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

DOCKET NUMBER 507-10-1778

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBER 625887	§	**OF**
ISSUED TO	§	
JANET A. NASH	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: JANET A. NASH
720 NORTH JOE WILSON ROAD, APT 2113
CEDAR HILL, TX 75104

PAUL D. KEEPER
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 21-22, 2010, 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 regarding the registered nursing license of Janet A. Nash with changes; 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 Respondent's presentation during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD as if fully set out and separately stated herein, with the exception that Conclusion of Law Number

12 is re-designated as a recommendation*. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

IT IS THEREFORE ORDERED that Registered Nurse License Number 625887, previously issued to JANET A. NASH, to practice nursing in Texas is hereby SUSPENDED and said suspension is ENFORCED until Respondent completes the following requirements:

(1) RESPONDENT SHALL successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It 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. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL successfully complete the course "Patient Privacy," a 5.4 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 program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: http://www.learningext.com/products/generalce/privacy/privabout.asp*.

(3) RESPONDENT SHALL successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: http://www.learningext.com/products/generalce/critical/ctabout.asp*.

(4) RESPONDENT SHALL pay a monetary fine in the amount of one thousand dollars ($1,000). Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

(5) RESPONDENT SHALL pay an administrative reimbursement in the amount of five thousand and ninety nine dollars ($5,099). Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

(6) IT IS FURTHER ORDERED that Permanent Certificate Number 625887 previously issued to JANET A. NASH, upon receipt of this Order, be immediately delivered to the office of the Texas Board of Nursing.

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

IT IS FURTHER ORDERED that while Respondent's license is encumbered by this order the Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER ORDERED, upon verification of successful completion of the above requirements, the Suspension will be STAYED, and RESPONDENT will be placed on PROBATION for two (2) years with the following agreed terms of probation:

(7) RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

(8) RESPONDENT SHALL pay all re-registration fees, if applicable, and RESPONDENT'S licensure status in the State of Texas will be updated to reflect the applicable conditions outlined herein.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING PROBATION CONDITIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE PROBATIONARY PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE

USE OF A REGISTERED NURSE (RN) LICENSE WITH ADVANCED PRACTICE AUTHORIZATION WILL NOT APPLY TO THIS PROBATIONARY PERIOD:

(9) RESPONDENT SHALL notify each present employer and all future employers in nursing of this Order of the Board and the probationary conditions on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer and all future employers prior to accepting an offer of employment.

(10) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(11) For the first year of employment as a Family Nurse Practitioner under this Order, RESPONDENT SHALL be directly supervised by a Family Nurse Practitioner or a Physician in the appropriate specialty. Direct supervision requires another Family Nurse Practitioner or a Physician to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT contract for services. Multiple employers are prohibited.

(12) For the second year of employment as a Family Nurse Practitioner under this Order, RESPONDENT SHALL be supervised by a Family Nurse Practitioner or a Physician proficient in the appropriate specialty who is on the premises. The supervising

Family Nurse Practitioner or Physician 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 Family Nurse Practitioner or Physician 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 contract for services. Multiple employers are prohibited.

(13) 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 Family Nurse Practitioner or Physician who supervises the RESPONDENT. These reports shall be submitted by the supervising Family Nurse Practitioner or Physician to the office of the Board at the end of each three (3) months for two (2) years of employment as a nurse.

IT IS FURTHER ORDERED that if during the period of probation, an additional allegation, accusation, or petition is reported or filed against the Respondent's license, the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

IT IS FURTHER ORDERED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

Entered this 22nd day of October, 2010.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-10-1778 (July 12, 2010).

*This re-designation is authorized under the Government Code §2001.058(e). Authority is also found in *Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed);*Sears vs. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex,App.-Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n vs. Brinkmeyer*, 662 S.W .2d 953, 956 (Tex. l984); *Granek vs. Tex. State Bd. of Med. Exam'rs*, 172 S.W .3d 761, 781 (Tex.App.-Austin 2005, pet. denied).

BOARD OF NURSING
STATE OF TEXAS

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

July 12, 2010

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

VIA INTER-AGENCY

RE: Docket No. 507-10-1778; Texas Board of Nursing v. Janet A. Nash

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.state.tx.us.

Sincerely,

Paul D. Keeper
Administrative Law Judge

PDK/ls
Enclosures
xc: John F. Legris, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTER-AGENCY**
Dina Flores, Legal Assistant Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – (with 2 - CD(s); Certified Evidentiary Record) – **VIA INTER-AGENCY**
Janet A. Nash, 720 North Joe Wilson Road, Apt. 2113, Cedar Hill, TX 75104 - **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-10-1778

TEXAS BOARD OF NURSING, Petitioner	§ § §	BEFORE THE STATE OFFICE
V.	§ §	OF
JANET A. NASH, Respondent	§ §	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing Board (Staff/Board) alleged that Janet A. Nash, R.N., Respondent, engaged in unprofessional conduct by improperly disclosing a patient's medical information. Ms. Nash denied Staff's allegations. The administrative law judge (ALJ) concludes that Ms. Nash did make improper disclosures, and the Board should impose disciplinary action against her.

I. JURISDICTION AND NOTICE

Neither party challenged jurisdiction or notice. Each will be addressed in the findings of fact and conclusions of law.

II. BACKGROUND

Ms. Nash is licensed in Texas as a registered nurse. She holds a designation as a family nurse practitioner with prescriptive drug authority. Ms. Nash also holds baccalaureate and master's degrees in nursing.[1]

On March 30, 2007, Ms. Nash and Robert Magruder, M.D., were working at Medical Center of Lancaster, Texas. Each was an employee of ED Care, an agency that supplied contract emergency medical service providers to hospitals. Ms. Nash was working as the primary

[1] Staff Ex. 1.

provider for the minor emergency complaints, and Dr. Magruder was the primary provider for major emergency complaints.

About 7:00 p.m., a patient, MA, who was also a registered nurse and an employee of the hospital, presented herself at the emergency room for treatment.[2] MA complained of pain in her lower back and flank and difficulty in urinating.[3] Although MA had a history of low back pain, MA identified this pain as different in its intensity and location. She reported a pain severity of 9 out of a possible 10.[4]

MA was admitted to the emergency room. She was seen by her colleague, Randy Durrett, also a registered nurse. He assessed her level of pain as extreme and ordered blood and urine tests. In keeping with orders, he started an intravenous line and took blood and urine samples before giving MA medications to control her pain. Mr. Durrett suggested that MA have a CT scan, but MA declined because she wanted the hospital to get her laboratory results first. Her goal was to avoid having to incur an insurance copayment for a CT scan, an expensive diagnostic procedure, if the laboratory results did not confirm the need for the scan.

MA asked to be seen by Ms. Nash instead of Dr. Magruder. Earlier in the day, MA had called Ms. Nash at the emergency room to describe her pain and ask her advice. According to MA, Ms. Nash had offered to prescribe Flexeril, a muscle relaxant. MA had declined the prescription because her pain was not musculoskeletal. Nonetheless, MA wanted to be seen by Ms. Nash because MA knew that Ms. Nash had some familiarity with her medical problem.

After examining MA in the emergency room, Ms. Nash discussed the case with Dr. Magruder. Ms. Nash told him that she believed that MA was a "drug seeker" and that MA

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[2] Before MA testified at the hearing in person, the ALJ confirmed with her on the record her understanding that her name, medical records, and testimony about her personal patient information would become part of the public record in this case. MA stated on the record her understanding and consented to the disclosures. To provide a modicum of protection of her identity, this proposal for decision will identify MA by initials only.

[3] Staff Ex. 6 at 14.

[4] Staff Ex. 6 at 4. MA also testified to these matters. Although a court reporter was present for the hearing on the merits, no transcript was generated for the preparation of this proposal for decision.

was simply trying to get prescription drugs. Dr. Magruder told Ms. Nash that she should act on her professional instincts. Without informing MA, Ms. Nash added a urine drug screening test to the list of laboratory tests that she was ordering for MA.

Jessica Markwardt, R.N., was working in the emergency room that evening. She was standing near the printer when the results of MA's initial drug screen were being printed. She gave the report to Ms. Nash, who stood in the physician's area with Dr. Magruder, near an open door adjacent to the nurses' station. Ms. Markwardt heard Ms. Nash and Dr. Magruder say that the initial drug screen showed positive results for amphetamines, opiates, tricyclic antidepressants, and tetrahydrocannabinol (THC), the active ingredient in marijuana.[5] Ms. Markwardt heard Ms. Nash tell Dr. Magruder that Ms. Nash intended to send MA's results to the Board. Dr. Magruder asked Ms. Nash to make him a copy of the report so he could share it with his lawyer. Ms. Markwardt watched Ms. Nash copy the report and hand it to Dr. Magruder. She watched Dr. Magruder put the document among his personal items.

April Kenemer, the unit secretary in the emergency room that night, also heard this discussion. Although Ms. Kenemer was not a nurse, she had taken the hospital's annual training in patient privacy practices, as required of every physician, nurse, and employee of the hospital. Ms. Kenemer concluded that Ms. Nash and Dr. Magruder were speaking at a volume that made it possible for other staff and patients to hear their discussions about MA's private medical information. She asked Ms. Nash and Dr. Magruder to take their discussion elsewhere. They did not comply.

Ms. Kenemer then called Jeffrey Chappelle, the hospital's nighttime house supervisor and after-hours liaison for hospital administration. Ms. Kenemer expressed to him her concerns about the possible breach of patient confidentiality. Mr. Chappelle came to the emergency room and interviewed Mr. Durrett, Ms. Markwardt, and Ms. Kenemer. He then took Dr. Magruder and Ms. Nash into a private area and told them that they were to be vigilant about the protection of MA's patient information. Dr. Magruder and Ms. Nash explained to Mr. Chappelle their reasons

[5] State Ex. 6 at 16.

for believing that a drug screen was appropriate. Mr. Chappelle informed them that their reasons were not his concern. He explained that preserving the confidentiality of MA's patient information was the issue, and he told them that they would abide by hospital policy.

What neither Ms. Nash nor Dr. Magruder knew was that MA had disclosed to the hospital administration when she was hired that she was taking Adderal, a prescription medication for the control of attention deficit disorder, and Lortab, a mild analgesic to control periodic bouts with low back pain. Mr. Chappelle knew about MA's disclosure and knew that these drugs would produce positive drug screens for amphetamines and opiates, respectively. Mr. Chappelle did not share these elements of MA's personal medical information with Ms. Nash or Dr. Magruder. As to the issue of the THC, drug screens were done in two steps: an initial screen in the hospital's laboratory, followed by another screen in an outside laboratory. The results for the second screen were available a few days after the submission of the specimen.

Around 10:00 p.m., Ms. Nash called Scott Rochelle, the director of the emergency department. Ms. Nash told him that MA, a staff nurse, was a patient in the emergency room. She told him that she had ordered a drug screen for MA because, in Ms. Nash's opinion, MA had been acting oddly and likely was a drug abuser. Mr. Rochelle told Ms. Nash that he would call her back, and he contacted the hospital's chief nursing officer, Patricia Matthews. Before he disclosed MA's identity, Ms. Matthews told him not to give her that information. Ms. Matthews told Mr. Rochelle what he already knew: if a person was admitted as a patient to the hospital, then the patient's medical information was not to be released to anyone, including to Ms. Matthews. She informed Mr. Rochelle that the undisclosed patient-employee was to be treated solely as a patient and not as an employee. Mr. Rochelle then called Ms. Nash back and relayed Ms. Matthews' restatement of hospital policy.

According to Ms. Markwardt, Ms. Nash and Dr. Magruder continued to discuss publicly MA's medical records at a volume that others could hear. Ms. Markwardt described their discussion as a source of entertainment to the two of them rather than as a reason for concern. She saw Dr. Magruder leave the emergency room with MA's initial drug screen report in his

pocket. Later that evening, Ms. Nash entered on MA's emergency room record diagnoses for urinary tract infection and for substance abuse. After her condition was stabilized, MA was released from the emergency room without being told of the substance abuse diagnosis.

On April 1, 2007, Ms. Nash prepared at her home a complaint letter about MA. She used MA's hospital records in preparing the letter, and she sent the letter to the Texas Peer Assistance Program for Nurses (TPAPN).[6] She did not provide a copy to the hospital or to MA. Ms. Nash's letter alleged that on March 30, 2007, while MA was a patient in the hospital emergency room MA had demonstrated an inability to practice nursing safely by reason of her use of drugs, misuse of controlled substances, and attempts to divert drugs and controlled substances.[7] No element of Ms. Nash's complaint related to MA's performance of her duties as a nurse.

On April 2, 2007, MA returned to the hospital to begin her shift as a nurse. She quickly learned that her personal medical information, including both of the diagnoses, had become a matter of common knowledge among her coworkers. MA went to the hospital records department and obtained a copy of her drug screen results. By that time, the hospital had received a second drug screen report, this one from an independent testing laboratory. This second report gave a negative screen for all drugs except amphetamines and opiates.[8] MA took the report to Dr. Magruder and asked him to review it. He refused. She went to Mr. Rochelle and asked him to review the report. He agreed, and MA asked him to call a meeting with Ms. Nash. Mr. Rochelle also suggested to MA that he invite Ms. Matthews and Brian Johnson, ED Care's local representative, to the meeting.

At the meeting, MA disclosed to the participants her medical conditions, her approved prescription drug list, her long-standing prior approval from the hospital to use Adderal and Lortab, and the results of both drug screening reports. In response, Ms Nash acknowledged that

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[6] TPAPN is a state-approved peer assistance program for nurses who are impaired by chemical dependency or mental illness. TEX. HEALTH & SAFETY CODE ANN. ch. 467.

[7] State Ex. 5 at unpaginated 6 and 7.

[8] State's Ex. 6 at 17.

she had not seen the second drug screening report before she wrote the diagnosis of "substance abuse" in MA's emergency room medical record. Ms. Nash explained to the group that she had been trying to act in MA's best interest and that, in her opinion, MA needed help. Ms. Nash did not admit any error or express remorse for her actions. MA stated her intention to bring an end to this episode and her desire to get on with her work at the hospital as a nurse. The hospital agreed to schedule non-overlapping shifts for Ms. Nash and MA.

About a week later, MA returned to Mr. Rochelle's office, this time to express her concern about new statements that Ms. Nash was making about MA's personal medical information. MA had learned from Joann Tatum, a licensed vocational nurse employed by the hospital, that Ms. Nash had told Ms. Tatum that MA was a "drug seeker," the same phrase that Ms. Nash had used during the evening of March 30. MA asked Mr. Rochelle to take action to stop Ms. Nash from further violations of her patient privacy rights. Mr. Rochelle then met with Ms. Tatum and instructed her to prepare a written statement of her recollection of her conversation with Ms. Nash about MA.[9] Ms. Tatum testified about these events at the hearing.

After MA registered this complaint, Ms. Nash told Victoria Norris, R.N., another hospital employee, that MA was a drug abuser. When Ms. Norris asked Ms. Nash how she knew this, Ms. Nash responded that she "just knew." Ms. Norris reported this discussion to the hospital, and she was asked by the hospital to prepare a written statement of her recollection of her conversation with Ms. Nash.[10] Ms. Norris testified about these events at the hearing.

Following an additional meeting with Ms. Nash, Ms. Matthews asked ED Care to remove Ms. Nash from the hospital as a contract service provider. ED Care agreed. Ms. Nash's role at the hospital was terminated. On August 8, 2008, ED Care terminated its contract with Ms. Nash.[11]

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[9] This document was used to refresh Ms. Tatum's recollection during her testimony but was not offered in evidence.

[10] This document was used to refresh Ms. Norris' recollection during her testimony but was not offered in evidence.

[11] State Ex. 5 at unpaginated 8.

The foregoing description of the events was cross-confirmed at the hearing on the merits by the live testimony of Mr. Durrett, Ms. Markwardt, Mr. Chappelle (testifying by telephone), Ms. Kenemer, Ms. Tatum, Mr. Rochelle, Ms. Matthews, Ms. Norris, and MA. But, Ms. Nash told a very different story, as confirmed by Dr. Magruder. In Ms. Nash's version, she did not have discussions with Dr. Magruder about MA's initial drug screen results where anyone else could hear them. Ms. Nash denied that Ms. Kenemer admonished them to keep their voices down or to avoid disclosing MA's patient health information. Ms. Nash denied that she had provided Dr. Magruder with a copy of MA's health information. Ms. Nash denied that she had improperly disclosed MA's health information to any person.

III. PROCEDURAL HISTORY

On August 20, 2009, Staff sent a copy of its formal charges to Ms. Nash, alleging that she had violated the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)[12] and three Board rules, 22 TEX. ADMIN. CODE (TAC) §§ 217.11(1)(E), 217.12(1)(C), and 217.12(6)(C). Staff sought revocation of Ms. Nash's license and recovery of at least $1,200 as costs of the proceeding.[13]

On December 16, 2009, Staff sent Ms. Nash notice of the hearing. After granting Ms. Nash's motion for a continuance, the ALJ reset the hearing on the merits for June 9, 2010. The hearing on the merits was convened as scheduled. Staff was represented by its counsel, John Legris, and Ms. Nash represented herself. At the hearing, in addition to the persons already named, Staff called Denise Benbow, a nursing practice consultant for the Board, who testified about rules of professional responsibility and the Board's enforcement authority. Ms. Nash testified on her own behalf and called Dr. Magruder as a witness.

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[12] Pub. L. No. 104-191, 110 Stat. 1936 (1996)(codified primarily in Titles 18, 26 and 42 of the United States Code and subject to a series of administrative rules published over time in the Federal Register).

[13] State Ex. 3.

When the hearing adjourned at the end of the day, the evidentiary and administrative record closed at that time.

IV. DISCUSSION

The issues in this case are: (1) whether Ms. Nash disclosed MA's patient health information in the emergency room after being admonished to stop; (2) whether Ms. Nash disclosed MA's patient health information when she sent the complaint letter to TPAPN; (3) whether Ms. Nash disclosed MA's patient health information to Ms. Tatum and/or Ms. Norris; and (4) if Ms. Nash violated the law by her actions, what disciplinary response, if any, would be appropriate?

A. Did Ms. Nash improperly disclose MA's patient health information in the emergency room?

She did. Although Ms. Nash denied that her actions amounted to a disclosure, the overwhelming weight of evidence proved otherwise. That evidence included the testimony of Mr. Durrett, Ms. Markwardt, Mr. Chappelle, Ms. Kenemer, Mr. Rochelle, and Ms. Matthews. To conclude that Ms. Nash's actions did not constitute a disclosure would require the ALJ to discount the testimony of each of these eyewitnesses. The ALJ does not.

Ms. Nash argued that MA was lying because she wanted to retaliate against Ms. Nash for not giving her prescription drugs and that the rest of the witnesses were lying because they were protecting MA. Ms. Nash's explanations are not credible. If MA had wanted to abuse a prescription, then presenting herself to her colleagues in the emergency room was not a reasonable way to achieve her ends. Although MA could have had a friend within the hospital staff who might have been willing to lie to help her obtain drugs, there is little likelihood that six colleagues would have independently agreed to collectively lie about the allegations and then perjure themselves at a later hearing. Instead, their testimony was direct, clear, unambiguous, uniform, and credible.

Further, their testimony reflected the hospital training that they had received about their obligations under HIPAA to prevent improper disclosures of a patient's private health information. Their testimony reflected the witnesses' individual decisions to take direct action in light of their training and to use the hospital's chain of command to express their concerns about Ms. Nash's apparent violations of the law.

MA's status as a nurse had no bearing on Ms. Nash's right to discuss MA's personal health information in a voice loud enough for others to hear. Because MA had colleagues among the nursing staff in the emergency room, that status should have heightened Ms. Nash's reasons to protect this information from disclosure. MA's colleagues were understandably especially vigilant about protecting MA's personal health information.

Dr. Magruder's testimony was not credible. He could not account for the disparity between his assertion that he and Ms. Nash were talking quietly in a private space about MA's test results and the other witnesses' statements that Ms. Nash's and Dr. Magruder's voices were sufficiently loud for others to hear. Dr. Magruder asserted that he had thrown away MA's initial drug screen report before he left the hospital—an assertion that seemed designed to eliminate any possibility of a charge that Dr. Magruder had removed medical records from the hospital without permission. If Dr. Magruder had a credible story to tell, he failed to tell it in this proceeding.

In summary, Ms. Nash's actions violated HIPAA. By violating HIPAA, Ms. Nash's actions violated Board Rule 217.11(1)(E) by failing to protect a patient's confidential information. In addition, Ms. Nash's actions were sufficient to establish a violation of Board Rule 217.12(1)(C) because she engaged in the unsafe practice of the improper management of MA's patient records.

B. Did Ms. Nash improperly disclose MA's patient health information by sending the complaint letter to TPAPN?

She did. Under Texas law, a nurse has a statutory obligation to report to the Board the conduct of another nurse if the reporting nurse has "reasonable cause to suspect" that the reportable nurse "has engaged in conduct subject to reporting."[14] In the alternative, the reporting nurse has the option to report the reportable nurse's conduct to a nursing peer review committee.[15] A "nursing peer review committee" includes a peer review committee established by the governing body of a hospital. And, if the reporting nurse believes that chemical dependency is the source of the problem, the reporting nurse may report to a peer assistance program, like TPAPN.[16]

But, different laws apply when the disclosure involves the personal health of a nurse as a patient. Under federal HIPAA law, a member of a hospital workforce may disclose protected health information only if: (1) the person believes in good faith that the hospital's care or services potentially endangers one or more patients or the public, and (2) the disclosure is made to a health oversight agency or public health authority authorized by law to investigate or oversee the hospital.[17]

Although Ms. Nash may have had some argument that she was permitted to report a nurse to TPAPN, few elements in these facts support that decision. First, the testimony in this case was that a second drug screen report was generated following the initial results in all drug testing. Until the second drug screen results became available, Ms. Nash had no confirmed basis to report MA of improper behavior for any of the drugs, including THC. Nonetheless, Ms. Nash may well have had good reason to be concerned about MA's competence as a nurse until those results were available. She had a number of options, including speaking directly to MA.

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[14] TEX. OCC. CODE ANN. § 301.402(b).

[15] TEX. OCC. CODE ANN. § 301.402 (e)(1).

[16] TEX. OCC. CODE ANN. § 301.410(a).

[17] 65 Fed. Reg. 82,802 (Dec. 28, 2000), as amended at 67 Fed. Reg. 53,267 (Aug. 14, 2002).

Second, improper behavior is not defined by a confirmed positive urine screen for amphetamines, tricyclic antidepressants, or opioids. A patient may have prescriptions for their use and hospital approval to work under their influence.

Third, it is debatable whether Ms. Nash reasonably identified MA's conduct as "subject to reporting." MA was engaged in seeking health care, not engaged in nursing. MA did not encounter MA stumbling down a hospital hallway or asleep in the cafeteria or talking to herself at the nurses' station. Nonetheless, it is possible that Ms. Nash believed that MA might have been impaired while she was on duty before she appeared at the emergency room. If that were the case, then Ms. Nash should have relied on a system of nursing consultation and advice within the hospital before reporting to TPAPN.[18] She was advised by Mr. Rochelle on the evening of March 30 that this information was not subject to disclosure. Ms. Nash chose to disregard this advice at her peril.

Of all of Ms. Nash's possible violations, this was the only one that might have been the subject of an arguably reasonable mistake in judgment. To conclude that Ms. Nash made a reasonable mistake requires a series of explanations that seem difficult to reach under the best of circumstances. Under a preponderance of the evidence standard, Staff proved this allegation.

C. Did Ms. Nash disclose MA's patient health information to Ms. Tatum and/or Ms. Norris?

She did. Ms. Nash made these disclosures after her meeting with MA, the hospital's director of nursing, and Ms. Nash's employment company's representative. The purpose of this meeting was to present all of the facts to Ms. Nash (among others) about the events of March 30. Ms. Nash chose not to accept this effort to bring the matter to an end. Ms. Nash made clear in her testimony that she understood that MA's drug screen information was part of MA's private health information, and not part of a drug testing program that had been ordered by the hospital or Board. Ms. Nash continued to publicly disclose the information that she knew was MA's

[18] According to Staff's argument, TPAPN refused to accept the letter when its staff realized that Ms. Nash was using HIPAA-protected patient information as the basis of her complaint. No witness from TPAPN was called, and no response letter from TPAPN was introduced.

private medical information. Ms. Tatum and Ms. Norris were credible witnesses with no stake in the outcome of this proceeding. Ms. Nash gave no credible evidence to support her claim that they were lying under oath. Further, MA testified that Ms. Nash's continued spread of false patient information about her caused her embarrassment and emotional injury. Of all of Ms. Nash's possible violations, the facts supported this one most clearly.

In addition to the violations found in subsection A, Ms. Nash's statements to others that MA was a drug abuser violated Board Rule 217.12(1)(C) prohibition against unprofessional conduct. Ms. Nash's comments were unethical and were likely to injure MA, despite Ms. Nash's protest that she was trying to help MA. This constituted a violation of Board Rule 217.12(6)(C), and the continuing nature of her violation constituted a separate violation of Board Rule 213.27's requirement that a nurse be able to consistently conform her conduct to the requirements of the Nursing Practice Act, the Board's rules and regulations, and generally accepted standards of nursing practice.

D. If Ms. Nash's actions violated the law, what disciplinary response is appropriate?

1. Scope of Board's authority

The Board has the authority to discipline nurses for violation of its statute or rules.[19] The Board has established the degree and type of sanctions in a disciplinary matrix that is part of Board Rule 213.33. The matrix is based on the thirteen subparts of TEX. OCC. CODE ANN. § 301.452(b), the statute that outlines the professional violations over which the Board has authority.

Staff alleged that Ms. Nash violated subparts (10) and (13) by: (1) repeatedly engaging in acts of unethical conduct that placed a patient at risk and that violated professional boundaries of the nurse/patient relationship, and (2) failing to care adequately for a patient or to confirm to

[19] TEX. OCC. CODE ANN. § 301.453.

minimum standards of nursing practice in a manner that exposes a patient unnecessarily to the risk of harm.

A violation of each subpart carries two possible levels of sanctions. Ms. Benbow asserted that Level II penalties, the more severe, should apply because of the aggravating circumstances associated with Ms. Nash's alleged violations. For a Level II violation of subpart (10), the Board may suspend a license until the nurse pays a fine, completes remedial education, and presents evidence of other rehabilitative efforts as prescribed by the Board. For a Level II sanction for a violation of subpart (13), the Board may suspend a license.

For both subparts, the relevant aggravating circumstances that the Board may consider include the number of events, the actual harm, the severity of harm, and patient vulnerability. The mitigating circumstances include proof of the nurse's voluntary participation in an established remediation program and demonstration of competence.

In addition, the Board has the authority to assess "administrative costs of conducting a hearing to determine the violation."[20]

2. Staff's proposed discipline

Staff proposed a two-part disciplinary action against Ms. Nash. In part 1, Ms. Nash's license would be suspended pending her: (1) completion of certain courses to be identified by the Board; (2) payment of a $1,000 fine; and (3) reimbursement of $5,099 to the Board for (a) court reporter's fee of $560; (b) service of process fees of $765; (c) witness fees of $270; (d) witness lodging expenses of $928; (e) witness meals of $1,136; (f) witness mileage expenses of $1,250; and (g) witness airfare of $190.90.[21]

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[20] TEX. OCC. CODE ANN. § 301.461.

[21] State Ex. 9. The exhibit included the statement, "Documentary evidence supporting the final amount of costs incurred by the Board will be submitted prior to the closing of the record." No additional evidence was submitted, and the amounts in the exhibit will be treated as the only administrative costs.

In part 2, Ms. Nash would be on probation for two years after her completion of her obligations in part 1. For the first year, Ms. Nash would be under direct supervision. In the second year, she would be under indirect supervision, all subject to the requirement of disclosure of the Board's order to any educational program in which would be enrolled or employer for whom she would be working.

3. Aggravating and mitigating factors

Staff proved that Ms. Nash was a well-educated, experienced nurse who knew better than to violate HIPAA. She repeatedly violated the law, even when she was given the opportunity to stop. Although MA suffered only the embarrassment of the disclosure of her information, the purpose of the law is to protect patients from that type of harm. Although MA was a nurse, she was also a patient when she sought care from the hospital emergency room in which Ms. Nash was working. As a patient in pain, MA was vulnerable, and Ms. Nash abused her authority in taking advantage of that vulnerability.

Ms. Nash presented no mitigating factors. She showed no remorse for her actions other than to assert that she was doing what she thought best under the circumstances.

4. Imposition of disciplinary action

This is a case about Ms. Nash's poor judgment in her dealings with a patient who happened to be a nurse. Although Ms. Nash may have been concerned for MA's need for assistance to address a drug problem, that concern did not authorize Ms. Nash to disclose MA's private health information to others. The record establishes that Ms. Nash committed a series of statutory and rule violations for which discipline is authorized under the law. Staff's proposed sanctions properly reflect the scope of the Board's disciplinary authority in this case and should be imposed.

V. FINDINGS OF FACT

1. Janet A. Nash, R.N., Respondent, holds a Texas Board of Nursing (Board) license as a registered nurse and is designated as a family nurse practitioner.

2. On March 30, 2007, Ms. Nash was working as a contract nurse practioner in the emergency room at Medical Center of Lancaster, Texas.

3. On March 30, 2007, MA (patient's name has been redacted for privacy purposes) was a hospital nurse who presented herself for treatment at the hospital's emergency room.

4. During her treatment of MA, Ms. Nash improperly disclosed MA's personal medical information to others after Ms. Nash was cautioned not to disclose the information.

5. On April 1, 2007, Ms. Nash disclosed MA's personal medical information to the Texas Peer Assistance Program for Nurses.

6. After MA returned to work at the hospital, Ms. Nash disclosed to her coworkers MA's personal medical information and Ms. Nash's opinions about MA's medical conditions.

7. As the result of her actions, Ms. Nash's employment as a contract nurse practitioner at the hospital was terminated.

8. Staff incurred these administrative expenses in conducting the hearing: (1) court reporter's fee of $560; (2) service of process fees of $765; (3) witness fees of $270; (4) witness lodging expenses of $928; (5) witness meals of $1,136; (6) witness mileage expenses of $1,250; and (7) witness airfare of $190.90.

9. On August 20, 2009, Staff sent a copy of its formal charges to Ms. Nash, alleging that she had violated the federal Health Insurance Portability and Accountability Act of 1996 and three Board rules.

10. On December 16, 2009, Staff sent Ms. Nash notice of the 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 a short, plain statement of the matters asserted.

11. The hearing on the merits was held on June 9, 2010. All parties appeared and participated in the hearing. The record closed that same day.

VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter. TEX. OCC. CODE ANN. ch. 301 (Nursing Practice Act).

2. SOAH has jurisdiction over matters related to the hearing in this matter, including the authority to issue a proposal for decision with findings of fact and conclusions of law. TEX. GOV'T CODE ANN. ch. 2003.

3. Proper and timely notice of the hearing was provided. TEX. GOV'T CODE ANN. ch. 2001; 22 TEX. ADMIN. CODE (TAC) § 213.10.

4. Ms. Nash failed to protect a patient's confidential information. 22 TAC § 217.11(1)(E).

5. Ms. Nash engaged in the improper management of a patient's records and unprofessional conduct. 22 TAC § 217.12(1)(C).

6. Ms. Nash's engaged in unethical behavior that was likely to injure a patient. 22 TAC § 217.12(6)(C)

7. Ms. Nash failed to consistently conform her conduct to the requirements of the Nursing Practice Act, the Board's rules and regulations, and generally accepted standards of nursing practice. 22 TAC § 213.27.

8. Ms. Nash engaged in acts of unethical conduct that placed a patient at risk and that violated professional boundaries of the nurse/patient relationship. TEX. OCC. CODE ANN. § 301.452(b)(10).

9. Ms. Nash failed to care adequately for a patient or to confirm to minimum standards of nursing practice in a manner that exposed a patient unnecessarily to the risk of harm. TEX. OCC. CODE ANN. § 301.452(b)(13).

10. The Board has the authority to assess administrative costs of conducting a hearing to determine the violation. TEX. OCC. CODE ANN. § 301.461.

11. The Board has adopted a Disciplinary Matrix that includes a fine of $500 per violation, suspension of a license, and requirements for remedial education. 22 TAC § 213.33 (relating to Second Tier Offense and Sanction Level II for TEX. OCC. CODE ANN. § 301.452(b)(10) and (13)).

12. Ms. Nash's violations warrant the Board's imposition of disciplinary action of the suspension of Ms. Nash's license, pending her: (1) completion of certain courses to be

identified by the Board; (2) payment of a $1,000 fine; and (3) reimbursement of $5,099 to the Board for its administrative expenses of conducting a hearing. In addition, Ms. Nash's violations warrant the Board's placing Ms. Nash on probation for two years after her completion of her completion of items (1) through (3). For the first year, Ms. Nash should be under direct supervision. In the second year, Ms. Nash should be under indirect supervision, all subject to the requirement of disclosure of the Board's order to any educational program in which would be enrolled or employer for whom she would be working.

ISSUED July 12, 2010.

PAUL D. KEEPER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS