the patient 30 mg of Propofol, an hypnotic sedative with a short half-life. Later the patient began to dig her nails into the technician's forearm once more, which the technician reported to the physician. The physician told Respondent to provide additional sedation. Respondent gave the patient 30 mg more of Propofol.

20. While the procedure was ongoing Respondent monitored the patient's vital signs. Before the procedure, the blood pressure was 142/100, the heart rate was 72. The second reading

on blood pressure taken by Respondent during the procedure occurred between 7:18 a.m. and 7:20 a.m., with a reading of 126/66.

21. Pulse oxygen readings that were recorded at the beginning and during the procedure reflected 98 percent and 95 percent saturation respectively.

22. When the physician began to withdraw the scope at the end of the procedure, Respondent told the patient that the procedure was being finished and that the physician was taking the scope out. The patient responded by giving a "thumbs up" gesture.

23. When the Doctor finished the procedure, Respondent asked the patient if the patient was doing "O.K." Respondent asked the patient if the patient was experiencing discomfort, the patient responded "not really." Respondent told the patient that the patient was being taken back to the holding area where she had been picked up before and brought into the procedure room.

24. While the physician was still in the procedure room, Respondent went to the door and opened it into the holding area, and the nurse from the PACU at Endosurg came into the procedure room. Maureen Mayhew, R.N., was that nurse.

25. When nurse Mayhew entered the procedure room, the vital signs in relation to blood pressure, pulse, and the pulse oximeter reading were still displayed on the monitor in the procedure room. Those readings at the end of the case were blood pressure 140/84, heart rate 74, respiratory rate 16 per minute and the saturated oxygen level 96 percent. At that time the patient responded to queries and stimuli. The reference to responding to queries means that the patient was able to converse with the Respondent.

26. When Respondent turned over the care to nurse Mayhew, she told the other nurse that the patient had high blood pressure and a history of bronchitis but that the chest was clear when listened to prior to the procedure. Respondent explained that the patient had undergone a colonoscopy, in which 2 mg of Versed, 50 mg of Fentanyl, which is the equivalent to 1 cc and a total of 60 mgs of Propofol, divided into two doses had been provided. Respondent told nurse Mayhew that the patient was awake and talking and that her blood pressure had started at 140, had drifted down to 120 and was back at 140, as to systolic readings.

27. After Respondent released the patient to the care of nurse Mayhew, she proceeded to address the next case. The administration of anesthesia to that patient commenced at 7:27 a.m.

28. At about 7:45 a.m. a C.N.A. at Endosurg came into the procedure room where the next case was underway. The C.N.A. stated that there was a problem with Patient M.M., in that the patient was not responding as she had been. The C.N.A. asked that the doctor and Respondent come and see the patient.

29. After arranging for someone to continue to monitor the patient that was being examined at that moment and with the placement of intravenous fluid with that patient to keep him hydrated, Respondent and the doctor left the procedure room and entered the holding area where Patient M.M. was found.

30. When Respondent and the physician approached the patient, the patient was alone, flat on the bed. Respondent checked the patient's pulse at her neck, while the physician checked the patient's pulse at the wrist. Respondent called the patient's name and rubbed on the patient's chest. The patient made no response. The patient had no pulse. Respondent told the doctor "I don't have a pulse here." The doctor responded "Neither do I." When Respondent and the doctor addressed the patient in the holding area, they were uncertain when the patient had stopped breathing. The doctor commenced chest compressions as a form of CPR. Respondent leaned over the patient and breathed two quick breaths into the patient through mouth-to-mouth CPR. Respondent asked someone else employed at Endosurg to bring the CODE cart. Someone asked the Respondent

if they needed to call 911. Respondent said, "yes" and the call was placed. Respondent was handed an ambubag with a valve mask to assist the patient in breathing. To check the bag's operation Respondent squeezed twice and found that the bag was not working. This bag belonged to Endosurg, and by inference Endosurg, not the Respondent is found to be responsible for its maintenance.

31. During the inception of the mouth-to-mouth resuscitation provided by her, Respondent noticed that the patient's chest rose which is an indication that the patient was being ventilated. By contrast, the initial ambubag provided no evidence that ventilation was occurring.

32. When the facility ambubag failed, Respondent asked another employee at Endosurg to go and pick up her personal ambubag that was located in another part of the procedure room. While someone went to retrieve Respondent's personal ambubag, the Respondent continued to provide mouth-to-mouth resuscitation while the physician gave closed chest compressions to the patient. During that time the chest was rising, indicating that the patient was making ventilatory efforts.

33. When the second ambubag, belonging to Respondent, was handed to her, it was connected to oxygen and it performed as expected. The patient was given several quick breaths of the oxygen through the ambubag. Respondent then used a laryngoscope

and an endotracheal tube to intubate the patient and the patient was intubated. While being ventilated through the endotracheal tube, Respondent used a stethoscope to listen to the breath sounds of the patient and she found evidence that the endotracheal tube was secure. While this was occurring the physician continued chest compressions. The physician also administered certain drugs to the patient to assist the patient. One drug being administered to the patient at the time was Epinephrine. The patient was then defibrillated.

34. The defibrillator did not have a separate monitor. It was one in which the paddles associated with the defibrillator were not hooked to a device that would produce print strips of the results when the paddles were applied. This defibrillator belonged to Endosurg. The Respondent and the physician relied upon the EKG monitor hooked up to the patient to gain information and her status.

35. When the Respondent and the doctor had come into the holding area, the patient was not on the monitor. The physician placed the leads on the chest of the patient to connect the monitor to reflect the pulse rate, if any were present. When the patient was first defibrillated and there was no change in the heart rhythm, another dose of Epinephrine was administered. About that time the fire rescue unit that had been summoned by the 911 call arrived. That was at 7:51 a.m.

36. The fire rescue personnel included an EMT paramedic qualified to maintain the airway for the patient. Those persons took over the patient and prepared the patient for transfer.

37. Respondent asked the doctor if it was acceptable to return to the procedure room and check the status of that patient. The physician gave her permission but Respondent did not return to the procedure room until the EMT paramedic had checked the position of the endotracheal tube in Patient M.M.

38. Through the efforts made by Respondent and the physician the patient regained her pulse. A note in the patient's records refers to the existence of the heart rate and pulse when the patient was turned over for transport to a hospital. That hospital was the Villages Regional Hospital. There the patient was diagnosed with cardiac arrest and anoxic brain damage, encephalopathy. Subsequently the patient was transferred to Leesburg Regional Medical Center. The decision was eventually made to remove the patient from life support, given her condition.

39. In an interview nurse Mayhew gave to an investigator with the Department of Health, relied upon by the parties at hearing, Ms. Mayhew told the investigator that five patients were in the PACU at Endosurg when Patient M.M. was transferred to that unit. At the time there was only one registered nurse and a single C.N.A. in the unit. Liz Singleton was the C.N.A.

Ms. Mayhew told the investigator that Ms. Singleton indicated to Ms. Mayhew that the patient was alert and talking when the patient entered the unit. Ms. Mayhew said that she gave Patient M.M. a rapid assessment shortly after the arrival of the patient in the unit. Ms. Mayhew told the investigator that she noted that the Patient M.M. had declined from alert to responsive at that time. When checking the color and vital signs, a decrease in blood pressure was noted and the patient was placed in the Trendelenberg position (head down, feet raised) to try to increase the blood pressure. Ms. Mayhew mentioned giving Patient M.M. a sternal rub. The patient was noticed to blink her eyes and move her shoulder. Fluids were started, and the patient was given Romazicon intended to reverse the effects of anesthesia that had been provided to the patient during the procedure. Ms. Mayhew told the investigator that she gave C.N.A. Singleton instructions not to leave the patient's bedside and to give the patient one-on-one care. Ms. Mayhew then went to arrange for another C.N.A. to assist in the PACU. At some time during the care provided by nurse Mayhew, she indicated that there was a monitor for blood pressure, oxygen saturation, respiration and pulse and that the alert alarms were set. Nurse Mayhew told the investigator that she was starting an IV two beds away and heard the second C.N.A. talking to Patient M.M. just before the alarms went off. She said that

Patient M.M. was in respiratory arrest and that she called a CODE, meaning nurse Mayhew called a CODE. Any entries concerning the vital signs in relation to Patient M.M. that were made following the procedure while the patient was in the holding area were made by C.N.A. Singleton, according to nurse Mayhew's statement. The monitor had printout capabilities at the time but was not activated. Notwithstanding these remarks attributed to nurse Mayhew in the interview process, it is found that when Respondent and the doctor addressed the patient in the holding area the monitor was disconnected.

40. Although in her remarks made to the investigator nurse Mayhew said that the vital signs were recorded by the C.N.A., the record of nursing assessments reflecting the recording of the vital signs was signed by nurse Mayhew. They show that at 7:30 a.m. the patient's blood pressure was 78/46, with a pulse rate of 52, and a respiratory rate of 12. At 7:35 a.m. the blood pressure was 74/42, with a pulse rate of 40, and a respiratory rate of 14.

41. The physician gave certain post-op orders concerning Patient M.M. which were noted by nurse Mayhew when she affixed her signature. One of those orders indicated that Ms. Mayhew was obligated to "notify physician for blood pressure less than 90/60, pulse >110." This order was not followed.

EXPERT OPINION:

42. Cenon Erwin Velvis, C.R.N.A., has been licensed in Florida for eleven years. He was called as an expert for Petitioner to testify concerning Respondent's care rendered Patient M.M. in this case. The witness was received as an expert.

43. Both the Respondent and Mr. Velvis have provided anesthesia on numerous occasions while patients were undergoing colonoscopies.

44. To prepare himself for the testimony, nurse Velvis reviewed medical records pertaining to Patient M.M. and the investigative report of the Department of Health. His opinion is that Respondent in caring for Patient M.M. fell below the standards expected of a C.R.N.A. when considering acceptable and prevailing nursing practice.

45. Concerning his opinion, nurse Velvis believes that Patient M.M. was transferred to the PACU in an unstable condition, that Respondent did not remain with the patient long enough to ascertain this instability and the need for treatment and to conduct an ongoing evaluation secondary to the side effects of the anesthesia, and that once the patient experienced difficulties, the airway and circulatory system were not secured by Respondent in a timely manner.

46. Nurse Velvis believes that the blood pressure reading at 7:30 a.m. of 78/46 and heart rate and pulse of 52 are low, dangerously so. According to nurse Velvis the normal range is 120/80 for blood pressure. There can be an acceptable 15 to 20 per cent departure from what is considered normal. This takes into account that nature of the procedure that the patient had undergone. The vital signs that were reflected at 7:30 a.m. demonstrate patient instability at 7:30 a.m., in Mr. Velvis' opinion. The Romazicon administered to the patient would not ordinarily be used given the amount of anesthesia provided the patient in the procedure. The patient's responsiveness had progressed to a point from what was initially assessed as responsive or responding to queries, to an unresponsive state. This would account for the administration of Romazicon, a reversal agent to the tranquilizer that had been used during the procedure. Nurse Velvis notes that the patient had gone from responding to inquiries to a state of unresponsiveness where the patient would only move when given painful stimuli.

47. Mr. Velvis was aware that the blood pressure at 7:35 a.m. was 74/42, with a pulse rate of 40, indicating a further decline. The approximate time of arrest for the patient was 7:45 a.m. from records reviewed by Mr. Velvis.

48. Mr. Velvis believes that the Respondent was responsible for verifying the patient's vital signs upon admission to PACU. He also originally expressed the opinion that Respondent failed to utilize the intubation equipment in a timely fashion to restore breathing following the emergency.

49. Mr. Velvis concedes that if the cardiac arrest that occurred with Patient M.M. were related to anesthesia, the respiratory response by the patient would be lowered. But the recording of a respiratory rate of 12 at 7:30 a.m. and 14 at 7:35 a.m. does not satisfy Mr. Velvis concerning the quality of ventilation in the patient, even with the efforts of the patient being recorded. He also makes mention that the level of oxygen saturation at those times was unknown when reviewing the record. He does acknowledge that a respiratory rate of 14 as such is not consistent with respiratory arrest.

50. Mr. Velvis acknowledges that nothing in the record indicates that nurse Mayhew notified the doctor when the low blood pressure readings were taken at 7:30 a.m. and 7:35 a.m., contrary to post-op orders.

51. When provided a hypothetical under interrogation at hearing, that reflects the facts that have been reported here concerning the Respondent and the doctor in their effort to restore Patient M.M.'s breathing, Mr. Velvis retreated from his opinion that the airway and circulatory system of the patient

was not secured in a timely manner when confronted with the crisis.

52. While Mr. Velvis changed his opinion during cross-examination at hearing concerning the response by Respondent leading to the defibrillation, he still continued to express the opinion that Respondent fell below the standard of care and was responsible for hypoxia in the patient, the patient not breathing. He also restated his opinion that Respondent was below the standard of care for her release of the patient from the procedure room into the PACU in an untimely manner.

53. Mr. Velvis expresses the opinion that immediate patient care was the Respondent's responsibility but in the atmosphere of team work the physician was the captain of the ship. Although the physician was the captain of the ship, the Respondent was responsible to do what was most important for the patient, according to Mr. Velvis.

54. Mr. Velvis recognizes that nurse Mayhew would have been more helpful if she had notified Respondent and the physician earlier about Patient M.M.'s condition in the holding area, and Ms. Mayhew's error in leaving the patient when the patient was unstable.

55. Mr. Velvis expresses the opinion that the mechanism behind the cardiac arrest in Patient M.M. was a lack of oxygen, in that the airway was not secure. Mr. Velvis in his testimony

concedes that the patient could have had cardiac failure not due to a problem with respiration.

56. Michael A. Binford, M.D., was called by Respondent as an expert. He is a practicing anesthesiologist in Florida who completed his anesthesiology residency approximately ten years ago. He works with C.R.N.A.s in his practice and as such is able to offer opinion testimony about the performance of C.R.N.A.s in their practice. He is familiar with the type of procedure which Patient M.M. was undergoing and the drugs administered to provide anesthesia.

57. Having reviewed the patient's records and the investigative report from the Department of Health, his opinion is that Patient M.M. was stable when transferred from Respondent's care to nurse Mayhew's care. That opinion is based upon vital signs recorded at the commencement, during, and at the end of the procedure. From what he saw in the record concerning the medication administered to the patient during the procedure, it was appropriate. Nothing that he saw in the record made Dr. Binford believe that the Respondent should have stayed with the patient for a longer period of time, given the amount of medication provided.

58. By contrast Dr. Binford refers to the vital signs recorded when the patient was under nurse Mayhew's care at 7:30 a.m. and 7:35 a.m. Those are not vital signs of a patient in a

stable condition. Dr. Binford believes that the patient was deteriorating at that time and that nurse Mayhew violated the physician's post-op order by not immediately notifying the doctor of the vital signs she found.

59. Dr. Binford in referring to nurse Mayhew's statement given to the investigator, reads the statement to indicate that the patient was stable when entering the PACU but declined from alert to responsive. To Dr. Binford this reflects a change in mental status in the patient. Definitive evidence in the change in status is borne out by the vital signs taken at 7:30 a.m., and 7:35 a.m., in Dr. Binford's opinion. Although the Romazicon given by Nurse Mayhew would not have been a drug of choice for Dr. Binford, he understands that nurse Mayhew may have considered it appropriate to provide an antidote to the Versed by using Romazicon. Dr. Binford did not believe that the Versed would have caused the low vital signs encountered by nurse Mayhew.

60. Having reviewed the autopsy report related to Patient M.M., Dr. Binford believes that a cardiac event was associated with the lower vital signs. He does not believe that the respiratory rate of 12 and 14 found at 7:30 a.m. and 7:35 a.m. respectively are consistent with respiratory arrest.
Dr. Binford explains that the process involved with a heart attack, which is also referred to a myocardial infarction, is in

relation to the entire heart or some segment within the heart not getting sufficient oxygen. If the patient is not breathing for a period of time, the total level of oxygen in the blood drops significantly. That is a possibility. The second possibility is that if there is plenty of oxygen in the blood, but one of the blood vessels supplying the heart muscle becomes blocked and no blood can get past the obstruction, this can also cause oxygen deprivation. Either explanation can cause damage to the heart and the brain. The first example is one in which problems are experienced in getting air and oxygen into the lungs, that can be picked up and transported around the body and the second explanation involves a problem with getting the blood flow into the area as needed. The first example related to problems of respiration is referred to by Dr. Binford as a primary respiratory event. The second example is referred to as a primary cardiac event, involving restricted blood flow.

61. In Dr. Binford's opinion if the patient has respiratory difficulty, the respiratory rate ranges from 0 to 8, which was not the case here.

62. In Dr. Binford's opinion neither the Versed or Romazicon were responsible for the vital signs shown in the patient while she was in the holding area.

63. In Dr. Binford's opinion the cause of the patient's decline was indicative of a primary cardiac event, as opposed to

a primary respiratory event and the anesthesia as a causative agent would not explain it. He expresses this opinion within a reasonable degree of medical certainty.

64. Given his knowledge of the case, Dr. Binford did not find any deficiencies in the way the Respondent treated the patient. Within a reasonable degree of medical certainty Dr. Binford believes that the Respondent met her obligations as to the basic standards for her profession in the pre-operative phase, during the procedure, upon the release of the patient to nurse Mayhew and in response to the emergency in the holding area.

65. Having considered the opinions of both experts, the opinion of Dr. Binford is more persuasive and is accepted as it exonerates Respondent for her conduct.

CONCLUSIONS OF LAW

66. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding in accordance with Sections 120.569, 120.57(1), and 456.073(5), Florida Statutes (2005).

67. Consistent with Section 456.072(2), Florida Statutes (2002), the Administrative Complaint leaves open the possibility of imposing one or more penalties, to include suspension or permanent revocation, restriction of Respondent's practice, imposition of an administrative fine, issuance of a reprimand,

placement Respondent on probation, and other forms of corrective action, and remedial education deemed appropriate by the Board of Nursing. With the prospect that the punishment may involve suspension or revocation, to prevail in this case Petitioner must prove the allegations in the Administrative Complaint by clear and convincing evidence. See Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

68. The meaning of clear and convincing evidence has been explained in the case In re: Davey, 645 So. 2d 398 (Fla. 1994), quoting with approval from Slomowitz v. Walker, 429 So. 2d 797 (Fla. 4th DCA 1983).

69. Specifically, Respondent is accused of violating Section 464.018(1)(n), Florida Statutes (2002), which states:

> (1) The following acts constitute grounds for . . . disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (n) Failing to meet minimum standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience.

70. The basis of the Administrative Complaint concerns the care provided Patient M.M. by Respondent on March 13, 2003 at Endosurg. The alleged failure to meet minimal standards of

acceptable and prevailing nursing practice in rendering that care has been previously described. Based upon the facts found, and the opinion expressed by Dr. Binford concerning Respondent's performance, it has not been shown that Respondent failed to meet standards of acceptable and prevailing nursing practice as alleged.

RECOMMENDATION

Based upon the facts found and the conclusions of law reached, it is

RECOMMENDED:

That a final order be entered dismissing the Administrative Complaint.

DONE AND ENTERED this 8th day of December, 2005, in Tallahassee, Leon County, Florida.

CHARLES C. ADAMS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of December, 2005.

COPIES FURNISHED:

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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.