

Before the
Administrative Hearing Commission
State of Missouri



STATE BOARD OF NURSING,)	
)	
Petitioner,)	
)	
vs.)	No. 13-1573 BN
)	
KIMBERLY LOWE,)	
)	
Respondent.)	

DECISION

Kimberly Lowe’s nursing license is not subject to discipline.

Procedure

On September 3, 2013, the State Board of Nursing (“the Board”) filed a complaint seeking to discipline Lowe. On September 6, 2013, Lowe was served with a copy of the complaint and our notice of complaint/notice of hearing. She filed an answer on October 4, 2013.

We held a hearing on August 19, 2014. Kevin J. Dolley and Laura Spencer Garth of the Law Offices of Kevin J. Dolley, LLC represented Lowe. Ian Hauptli represented the Board. At the hearing, the Board moved to amend its complaint to state that one of the medication errors leading to Lowe’s termination occurred on June 29, 2010, as opposed to September 17, 2010, as originally pled. Lowe objected to the oral motion on the basis that the changed date deprived her of adequate notice of the conduct for which the Board sought to impose discipline. Based on the

totality of the circumstances and evidence presented, we determined that Lowe had adequate notice of those issues, and we granted leave to the Board to amend its complaint by interlineation to reflect the June 29, 2010 date.

The case became ready for our decision on January 2, 2015, the date the last written argument was due.

Findings of Fact

1. Lowe was licensed by the Board as a registered professional nurse (“RN”) in 2007, and her license has remained current and active since that time.

2. Lowe worked as an RN at North Kansas City Hospital (“NKCH”) in Kansas City, Missouri, from 2007 until her termination on March 14, 2011.

3. NKCH nurse manager Darla Easley reported the termination to the Board in a letter dated March 14, 2011, wherein she stated that Lowe was dismissed because she committed two “significant” medication errors over the course of six months at NKCH, in September 2010 and March 2011.

4. The two medication errors to which Easley referred in reporting the termination to the Board actually occurred on June 29, 2010 and March 7, 2011.

Medication Administration at NKCH

5. During the relevant time period, nurses who administered medication at NKCH were supposed to follow a multi-step process. First, the nurse reviewed the patient’s electronic medical administration record (“E-MAR”) to determine the appropriate medication.

6. The nurse would then retrieve the medication from its storage container, which could be the refrigerator, a locked drawer, or Pyxis machine,¹ and take it to the patient’s room.

¹ “Pyxis” is a brand name for an automated medication dispensing system.

7. Once in the patient's room, the nurse would scan the bar code on the patient's arm band and the bar code on the medication with an electronic hand-held "care-mobile" device. If the two scans matched, the nurse could administer the medication.

8. After the medication was administered, the nurse pressed a button on the care-mobile device, which was supposed to submit the information regarding the medication administration to download to the patient's E-MAR. Sometimes, however, the device froze, and the information was not transmitted to the E-MAR.

Insulin Error

9. On June 29, 2010, Lowe incorrectly read an order for insulin, and administered too much of it to a patient in her care.

10. The order Lowe read was not yet entered into the computer, so Lowe obtained the medication order from the patient's "Medication Reconciliation Report."

11. The Medication Reconciliation Report is a list of medications prescribed for a patient that is compiled at or near the time of the patient's admission to the hospital. The report is used to inform the treating physician about the patient's regular home medications and to allow the physician to decide whether or not to continue the same medications in the hospital.

12. Three lines of printed type regarding insulin appeared on the patient's Medication Reconciliation Report. The top line, in bold lettering, listed the strength of the insulin (100 units/ml), and the third line, in regular lettering, stated the dosage as "20 units Subcutaneous Bedtime."

13. Lowe focused on the bolded type and administered 100 units of insulin to the patient.

14. The error was discovered by the NKCH's diabetes educator, Melissa Zalonist, RN, the next day.

Amoxicillin Error

15. On March 7, 2011, Lowe retrieved a small, opaque bottle containing a small amount of the powdered form of the antibiotic amoxicillin from the medication drawer for a particular patient.

16. Although the hospital pharmacy usually delivered liquid medications in liquid form, the amoxicillin delivered for this patient had not been reconstituted (mixed with water to create a liquid suspension).

17. When Lowe used a scanner to obtain electronic information from the patient's arm band, it indicated an order for amoxicillin 800 mg. The label on the bottle also said 800 mg. This was the dose; the actual amount in the bottle was 7500 mg.

18. Lowe added 90 ml of water to the bottle, per the instruction on the label, and gave the entire amount to the patient, thus giving the patient 7500 mg of amoxicillin rather than 800 mg.

19. After administering the medication, Lowe removed and discarded the label in a locked shredder box in accordance with hospital policy for protection of private health information.

20. The next day, the patient told his wife that Lowe had given him an entire bottle of amoxicillin. The wife reported the incident to Easley.

21. Lowe has seen orders for a single dose of 100 units of insulin and a single dose of oral suspension antibiotic. In her view, such orders were unusual but not unprecedented.

Lowe's Termination and Aftermath

22. Based on the amoxicillin and insulin incidents, NKCH terminated Lowe's employment.

23. Upon learning of Lowe's termination from NKCH, the Board undertook an investigation of Lowe's tenure there and reviewed records and conducted interviews with NKCH personnel.

24. At the Board's suggestion, Lowe completed the following six internet-based training courses offered by the National Council of State Boards of Nursing between April 16, 2012 and April 18, 2012: Disciplinary Actions: What Every Nurse Should Know; Documentation: A Critical Aspect of Client Care; Ethics of Nursing Practice; Medication Errors – Detection & Prevention; Nurse Practice Act – Missouri; and Professional Accountability and Legal Liability.

25. At the time of the hearing, Lowe worked as a health care coordinator at a group home for the developmentally disabled.

Evidence

The Board's evidence in this case consists of a single exhibit. Exhibit 1 is an affidavit from the Board's executive director, with attached records. The affidavit states, *inter alia*, that the executive director is "personally acquainted with the facts herein stated," and that:

3. The 31 page(s) of records are kept by the Board in the regular course of business, and it was the regular course of business of the Board for an employee or representative of the Board with knowledge of the act, event condition [sic], opinion or diagnosis recorded to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time of the act, event, condition, opinion or diagnosis.

Attached to the affidavit is a document titled "DETAILS OF INVESTIGATION." It summarizes interviews with Easley, Zalonist, and Lowe. The majority of the 31 pages consists of printouts from NKCH's Pyxis system with unattributed, hand written notes on a few pages. All of it is hearsay, none of it is authenticated, and much of it is difficult to read and interpret.

On August 19, 2014, Lowe filed a notice of objection to Exhibit 1, which the Board had pre-filed. Lowe objected under § 536.070(10)² because the affidavit and business records contained therein lacked the proper foundation to render them admissible. She also objected to the hearsay contained within the exhibit. Additionally, Lowe objected based on § 536.070(12) because the affidavit and business records were not tendered to her until August 15, 2014, four days before the hearing.

Section 536.070(12) merely provides that a party who fails to object within seven days to an affidavit served eight or more days before the hearing waives its objection to the use of an affidavit on the ground that it is in the form of an affidavit. No such waiver would apply in this case.

Section 536.070(10) allows for the admission of business records into evidence when a proper foundation is laid. However, the Board's purported business records are rife with inadmissible hearsay; for example, the investigator's narrative and interview summaries offered to prove the truth of matters asserted to the investigator by persons unaffiliated with the Board. The other records, from NKCH, are also hearsay. The Board's executive director, who executed a business records affidavit, is not competent to testify that the records that came from NKCH were made at or near the time of the events to which they relate, by a person with the duty to make them.

Although § 536.070(10) relaxes the foundation requirements for business records, it does not abrogate them. The fundamental rules of evidence apply to contested case administrative proceedings such as this one. *State Board of Registration for the Healing Arts v. McDonagh*, 123 S.W.3d 147,154 (Mo. banc 2004), citing *Missouri Church of Scientology v. State Tax Commission*, 560 S.W.2d 837, 839 (Mo. banc 1977). Thus, while Exhibit 1 was admitted as part

²Statutory references are to the RSMo. Cum. Supp. 2013 unless otherwise noted.

of the record in this case, we consider the weight to give its contents. We rely on them only insofar as they fall within exceptions to the hearsay rule – the Board’s own business records or Lowe’s own statements, for example – or otherwise appear to be reliable.

Conclusions of Law

We have jurisdiction to hear the Board’s complaint. Sections 335.066.2 and 621.045. The Board bears the burden of proving that Lowe’s license is subject to discipline by a preponderance of the evidence. *See Kerwin v. Mo. Dental Bd.*, 375 S.W.3d 219, 229-30 (Mo. App. W.D. 2012)(dental licensing board demonstrates “cause” to discipline by showing preponderance of evidence). A preponderance of the evidence is evidence showing, as a whole, that “the fact to be proved [is] more probable than not.” *Id.* at 230 (*quoting State Bd. of Nursing v. Berry*, 32 S.W.3d 638, 642 (Mo. App. W.D. 2000)). This Commission must judge the credibility of witnesses and the weight and value to be given to their testimony. *Koetting v. State Bd. of Nursing*, 314 S.W.3d 812, 815 (Mo.App. W.D. 2010). Our findings of fact reflect our credibility assessments.

The Board alleges that there is cause for discipline under § 335.066.2(5) and (12):

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or his certificate of registration or authority, permit or license for any one or any combination of the following causes:

* * *

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;

* * *

(12) Violation of any professional trust or confidence[.³]

Miscellaneous Medication Errors

The allegations against Lowe contained in paragraphs 5 through 8 of the complaint involve four medication documentation errors Lowe allegedly committed between July 22, 2010 and September 7, 2010. To make its case against Lowe related to these alleged errors, the Board relies exclusively on material that appears in its Exhibit 1 at parts 9-1 through 9-8. The attachments consist of a counseling memorandum dated September 17, 2010, signed by Lowe, followed by several pages of Pyxis medication inventory records containing handwritten notations of unknown origin. Although Lowe recognized that some transaction entries within those pages were related to the allegations in paragraphs 5 through 8, she could not recognize or identify many of the others. Lowe credibly testified that some of the pages contained no records related to the counseling memo or to the allegations in the complaint at all. Lowe signed the counseling memo, but did not write comments on it. The Board asks us to infer, therefore, that she agreed she was culpable for the medication errors listed on the memo.

However, the Board points to no legal authority that the signed counseling memo represents an admission of anything. There is no evidence to support the Board's argument that "Respondent was given an opportunity to review and comment on the allegations when she signed the counseling memorandum." No such statement appears on the form. We simply do not know the circumstances, and there was no witness from NKCH to explain them. Moreover, Lowe testified that the counseling memo was given to her at a time when several purported medication documentation errors were discovered, some attributed to other nurses, and that many were found to have been caused by malfunctioning of the care-mobile device and its imperfect communication with the E-MAR.

³ RSMo Supp. 2010.

Lowe testified, credibly, that she had no independent recollection, nearly four years after the date of the counseling memorandum, as to whether she made the documentation errors or omissions alleged by the Board in paragraphs 5-8 of its complaint. The record contains Pyxis records, but not records from the hospital's E-MAR that could, with proper foundation, confirm the handwritten entries indicating Lowe's documentation mistakes. Thus, we have only hearsay statements, to which Lowe timely objected, to support the Board's allegations that Lowe erred in her documentation of the miscellaneous medications. The Board has failed to meet its burden as to the medication errors described in paragraphs 5 through 8 of the complaint.

Insulin and Amoxicillin Administration Errors

The Board did show, however, that Lowe made significant medication errors involving insulin and amoxicillin. Exhibit 1 contains hearsay related to these incidents, but there is also a letter Lowe admits sending the Board, which it properly authenticated as being kept in the ordinary course of its business, in which she discusses the incidents. Thus, we consider whether those errors constitute cause for discipline under § 335.066.2(5) and (12).

With respect to the insulin error, Lowe admitted that she misread or misinterpreted an insulin order, administering 100 units instead of 20 units, as the physician had ordered. Both numbers appeared on the physician's order for insulin, and Lowe's attention focused upon the "100 units" in bold lettering, while overlooking the actual dose of "20 units Subcutaneous Bedtime," which appeared below it on the Medication Reconciliation Report. Lowe administered 100 units of insulin to the patient and documented that dose on the Blood Glucose and Insulin Record for the patient, and Zalonist discovered the medication error. Lowe admitted this in her testimony, and there was no evidence to the contrary.

The second medication error, involving the administration of amoxicillin liquid to a patient on March 7, 2011, is not as easily laid at Lowe's feet. She found a bottle containing

powdered amoxicillin when she went to the patient's medication drawer, so she had to reconstitute it before it could be administered. The actual label for the bottle and the bottle itself were not in evidence. In the Board's written argument, it asserts that "Respondent admitted she did not normally reconstitute medications, and she did not confirm the order with the pharmacy prior to administering the medication." But the Board did not explain why Lowe should have sought such a confirmation. Lowe testified that she verified, by looking at the label on the bottle and the E-MAR associated with the patient's arm band scan, that he was to receive 800 mg of amoxicillin. Although Lowe gave the patient too much amoxicillin, it is unclear whether she or the pharmacy was primarily responsible for the mistake.

We find that Lowe was responsible for the insulin error, but we cannot find there is a preponderance of competent evidence that she was responsible for the amoxicillin error. We therefore examine the insulin error to independently determine if it constitutes cause for discipline under the law cited by the Board. *Kennedy v. Missouri Real Estate Comm'n*, 762 S.W.2d 454, 456-57 (Mo. App. E.D. 1988).

Professional Standards – Subdivision (5)

The Board alleges that Lowe's medication errors constituted incompetency, misconduct, fraud, and dishonesty. Therefore, we limit our analysis under this subdivision to these issues.

Incompetency is a general lack of professional ability, or a lack of disposition to use an otherwise sufficient professional ability, to perform in an occupation. *Tendai v. Missouri State Bd. of Reg'n for the Healing Arts*, 161 S.W.3d 358, 369 (Mo. banc 2005). We follow the analysis of incompetency in a disciplinary case from the Supreme Court, *Albanna v. State Bd. of Reg'n for the Healing Arts*, 293 S.W.3d 423 (Mo. banc 2009). Incompetency is a "state of being." *Id.* at 435.

Competent evidence establishes that Lowe made a significant error in administering 100 units of insulin to a patient rather than 20. But neither the disciplinary statutes nor the case law authorize us to find licensees subject to discipline for isolated, “incompetent” acts. Therefore, we do not find Lowe subject to discipline for incompetency.

Misconduct means “the willful doing of an act with a wrongful intention[;] intentional wrongdoing.” *Missouri Bd. for Arch’ts, Prof’l Eng’rs & Land Surv’rs v. Duncan*, No. AR-84-0239 (Mo. Admin. Hearing Comm’n Nov. 15, 1985) at 125, *aff’d*, 744 S.W.2d 524 (Mo. App., E.D. 1988). We may infer the requisite mental state from the conduct of the licensee “in light of all surrounding circumstances.” *Duncan*, 744 S.W.2d at 533. We have neither direct nor circumstantial evidence that Lowe possessed the requisite mental state for an intent to do anything wrong, whether it was an erroneous administration of insulin to a patient or delivering too much antibiotic to another.

Fraud is defined “generally under the common law as an intentional perversion of truth to induce another, or to act in reliance upon it.” *Hernandez v. State Bd. of Registration for the Healing Arts*, 936 S.W. 2d 894, 899, n. 3 (Mo. App. W.D. 1997). at 899 n.2. It necessarily includes dishonesty, which is a lack of integrity or a disposition to defraud or deceive. WEBSTER’S THIRD INTERNATIONAL DICTIONARY 650 (unabr. 1986). There is no evidence, competent or otherwise, that Lowe perverted the truth or acted dishonestly in her interactions with the hospital, the Board, her supervisor, or her patients.

We find no cause for discipline under § 335.066.2(5).

Professional Trust – Subdivision (12)⁴

The phrase “professional trust or confidence” is not defined in Chapter 335, nor has the phrase been defined in the case law. Absent a statutory definition, the plain meaning of words

⁴ RSMo Supp. 2012.

used in a statute, as found in the dictionary, is typically relied on. *E&B Granite, Inc. v. Dir. of Revenue*, 331 S.W.3d 314, 318 (Mo. banc 2011). The dictionary definition of “professional” is

of, relating to, or characteristic of a profession or calling...[;]...
engaged in one of the learned professions or in an occupation
requiring a high level of training and proficiency...[;]
and]...characterized or conforming to the technical or ethical
standards of a profession or occupation....

WEBSTER’S THIRD NEW INT’L DICTIONARY UNABRIDGED 1811 (1986). “Trust” is

assured reliance on some person or thing [;] a confident
dependence on the character, ability, strength, or truth of someone
or something...[.]

Id. at 2456. “Confidence” is a synonym for “trust.” *Id.* at 475 and 2456. Trust “implies an assured attitude toward another which may rest on blended evidence of experience and more subjective grounds such as knowledge, affection, admiration, respect, or reverence[.]” *Id.* at 2456. Confidence “may indicate a feeling of sureness about another that is based on experience and evidence without strong effect of the subjective[.]” *Id.* Therefore, we define professional trust or confidence to mean reliance on the special knowledge and skills that professional licensure evidences. It may exist not only between the professional and her clients, but also between the professional and her employer and colleagues. *See Cooper v. Missouri Bd. of Pharmacy*, 774 S.W.2d 501, 504 (Mo App. E.D. 1989).

We have found competent and substantial evidence that Lowe was responsible for one significant medication error, when she administered 100 units of insulin to a patient rather than 20. We do not intend to minimize such an error, which we understand could have grave medical consequences. At the same time, we are aware from the evidence in this case as well as many others that even the best nurses make occasional mistakes. In this case, the Board did not establish that Lowe was responsible for repeated medication errors such that her license should be subject to discipline under § 335.066.2(12).

Summary

The Board has failed to meet its burden. We find no cause for discipline against Lowe's license.

SO ORDERED on April 29, 2015.

\s\ Karen A. Winn
KAREN A. WINN
Commissioner