ORIGINAL

IN THE SUPREME COURT OF OHIO

14-1092

Beverly Clayton, C.N.P., R.N.,	:	
	:	On Appeal from the Franklin
Appellant,	:	County Court of Appeals Tenth
	:	Appellate District
vs.	:	
	:	
Ohio Board of Nursing	:	Court of Appeals
	:	Case No. 13-AP-726
Appellee.	:	

MEMORANDUM IN SUPPORT OF JURISDICTION
OF APPELLANT BEVERLY CLAYTON

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TABLE OF CONTENTS

EXPLANATION OF WHY THIS CASE IS A CASE OF PUBLIC OR GREAT GENERAL INTEREST AND INVOLVES A SUBSTANTIAL CONSTITUTIONAL QUESTION. 1

STATEMENT OF THE CASE AND FACTS. 2

ARGUMENT IN SUPPORT OF PROPOSITIONS OF LAW. 13

Proposition of Law Number 1: In an administrative evidentiary hearing held before a Hearing Examiner (H.E.) of the Ohio Board of Nursing (OBN) involving alleged nursing practice violations against the license of Appellant Nurse, it is reversible error, contrary to law and in violation of Due Process of Law for the Hearing Examiner to prohibit and deny Appellant Nurse the right to obtain by hearing subpoena and present in the hearing evidence highly relevant and material to her defense against the charges and to her defense in mitigation of sanctions. 13

Proposition of Law Number 2: The Hearing Examiner erroneously shifted the burden of proof by a preponderance of the evidence from the OBN/State to Appellant. 14

Proposition of Law Number 3: It was reversible error to have permitted Nurse Klenke, a member of the Board during its investigation into the performance of Appellant, to testify as an expert witness (when she was thereafter no longer a Board member) and for the Board to deliberate and decide upon its Adjudication Order in this case when Nurse Klenke had returned to the Board and was a member of the Board while the Board engaged in its deliberations and made its decision in this case. 14

CONCLUSION 15

CERTIFICATE OF SERVICE 16

APPENDIX

Opinion of the Franklin County Court of Appeals (May 15, 2014) . . . . . A

Judgment Entry (May 15, 2014) . . . . . B

EXPLANATION OF WHY THIS CASE IS A CASE OF PUBLIC OR GREAT GENERAL INTEREST AND INVOLVES A SUBSTANTIAL CONSTITUTIONAL QUESTION

Nurses have a substantial interest in retaining their licenses and to practice their profession without unjustified restrictions and/or crippling probationary terms, often preceded by periods of unstayed suspensions. Disciplinary Board action against a nurse's license (or an attorney's license, or a physician's license, et cetera) has life-impacting career consequences, both economic and personal.

There is no right of pre-hearing discovery. The Board has the unlimited power to secretly subpoena any records or witnesses under its "investigatory" authority. The Board is required to produce to the Respondent nurse only those records ***(or parts of them)*** which they intend to offer in the evidentiary hearing. At the same time, the nurse can only subpoena records or witnesses ***for production on the day of the hearing.***

This Ohio Supreme Court has rarely reviewed the tilted playing field confronting nurses charged with career-impacting Nursing Practice Act violations. One decision of this Ohio Supreme Court, *Henry's Café v. Board of Liquor Control*, 170 Ohio St. 233 (1959), prohibits any judicial review on any basis of the disciplinary sanctions imposed by a Board. This is *carte blanche* for any Board to impose without limitation draconian punishments far in excess of anything reasonable or warranted.

Given all of the impediments to fair play facing nurses charged with disciplinary violations, the very least, absolutely minimum requirement ought to be that a nurse should not be precluded from requiring by subpoena *duces tecum* productions of records ***on the day of the evidentiary hearing*** critical to her defense, including her mitigation defense.

The Court of Appeals in its Decision in this case shockingly failed to even mention Appellant's expert, Nurse Gallagher, who testified that he needed to review the ICU records of

the one-night shift in question of 7 patients in order to render an informed opinion about the total context and circumstances impinging upon Appellant Beverly Clayton. This is not even about admission of such evidence, although it is hard to imagine how those patient records would not be highly relevant and admissible. The Hearing Examiner did not even think we had a right to look at them. This was an abuse of discretion and a violation of Due Process of Law.

However, the Common Pleas Court and the Court of Appeals disagreed:

> Because the hearing examiner afforded Clayton the opportunity to present witness testimony regarding the needs of the other patients, Clayton cannot now demonstrate prejudice due to the nondisclosure of the other patients' medical records. (Decision of the Court of Appeals, Appendix at p. 10)

The best evidence of the needs and conditions of the other 7 patients that night in the ICU are these patients' concurrently created records and charts. The events in questions took place two years before the evidentiary hearing. The Common Pleas Court and the Court of Appeals stated that it was sufficient to call as witnesses other nurses in the ICU including Appellant, ***to testify without records from their own recollections off the top of their heads about 7-8 other patients on one night shift two years earlier.*** And even if such shaky unrefreshed "recollection" testimony was given, exactly how was it to be reviewed and considered by our expert witness in the middle of a hearing?

In combination with known facts, these records could refresh recollections to permit informed witness testimony and would provide powerful support for Appellant's mitigation defense.

This case cries out for merits review.

STATEMENT OF THE CASE AND FACTS

This appeal arises out of a timely filed administrative appeal to the Franklin County Common Pleas Court of an Adjudication Order of Appellee Ohio Board of Nursing brought by

Appellant/Respondent Nurse Beverly Clayton. The lower court affirmed the Adjudication Order of Appellee Ohio Board of Nursing. Appellant Beverly Clayton timely perfected her appeal to the Court of Appeals, which affirmed the Common Pleas Court, this timely jurisdictional Notice and Memorandum followed.

Appellant Beverly Clayton became an RN in 1987. At the present time, Appellant is also an MSN (Master of Science in Nursing), APN (Advanced Practice Nurse with prescription-writing authority), CCRN (Critical Care Registered Nurse), CMC (Cardiac Medicine Certification) as well as a respiratory therapist).(T.77) She is a well-educated, intelligent, highly credentialed professional nurse with 25 years of experience without any prior practice violations.

The incident in question occurred during her ICU shift at Mercy Hospital Western Hills in Cincinnati from 7:00 p.m. on August 27, 2009 to 7:00 a.m. on August 28, 2009, the night shift. (T. 78-9)

It is our contention that Appellant Beverly Clayton is the unfortunate victim of a shockingly understaffed and inadequate medical administration headquartered in Cincinnati, which invites inevitable errors and oversights. She was made an unjustified scapegoat for the gross shortcomings of a deficient system driven by profit rather than patient care. We were denied the right to obtain and present evidence highly relevant to our defenses to the nursing practice charges and to our proof of substantial mitigation. ***As will be discussed in more detail hereafter, during this overcrowded, understaffed ICU night shift, Appellant Beverly Clayton had the duties of three jobs: she was the Charge Nurse, she was the Unit Secretary and she was a Staff Nurse with two patients directly assigned to her, including the patient in issue, Patient 1. The two other nurses who started the shift with her were both so inexperienced and useless that neither of them was able to insert i.v.'s into their own 4 patients. All of these 6 critically ill patients at the outset of***

the shift effectively came under the care and responsibility of Appellant, <u>in addition to her two other roles of Charge Nurse and Unit Secretary</u>.

Patient 1 (Appellant's patient in issue) was an 80-year-old male, a 70-year smoker (T. 151), who entered the Emergency Room of Mercy Hospital at 4:00 p.m. on August 27, 2009 from a nursing home with a history of 4 days of shortness of breath. (State's) Exh. 5, p.6) He was diagnosed with renal failure, anuria (no urine output), congestive heart failure (CHF), pneumonia, tachycardia, cardiac afibrillation, COPD (chronic obstructive pulmonary disease) and was DNR-CC (Do Not Resuscitate – Comfort Care). (State's (OBN)'s Exh. 5, p.3; Exh. 12, second page; T. 92-3) His chances of survival were "very slim", at the very best a matter of "days"(T. 542) or for a day or two, irrespective of whatever care or treatment he received. (T. 205-6) He was "critically ill with a poor prognosis" with a poor chance of "leaving the hospital alive". (T. 699-701) Although he was admitted to the ICU, his family prohibited his being intubated (put on a ventilator). Without being intubated, "it was going to be difficult to get him through this", according to the attending physician, Dr. Bowers. (T. 701) Dr. Bowers further testified that if everything she ordered was done for Patient 1, "absolutely" and "without a doubt" he could have been near death by the end of Respondent's shift at 7:00 a.m. on 8-28-09. (T. 750) The fact is that when Patient 1 came under the care of Respondent in the ICU, he was an acutely terminal patient about to expire and upon arrival in the ER, without additional measures, was going to die "within a very short period of time". (T. 681) Nevertheless, contrary to all of the expert medical testimony from both the Appellee's and Appellant's experts, the Hearing Examiner concluded that "Respondent's [Appellant's] failure to practice with acceptable and prevailing standards of safe nursing care in Ohio, as noted above, did not directly result in Patient 1's demise but did lower his chance of surviving". (H.E. Rpt. & Rec., p. 45, par. 17, Appx. F) In fact, the evidence is undisputed that Patient 1 had no chance of "surviving" in any meaningful sense. This does not mean that he wasn't

entitled to safe and competent quality care. But in a grossly understaffed, overburdened and inadequate ICU, care and attention must be prioritized, since the attendant deficiencies in the system (for which Appellant was not responsible) created inherent danger and lack of safety for all patients in the ICU.

Some of the charges against Appellant were unsupported by evidence and were not adopted as findings by the Hearing Examiner.

Other charges were found to be established by the Hearing Examiner, such as failure to locate the handwritten Physician Orders of the attending physician in the ER, Dr. Bowers, which led to failure to obtain the cardiac and pulmonary consults and to initiate a Cardizem "drip", and failure to call the night hospitalist, Dr. Chaudhry, sooner than 4:00 a.m. to see Patient 1. (H.E. Rpt. & Rec., Appx. F, pp. 42-45, pars. 9-10, 13-17) Appellant's defense to these charges was simple and straightforward: under the circumstances that existed in the ICU during Appellant's entire shift, it was impossible for her to comply with all of the handwritten physician orders for Patient 1 without jeopardizing the lives of several other patients in the overcrowded and understaffed ICU. (Appellant relied on the Physician Orders entered into the computer, which is reasonable for an ICU nurse to rely upon. (T. 578-9; T. 725)). Indeed, it is typically the task of an ICU unit secretary to "look at a set of Physician Orders and enter orders into the computer". (Keegan, State's Expert Nurse, VP for Nursing at Mercy Hospital Western Hills (T. 351)) If Appellant Beverly Clayton had disregarded the life-saving care needs of the other patients who required it in favor of dotting every "i" and crossing every "t" for the terminally ill "Do Not Resuscitate" Patient 1, she risked being charged with violations for causing the avoidable deaths of some of the other 7 patients. It is our position that no nurse's license should be sanctioned for failure to do the impossible. Moreover, even if, *arguendo*, a nurse failed to do the impossible, such evidence clearly goes to the issue of mitigation of sanctions as well. ***The admissibility of relevant mitigation evidence is just***

as important as the admission of relevant exoneration evidence. The Hearing Examiner rejected our claim of mitigation but, in doing so, ***adamantly denied every pre-hearing Motion of Appellant to obtain this evidence, and quashed every hearing subpoena to obtain this evidence which Appellant requested.*** (Respondent's Opposition to OBN's Motion to Limit [Respondent's] Subpoena Request, Appx. H). In the hearing, the Hearing Examiner ***precluded every attempt of Appellant (over Appellant's objections and proffers of proof) to obtain or admit into evidence any testimony whatsoever concerning the status, needs, conditions, or life-threatening medical emergencies of the 7 other ICU patients during Appellant's shift.*** (Respondent's Requests for Issuance of Subpoenas, filed 9-20, 9-26 and 10-13-11 (Appx. G); JE filed 10-28-11, p. 4, Appx. I; JE filed 11-2-11, p. 3, pt. 2, Appx. J; T. 559, ll. 23-25, T. 560-62, ll. 1-3).

The testimony of Nurse Gallagher, RN, BSN, Appellant's expert (the only expert who has almost exclusively worked (and currently works) in multiple types of ICU's for the past decade, T. 529-30), vividly demonstrates the preservation of this claimed prejudicial error, including Appellant's offer of proof:

> Q. The chaos that was referenced previously in other testimony, some of which you heard, related only to the change of shift time. Do you have any reason to believe that there was an overwhelming or chaotic situation, you pick the adjective, between 7 a.m. and 7 p.m. during her shift -- 7 p.m. to 7 a.m. sorry.
>
> A. From the notes from Mary Nutt, who herself admits that there was lack of experience, a busy night, she said something else, it appears to me that it was total chaos; numerous admissions during that period of time with inexperienced staff. I believe that it was an absolutely insane night the entire night. ***However, without the other documentation that we requested, we don't have anything that says we*** had ***to run over here. There's another rapid response; here's another admission; here's another admission; here's another admission. I believe that that kind of thing went on that entire time.***
>
> Q. What are you referring to?
>
> A. ***I'm referring to Beverly having to run from room to room to room putting out fires because this person is having trouble doing this and that person is having trouble doing that, and/or the supervisor's on the phone sending me***

another admission when I have no nurses to accept transfer of care for that admission.

Q. Okay. Are there any kinds of, any sources of information that you did not have available which would have shed more light on this?

MR. APPEL: Objection.

HEARING EXAMINER STEHURA: Well, consistent with the other orders that is subject to the ruling that I have made previously in this matter.

MR. SINDELL: So you're sustaining that objection?

HEARING EXAMINER STEHURA: Sustained. Yes.

MR. SINDELL: ***I will make an offer of proof that if permitted to answer that question, this witness would testify that the records of the other patients in the emergency room are essential to a full understanding of the chaos that he is describing.*** And as an offer of proof, he will further testify and in his written report to that effect, preliminary report, that ***if he had those records, he would be able to describe in better detail one way or the other, frankly, what the chaos was that impinged upon my client.***

HEARING EXAMINER STEHURA: Move on. You made your record. (Emphasis added)(Nurse Gallagher, T. 559-562)

Respondent's Expert Nurse Gallagher could not render a fully grounded expert opinion because the Hearing Examiner refused to allow this crucial evidence to be obtained or admitted. As a result of the absence of this determinative evidence, the Hearing Examiner rendered a finding on mitigation (which finding is also applicable to exoneration as well) based upon grotesquely incomplete facts, and thus rejected Appellant's defense with rank speculation:

> I find that the nature of providing registered nursing care in an ICU setting may at times be chaotic; ***however, none of the factors alleged by Respondent was necessarily unusual for an ICU setting.*** (Emphasis added)(H.E. Rpt. & Rec., Appx. F, p. 45, par. 18)

We ask: how can the Hearing Examiner or the Board conclude that "none of the factors alleged by Respondent was necessarily unusual for an ICU setting" without considering the most relevant evidence of what those factors were?

The best evidence of what was "unusual" and how "unusual" the demands and pressures on Appellant were during her ICU shift that night would clearly be the records and charts of the other 7 patients. These records were made at or near the times of the medical events for these other patients as those events actually occurred. The trial court below opined and the Court of Appeals agreed that multiple witnesses should have been inconvenienced and called to testify without records about what details they remembered about 7 – 8 patients on one shift in the ICU two and a half years earlier! The lower courts advanced the strange notion that people should preferably testify from unrefreshed memory about detailed medical events and treatment for 7-8 patients which occurred on a single ICU night shift two and a half years earlier without reference to the medical records and charts which detailed those events and treatment at the time they occurred.

The hospital, upon Appellant's request, was able to add only one more nurse after there was a sudden influx of several new patients. (T. 416-17; T. 564-5)

The reasons given by the Hearing Examiner for denying Appellant the right to subpoena for the hearing the medical charts of the other ICU patients during her shift (of course, with patient names, addresses and social security numbers redacted and numerical designations substituted), include that the evidence Appellant was seeking is: "...either likely irrelevant, beyond the scope of the charges against Respondent in this matter, outweighed by the privacy and confidentiality protection afforded to others..." (JE, filed 10-28-11, Appx. I, p. 4) These reasons are patently vacuous. The best evidence of the circumstances in the ICU on August 27-28, 2009 are these medical records themselves, not the unrefreshed recollections of persons present on a one-night shift two years earlier.

The circumstances of Appellant's night shift which were admitted into evidence clearly demonstrate an unremitting excess of responsibility and pressure imposed disproportionately upon

one isolated nurse, Appellant Beverly Clayton. Had the most revealing evidence been obtained and admitted in evidence, namely, ***the actual conditions, emergencies and needs of all of the critically ill ICU patients,*** the evidence of exoneration, impossibility and strong mitigating factors would be overwhelming.

What we do know about the circumstances during appellant's night shift is as follows:

Appellant Beverly Clayton, throughout her entire night shift, served three simultaneous roles, that of Charge Nurse, Unit Secretary and Direct Care Nurse. This is an unreasonable, unsafe burden to place on one single ICU nurse, as all expert witnesses (Keegan, Klenke and Gallagher) for both parties testified.

The role of Charge Nurse includes the duties of locating records, answering phone calls, making patient assignments for new admissions and ***assisting other nurses with their patients.*** (T. 81-2; T.237-8; T. 298 and T. 567-8).

The vital and indispensable role of Unit Secretary includes the duties of compiling the patient charts (T. 573), locating physician orders, including calling physicians, if necessary, to establish or hunt down the Physician Orders (T. 573-4) and entering them from the written chart into the computer, (T. 351 and T. 565), taking phone calls from physicians, family members, clinical administrators, and other departments, such as the lab (T.354; T. 351-2), ordering supplies, (T. 351) entering lab orders and tests into the computer (T. 351), passing messages to the correct person (T. 353), determining physician orders for consults and calling these physician to come to the ICU for those consults, checking physician medication orders against pharmacy orders (T. 246-7; T. 303, T. 351 and T. 379), and locating and contacting off-duty nurses to obtain missing patient details not reported during shift changes (T. 306, T. 573-4).

Finally, in addition to the role of Charge Nurse and the role of Unit Secretary, Appellant Beverly Clayton also had the role of a Direct Care Nurse with assignment responsibilities for two patients, one of whom was Patient 1.

The duties of these three roles were to be simultaneously performed by Appellant in circumstances in which the two other ICU nurses, each one with 2 to 3 direct care patients of their own (T. 564-5), were so inexperienced that they should never have been assigned to ICU nurse duty, according to the Appellee Board's expert witness, Nurse Joyce Keegan, an executive administrative employee of Mercy Hospital (T. 341); ***these two nurses lacked the knowledge and ability to set up IV's, insert the IV's, insert the IV lines and needles into their own patients and start up the IV's*** (T. 81-2), resulting in Appellant Beverly Clayton having to effectively undertake direct patient care responsibility for ***a total of 6 patients, rather than just the two assigned to her*** (T. 82). State's Expert Nurse Klenke agreed. (T. 237).

With respect to Patient 1, he was transferred from the ER to the ICU ***before Appellee began her shift at 7 p.m.*** (T. 304, Exh. 5, p. 4; T. 314, Exh. 12, p. 2) and was dropped off in the ICU by the transferring ER Nurse ***and left alone, unattended by and unassigned to anyone*** (T. 536) for over an hour (during which time he could have died (T. 272)), without any change-of-shift report from the outgoing charge nurse, Tina Forte, to Appellee Beverly Clayton (H.E. Rpt. & Rec., Appx. F, p. 41, par. 6), and without reporting any physician orders to any ICU Nurse (T. 501-2, 508-9).

A sudden influx of new ICU admissions occurred in the first several hours of Appellant's shift (T. 564-5). When Respondent called her supervisor to request more assistance (T. 416-17), only one additional nurse was sent to the ICU at 11:00 p.m. A nationally recognized understaffing nurse-patient ICU ratio of 1:3 (T. 563-4) existed during the first four hours of Appellant's shift (a total of 8 patients including Patient 1 (T. 553-5) with 3 nurses, two of whom were unqualified for

ICU service). ***Moreover, the hospital had no policy on appropriate ICU nurse-patient ratios*** (T. 332).

There was considerable testimony from both experts, Appellee OBN Nurse Joyce Keegan and Appellant Nurse Terry Gallagher, that the absence of a separate full-time Charge Nurse ***and, in particular, a full-time Unit Secretary in the night shift*** was a critical deficiency. According to Nurse Gallagher, there was no justification to be without a Unit Secretary in the ICU at night and the absence of a Unit Secretary contributed "hugely" to the overall chaos (T. 566-7); Nurse Keegan, the OBN expert, testified that staffing requirements in the ICU are the same whether during the day or night shift (T. 346), that on the day shift in the ICU, the Unit Secretary is a full-time job for a 12-hour shift, and that the absence of any Unit Secretary on the night shift could be a deficiency. (T. 355) ***Nurse Keegan further testified that one of the duties of the ICU Unit Secretary was to enter Physician Orders into the computer and answer the phone.*** (T. 351) ***In other words, the undisputed evidence clearly demonstrates that many of the alleged performance failures claimed against Appellant Beverly Clayton were functions which are normally done by the Unit Secretary. These functions include finding the Physician Orders (in this case from the ER), contacting the physicians ordered to do the consults, entering Physician Orders into the computer (which was primarily the source of orders used by Respondent Beverly Clayton and other ICU Nurses during her shift), check the Pharmacy Orders to determine if they conform to the Physician Orders, call the off-duty charge nurse on the preceding shift to fill in any missing details in the change-of-shift report, arrange the medical chart of the newly admitted ICU patients, et cetera.*** (*supra*, p.9) As Appellant's Expert Nurse Gallagher testified, "Secretaries are worth their weight in gold" (T. 574).

The sanctions recommended by the Hearing Examiner and those slightly reduced and ultimately adopted by the Board in the Adjudication Order were, in our view, harsh, extreme and unwarranted:

Respondent Beverly Clayton was ordered to suffer a complete unstayed suspension for one year before she can even apply for reinstatement. Her suspension is indefinite; after reinstatement, her suspension must continue for not less than 2 more years subject to a stay based upon certain probationary terms. Those terms include temporary practice restrictions prohibiting her from working independently in any facility or home on her own without on-site supervision or to serve in any management or supervisory capacity with respect to other nurses or nursing responsibilities, or supervising and evaluating any nursing practice. "Any period during which Ms. Clayton does not work in a position for which a nursing license is required shall not count toward fulfilling the probationary period imposed by this Order." (As to quote, Adjudication Order, Appx. E, p. 5 and otherwise, throughout entire Adjudication Order). There are also numerous other onerous terms.

We submit that these are draconian punishments. What employer is going to hire (and submit quarterly performance reports about) an RN/NP (particularly a Nurse Practitioner) who cannot exercise any supervisory or evaluation authority, particularly in this tight employment market? Without a job requiring the use of her license, Appellant Beverly Clayton will be unable to work off with "good time" her ***minimum*** 2 required probationary years, after serving a full one-year ***unstayed*** suspension. What employer in this current economy is going to hire an RN or NP with this kind of baggage? What will the impact be on her career of an entire year of unstayed suspension?

And, most importantly, the issue in this appeal is: should these violations and sanctions be imposed ***without giving Appellant the opportunity to obtain, review and produce in her hearing the most critical evidence available in support of her defense?***

Appellant's highly qualified expert repeatedly testified most compellingly, even though deprived of the most important evidence which could further and mightily substantiate Appellant's exculpation and mitigation:

> It appears to me that it was total chaos; numerous admissions during that period of time with inexperienced staff. [Direct Care Nurses unable to set up and insert IV's.] I believe that it was an absolutely insane night the entire night. ***However, without the other documentation that we requested, we don't have anything...*** (Emphasis added) (T. 560-1)
>
> ■■■
>
> I would hold the nursing supervisor and the hospital administration at fault for not having sufficient numbers of staff available and/or well trained that night. One person can only be in so many places at a time, and ***we asked of Beverly Clayton to do things that are far above what is reasonable and prudent.*** (Emphasis added)(T. 571)
>
> ***
>
> I believe she was forced into a situation where ***errors were set up to occur; we set her up to fail.*** (Emphasis added)(T. 572)
>
> ***
>
> You had a ***systemic breakdown of the entire system that night.*** You had miscommunication starting from the ER to the ICU. You had a rapid response where the [previous charge] nurse [Tina Forte] did not report off or transfer her care [to Beverly Clayton].
>
> Then you have more patients than are reasonable and prudent in a given situation. You have got a nursing supervisor that continues to send patients to an already overwhelmed ICU without coming down and offering assistance. No, you need to go to the top and work your way down on this one. (Emphasis added)(T. 584)

ARGUMENT IN SUPPORT OF PROPOSITIONS OF LAW

Proposition of Law No. 1: In an administrative evidentiary hearing held before a Hearing Examiner (H.E.) of the Ohio Board of Nursing (OBN) involving alleged nursing practice violations against the license of Appellant Nurse, it is reversible error, contrary to law and in violation of Due Process of Law for the Hearing Examiner to prohibit and deny Appellant Nurse the right to obtain by hearing subpoena and present in the hearing evidence highly relevant and material to her defense against the charges and to her defense in mitigation of sanctions.

Due Process of Law, as recognized in the Fourteenth Amendment to the United States Constitution and in Section 16, Article I of the Ohio Constitution is applicable to administrative license hearings in Ohio. *Natoli v. The Ohio State Dental Board*, 177 Ohio App. 3d 645 (C.A. 10th Dist., Franklin Cty., 2008)(at P18).

Thus, reconsideration of the penalty must be determined in Appellant's case, depending upon which alleged violations, ***if any***, are validly proven and which ones are not, ***after the inclusion of the evidence which was improperly excluded.***

Proposition of Law No. 2: The Hearing Examiner erroneously shifted the burden of proof by a preponderance of the evidence from the OBN/State to Appellant.

The Court of Appeals noted that the Hearing Examiner made a statement which could be construed by some as altering the placement of the burden of proof. (Decision, Appx., p. 8) We believe that upon review, it will become apparent that the Hearing Examiner, on a crucial point, did not correctly apply the burden of proof.

The Hearing Examiner wrote in his Report and Recommendation, (Appx. F) as follows:

> As part of her argument and proposed evidence, Respondent has contended that Dr. Bower's Physician's Orders were not part of Patient 1's chart when he was admitted to the Hospital ICU from the ER. As noted in my Findings of Fact, ***I do not find that this contention is supported by the preponderance of the evidence.*** (Emphasis added) (pp.35-6)

We submit that it was reversible error to impose upon Appellant the burden of proving by a preponderance of the evidence that the handwritten Physician Orders of Dr. Bowers were ***not*** in the chart when she reviewed it in the ICU.

Proposition of Law No. 3: It was reversible error to have permitted Nurse Klenke, a member of the Board during its investigation into the performance of Appellant, to testify as an expert witness (when she was thereafter no longer a Board member) and for the Board to deliberate and decide upon its Adjudication Order in this case when Nurse Klenke had returned to the Board and was a member of the Board while the Board engaged in its deliberations and made its decision in this case.

We believe that this Proposition No. 3 is self-evident. Why would the State pick a recently former Board Member as its expert witness, particularly someone with very little current knowledge of ICU practice?

Ms. Klenke had served on the Board for years and was obviously a colleague of other Board members. Nurse Klenke had extremely limited ICU experience in a small community hospital decades earlier. (T. 163-4; T. 167-9).

Nurse Klenke had returned to membership on the Board by the time we appeared at the Board Meeting to argue to the Board Members our objections to the Report and Recommendation of the Hearing Examiner.

The Board inserted in its Adjudication Order a rather unique statement:

> The Board moved that the record in this matter reflect that although the State's expert witness, Lisa Klenke, was appointed by the Governor to this Board in July 2012, after the hearing had concluded, the Board has not given any deferential regard, or heightened weight, to Ms. Klenke's testimony, and accepts that testimony only to the extent it was incorporated in the Findings of Fact and Conclusions of Law made by the Hearing Examiner. (Appx. E, Adjudication Order, p.2)

The very need to expressly disavow bias implies its very presence.

CONCLUSION

For all of the foregoing reasons, we urge this Ohio Supreme Court to assume jurisdiction and grant merits review in this matter.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that a true and accurate copy of the foregoing Memorandum in Support of Jurisdiction of Appellant Beverly Clayton was served upon the following by Regular U. S. Mail and e-mail on June 27, 2014:

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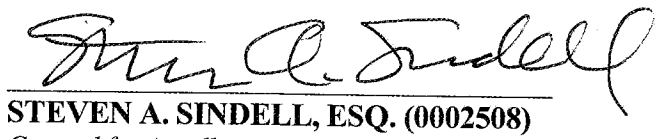

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APPENDIX

Court of Appeals Decision . . . . . A

Court of Appeals Judgment Entry . . .B

Court of Appeals Decision

Exhibit A

EXHIBIT
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A

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Beverly Clayton, C.N.P., R.N.,	:	
Appellant-Appellant,	:	
v.	:	No. 13AP-726 (C.P.C. No. 12CV-13572)
Ohio Board of Nursing,	:	(REGULAR CALENDAR)
Appellee-Appellee.	:	

D E C I S I O N

Rendered on May 15, 2014

Sindell and Sindell, LLP, *Steven A. Sindell* and *Rachel Sindell*, for appellant.

Michael DeWine, Attorney General, and *Henry G. Appel*, for appellee.

APPEAL from the Franklin County Court of Common Pleas

KLATT, J.

{¶ 1} Appellant-appellant, Beverly Clayton, appeals a judgment of the Franklin County Court of Common Pleas affirming the order of appellee-appellee, the Ohio Board of Nursing ("Board"), that suspended Clayton's registered nursing license and certified nurse practitioner certificate. For the following reasons, we affirm the trial court's judgment.

{¶ 2} At approximately 4:10 p.m. on August 27, 2009, Patient 1, an 80-year-old man, arrived at the emergency department of Mercy Franciscan Hospital – Western Hills

("Mercy").[1] Patient 1 was in poor health; he suffered from congestive heart failure, atrial fibrillation, chronic renal failure, and chronic obstructive pulmonary disease. He presented at Mercy complaining of shortness of breath.

{¶ 3} Dr. Jamelle Bowers, a Mercy hospitalist,[2] was assigned as Patient 1's attending physician. Bowers examined Patient 1 and decided to admit him to Mercy's intensive care unit ("ICU"). At 6:15 p.m., Dr. Bowers handwrote a series of orders on a single-page form marked "PHYSICIAN'S ORDERS." In relevant part, those orders included: the administration of 40 milligrams of the drug Lasix (also known as furosemide) every eight hours to stimulate urine output; the administration of a 15 milligram bolus of the drug Cardizem (also known as diltiazem) and then an intravenous Cardizem drip titrated to bring Patient 1's heart rate below 100 beats per minute; a consultation with Dr. Kennealy, a pulmonologist; a consultation with Dr. Desai, a cardiologist; and a saline lock, which precluded the administration of normal saline to Patient 1. An emergency department nurse faxed Dr. Bowers' orders to the hospital pharmacy.

{¶ 4} Patient 1 was transferred to the ICU sometime between 6:30 and 6:50 p.m. Soon after Patient 1 arrived at the ICU, Clayton's 7:00 p.m. to 7:00 a.m. shift as the ICU charge nurse began. Patient 1 was assigned to Clayton's care.

{¶ 5} According to Clayton, she was overloaded with responsibilities during her shift. She was assigned the direct care of two patients. Additionally, she frequently had to step in to assist two inexperienced nurses with the care of their patients. She also had to act as unit secretary, which required her to enter physician's orders into the hospital computer system, initiate consultations, and answer the ICU phone.

{¶ 6} Clayton did not review the physician's orders for Patient 1. Instead, Clayton relied on the information in the hospital computer system to care for Patient 1. Because a hospital pharmacist had entered that information into the computer system, it related solely to the medications that Dr. Bowers had ordered for Patient 1. Not only was the information limited, it was also wrong. The pharmacist had incorrectly entered into the

[1] We, like the Board and trial court, refer to the patient involved in this case as "Patient 1" to protect his privacy.

[2] Dr. Bowers is actually Mercy's lead hospitalist and directs Mercy's hospitalist program.

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

computer Dr. Bowers' order for the administration of Cardizem. Rather than calling for a 15 milligram bolus and then a titrated dose to decrease Patient's 1 heart rate to less than 100 beats per minute, the information entered into the computer indicated that Patient 1 was to receive one 25 milligram bolus. Clayton administered a 25 milligram bolus of Cardizem to Patient 1 at 10:16 p.m. She also administered one 40 milligram bolus of Lasix at 10:16 p.m.

{¶ 7} During the course of Clayton's shift, Patient 1 received 1,097 milliliters of normal saline, despite the saline lock ordered by Dr. Bowers. In addition to failing to maintain the saline lock, Clayton did not carry out Dr. Bowers' orders to: (1) administer 40 milligrams of Lasix every eight hours, (2) establish an intravenous Cardizem drip and titrate the drip to achieve a reduction in Patient 1's heart rate to less than 100 beats per minute, and (3) initiate the pulmonary and cardiology consultations.

{¶ 8} Throughout the night, Patient 1's heart rate remained above 100 beats per minute. At 2:00 a.m., his blood pressure had fallen to 99/45, and it continued to fall after that point. Despite the administration of Lasix at 10:16 p.m., his fluid output did not increase. The administration of Cardizem (also at 10:16 p.m.) was likewise ineffective.

{¶ 9} At 4:00 a.m., Clayton notified the hospitalist on call, Dr. Kern Chaudhry, of Patient 1's condition. Although Dr. Chaudhry treated Patient 1, his condition continued to deteriorate.

{¶ 10} Dr. Bowers arrived at the hospital at 7:00 a.m. on August 28, 2007. She visited Patient 1 and found him unresponsive and near death. Dr. Bowers became agitated when she saw that her orders had not been followed. Patient 1 died at 11:17 a.m.

{¶ 11} In a notice dated November 19, 2010, the Board informed Clayton that it proposed to revoke, suspend, or restrict her registered nursing license and certified nurse practitioner certificate because of the allegedly substandard care that Clayton had provided to Patient 1. The notice asserted that the Board could take disciplinary action against Clayton under R.C. 4723.28(B)(16), because she had violated rules adopted under R.C. Chapter 4723, and (2) R.C. 4723.28(B)(19), because she had "[f]ail[ed] to practice in accordance with acceptable and prevailing standards of safe nursing care." The notice alleged that Clayton had violated:

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

- Ohio Adm.Code 4723-4-06(H), which requires a licensed nurse to "implement measures to promote a safe environment for each patient;"

- Ohio Adm.Code 4723-4-03(C), which requires a registered nurse to "demonstrate competence and accountability in all areas of practice in which the nurse is engaged [including] (1) [c]onsistent performance of all aspects of nursing care; and (2) [r]ecognition, referral or consultation, and intervention, when a complication arises;"

- Ohio Adm.Code 4723-4-03(E), which requires a registered nurse to, "in a timely manner: (1) [i]mplement any order for a patient * * * [and] (2) [c]larify any order for a patient when the registered nurse believes or should have reason to believe the order is: (a) [i]nacurrate; (b) [n]ot properly authorized; (c) [n]ot current or valid; (d) [h]armful, or potentially harmful to a patient; or (e) [c]ontraindicated by other documented information;" and

- Ohio Adm.Code 4723-4-03(G), which requires a registered nurse to, "in a timely manner, report to and consult as necessary with other nurses or other members of the health care team and make referrals as necessary."[3]

{¶ 12} Clayton requested a hearing. At the hearing, Clayton testified that she reviewed Patient 1's chart, but the physician's orders were missing from the chart. She was too busy dealing to more urgent matters to seek out the physician's orders. Clayton waited until 4:00 a.m. to request Dr. Chaudhry's intervention because Patient 1 was awake and communicating with her prior to that time. Clayton claimed that she gave Patient 1 1,097 milliliters of normal saline, despite the saline lock, because Dr. Chaudhry verbally ordered it.[4]

{¶ 13} The Board presented witness testimony that cast doubt on Clayton's contention that she did not read the physician's orders because they were absent from the

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[3] Each of these rules appears in Ohio Adm.Code Chapter 4723-4, which establishes "[m]inimal acceptable standards of safe and effective nursing practice for a registered nurse and a licensed practical nurse in any setting." Ohio Adm.Code 4723-4-01(A)(1).

[4] A subsequent physician's order will supercede a conflicting, earlier physician's order. Clayton, therefore, could not be faulted for failing to maintain a saline lock if Dr. Chaudhry gave orders at 4:00 a.m. that contradicted the saline lock that Dr. Bowers ordered at 6:15 p.m. the prior day.

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

chart. Joyce Keegan, the vice president for nursing at Mercy and Mt. Airy Hospital, investigated the incident for Mercy. Keegan testified that Clayton had told her that she lacked the time to look at Patient 1's chart, rather than, as Clayton testified at trial, that she looked but could not find Patient 1's physician's orders in the chart. Diane Helferich, a Board compliance agent, interviewed Clayton after the Board received a complaint regarding her care of Patient 1. She also testified that Clayton had told her that she did not review the physician's orders because she did not have the time to do so. Finally, Dr. Bowers testified that on the morning of August 28, 2009, she "very easily" found the physician's orders in Patient 1's chart. (Tr. 675.)

{¶ 14} The Board also pointed out the absence of any written order from Dr. Chaudhry directing the administration of normal saline. The medical records only include a nurse's note, written by Clayton at 4:00 a.m., that states, "IVF Æ 'd to 250 cc NS." In other words, Clayton increased Patient 1's receipt of intravenous fluids to 250 milliliters of normal saline at 4:00 a.m. Even if this nurse's note memorialized a verbal order from Dr. Chaudhry to give Patient 1 a 250 milliliter bolus of normal saline, it did not account for 847 milliliters of the total amount of 1,097 milliliters of normal saline administered to Patient 1 during Clayton's shift.

{¶ 15} To establish that Clayton did not meet the minimum standards of safe nursing care, the Board offered the expert testimony of Lisa Klenke, a registered nurse. Klenke testified that Clayton failed to practice in accordance with acceptable and prevailing standards of safe nursing care when she did not review and implement the physician's orders for the care of Patient 1. According to Klenke, if Clayton could not find physician's orders for Patient 1 in his chart, she should have contacted the physician. Keegan, the vice president of nursing at Mercy, testified similarly. Keegan explained that the absence of physician's orders triggers an obligation to call the physician. As Keegan stated, physician's orders are "the crux of everything [a nurse] ha[s] to do for that patient[;] * * * a nurse only acts on orders from a physician for dependent care of that patient." (Tr. 392.)

{¶ 16} Klenke was also critical of Clayton's failure to timely recognize that Patient 1's deteriorating condition required intervention by a physician. Klenke testified that Clayton should have notified a physician that Patient 1 had not responded to the Lasix

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

administered at 10:16 p.m. Clayton should have also sought a physician's assistance when she measured Patient 1's systolic blood pressure at 99 at 2:00 a.m. Dr. Bowers generally concurred with Klenke's assessment. Dr. Bowers testified that Clayton should have called for a physician by midnight because Patient 1 had not responded to the Cardizem, which like the Lasix, was administered at 10:16 p.m. Dr. Bowers also testified that, as a physician, she would have expected Clayton to call at 2:00 a.m. when Patient 1's systolic blood pressure dropped below 100.

{¶ 17} Finally, Klenke rejected the opinion of Clayton's expert witness that it was impossible for Clayton to comply with the standard of care for Patient 1. Klenke stated that Clayton should have asked for help once she realized that she could not adequately care for Patient 1 given the other demands on her time. Keegan testified to Mercy's protocol for obtaining additional nursing assistance. According to Keegan, the charge nurse should contact her supervisor, the clinical administrator, or, in the absence of the clinical administrator, the emergency department charge nurse. Those individuals might seek the assistance of an on-call nurse, switch a nurse from a different unit to the busy unit, or call on other staff.

{¶ 18} In a report and recommendation dated July 31, 2012, the hearing examiner found that the physician's orders were in Patient 1's chart when Patient 1 was admitted to the ICU from the emergency department and remained part of the chart throughout the time Patient 1 was in the ICU. The hearing examiner also found that, after arriving at Patient 1's bedside at approximately 4:00 a.m., Dr. Chaudhry gave Clayton an order to give Patient 1 a 250 milliliter bolus of normal saline, but Dr. Chaudhry did not order any additional normal saline from that point on. Finally, the hearing examiner found that Clayton should have consulted with a physician as early as 10:16 p.m. after the bolus of Cardizem failed to reduce Patient 1's heart rate, or at least by 2:00 a.m. due to Patient 1's significant drop in blood pressure from the previous reading.

{¶ 19} Based on the evidence, the hearing examiner determined that Clayton failed to practice in accordance with acceptable and prevailing standards of safe nursing care and violated the specified administrative rules by: (1) failing to locate and implement the physician's orders, and (2) failing to timely consult with a Mercy physician about Patient 1's declining condition. The hearing examiner also found that the chaotic and

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

overwhelming circumstances of the ICU did not relieve Clayton of her duty to practice within the acceptable and prevailing standards of safe nursing care. However, the hearing examiner did consider the chaotic and overwhelming circumstances a mitigating factor in determining the appropriate discipline.

{¶ 20} The hearing examiner recommended that the Board suspend Clayton's registered nursing license and certified nurse practitioner certificate indefinitely, but not less than one year. The hearing examiner specified conditions for reinstatement; probationary terms, conditions, and limitations to apply for a minimum of two years after the reinstatement of Clayton's license; and permanent practice restrictions.

{¶ 21} In an adjudication order dated September 21, 2012, the Board accepted the hearing examiner's findings of fact and conclusions of law. The Board modified the recommended sanction by changing the conditions for reinstatement; altering the terms, conditions, and limitations for the probationary period after reinstatement; and deleting the permanent practice restrictions.

{¶ 22} Clayton appealed the Board's order to the trial court. After considering Clayton's assignments of error, the trial court affirmed the Board's order.

{¶ 23} Clayton now appeals the July 25, 2013 final judgment of the trial court, and she assigns the following errors:

> (1) In an administrative evidentiary hearing held before a Hearing Examiner (H.E.) of the Ohio Board of Nursing (OBN) involving alleged nursing practice violations against the license of Appellant Nurse, it is reversible error, contrary to law and in violation of Due Process of Law for the Hearing Examiner to prohibit and deny Respondent Nurse the right to obtain by hearing subpoena and present in the hearing evidence highly relevant and material to her defense against the charges and to her defense in mitigation of sanctions.
>
> (2) There is no evidence in the record to support the charge against Appellant that she continued uninterruptedly to administer IV saline to Patient 1 during her shift, despite the fact that a physician had ordered a saline lock * * *.
>
> (3) Although not listed as an allegation in the Notice of Opportunity for Hearing, there is scant if any evidence that

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

> Appellant gave Patient 1 a saline bolus without any Physician Order.
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> (4) Appellant gave Patient 1 a 25 mg. Cardizem (also known as Diltiazem) bolus and not a 15 mg. Cardizem drip because she followed the erroneous pharmacy order to do so which had been entered into the computer.
>
> (5) The claimed violation in the Notice of Opportunity for Hearing that Appellant waited too long, until 4:00 a.m. on August 28, 2009, to notify the night hospitalist, Dr. Chaudhry, is an unfounded exercise in 20/20 hindsight.
>
> (6) The Hearing Examiner erroneously shifted the burden of proof by a preponderance of the evidence from the OBN/State to Appellant.
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> (7) It was reversible error to have permitted Nurse Klenke, a member of the Board during its investigation into the performance of Appellant, to testify as an expert witness (when she was thereafter no longer a Board member) and for the Board to deliberate and decide upon its Adjudication Order in this case when Nurse Klenke had returned to the Board and was a member of the Board while the Board engaged in its deliberations and made its decision in this case.

{¶ 24} Pursuant to R.C. 119.12, when a common pleas court reviews an order of an administrative agency, the court must consider the entire record to determine if the agency's order is supported by reliable, probative, and substantial evidence and is in accordance with law. To be "reliable," evidence must be dependable and true within a reasonable probability. *Our Place, Inc. v. Ohio Liquor Control Comm.*, 63 Ohio St.3d 570, 571 (1992). To be "probative," evidence must be relevant or, in other words, tend to prove the issue in question. *Id.* To be "substantial," evidence must have some weight; it must have importance and value. *Id.*

{¶ 25} In reviewing the record for reliable, probative, and substantial evidence, the trial court " 'must appraise all the evidence as to the credibility of the witnesses, the probative character of the evidence, and the weight thereof.' " *AmCare, Inc. v. Ohio Dept. of Job & Family Servs.*, 161 Ohio App.3d 350, 2005-Ohio-2714, ¶ 9 (10th Dist.), quoting *Lies v. Ohio Veterinary Med. Bd.*, 2 Ohio App.3d 204, 207 (10th Dist.1981). In doing so,

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

the trial court must give due deference to the administrative resolution of evidentiary conflicts because the agency, as the fact finder, is in the best position to observe the manner and demeanor of the witnesses. *Univ. of Cincinnati v. Conrad*, 63 Ohio St.2d 108, 111 (1980).

{¶ 26} Unlike a trial court, an appellate court may not review the evidence. *Pons v. Ohio State Med. Bd.*, 66 Ohio St.3d 619, 621 (1993). An appellate court is limited to determining whether the trial court abused its discretion. *Id.* Absent such an abuse of discretion, an appellate court must affirm the trial court's judgment, even if the appellate court would have arrived at a different conclusion than the trial court. *Lorain City School Dist. Bd. of Edn. v. State Emp. Relations Bd.*, 40 Ohio St.3d 257, 261 (1988). When reviewing the trial court's judgment as to whether an agency's decision is in accordance with law, an appellate court's review is plenary. *Spitznagel v. State Bd. of Edn.*, 126 Ohio St.3d 174, 2010-Ohio-2715, ¶ 14.

{¶ 27} By her first assignment of error, Clayton argues that the hearing examiner erred in refusing to fulfill her request to issue a subpoena for the medical records of the other patients present in the ICU during her shift. Even if the hearing examiner erred as alleged, Clayton is not entitled to reversal because she has not shown how that alleged error prejudiced her.

{¶ 28} Pursuant to R.C. 119.09:

> the agency may, and upon the request of any party receiving notice of the hearing as required by section 119.07 of the Revised Code shall, issue a subpoena for any witness or a subpoena duces tecum to compel the production of any books, records, or papers, directed to the sheriff of the county where such witness resides or is found, which shall be served and returned in the same manner as a subpoena in a criminal case is served and returned.

Thus, if requested by a party to an adjudicatory hearing, an administrative agency must issue a subpoena to compel the attendance of a witness or the production of documents at the hearing. *Ohio State Bd. of Pharmacy v. Frantz*, 51 Ohio St.3d 143, 145 (1990); *Walters v. Ohio State Dept. of Adm. Servs.*, 10th Dist. No. 06AP-472, 2006-Ohio-6739, ¶ 29; *Northfield Park Assoc. v. Ohio State Racing Comm.*, 10th Dist. No. 05AP-749, 2006-Ohio-3446, ¶ 63. However, to secure a reversal on the basis that the administrative

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

agency failed to issue a requested subpoena, a party must demonstrate that the failure resulted in prejudice. *Burneson v. Ohio State Racing Comm.*, 10th Dist. No. 08AP-794, 2009-Ohio-1103, ¶ 24; *Korn v. Ohio State Med. Bd.*, 61 Ohio App.3d 677, 686 (10th Dist.1988).

{¶ 29} Here, Clayton sought the medical records of the other ICU patients in order to show the care required by and provided to those patients during her shift. Clayton wanted that information so she could point to circumstances involving those patients that demanded her intervention. The hearing examiner denied Clayton's subpoena request to avoid infringing on the privacy and confidentiality protections afforded to the other patients and because the information Clayton sought could be obtained through other sources.

{¶ 30} Although the hearing examiner refused to issue a subpoena for the other patients' medical records, he granted Clayton's request to issue subpoenas to two ICU nurses who worked the overnight shift on August 27 and 28, 2009. Those nurses could have testified regarding what occurred during the shift, including the assistance Clayton had to provide to other patients. Clayton, however, did not call either nurse to testify. The hearing examiner also allowed Clayton to testify regarding the care she provided to other patients. Clayton stated that she "put[ ] I.V.s in for nurses that [could] not do that themselves" and "start[ed] Amiodarone drips for another patient where a nurse did not know what [an] Amiodarone drip was." (Tr. 81.) Because the hearing examiner afforded Clayton the opportunity to present witness testimony regarding the needs of the other patients, Clayton cannot now demonstrate prejudice due to the nondisclosure of the other patients' medical records.

{¶ 31} In a last ditch effort to show prejudice, Clayton argues that witnesses' memories fade, and the medical records would have been necessary to refresh those memories. If Clayton had established at the hearing deficiencies in her or the other nurses' memories, this argument might have succeeded. However, Clayton failed to establish any such deficiencies. Accordingly, we conclude that no prejudice resulted from the hearing examiner's failure to issue the subpoena in question, and we overrule Clayton's first assignment of error.

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

{¶ 32} Both Clayton's second and third assignments of error concern her administration of normal saline to Patient 1. We will address them together. By her second assignment of error, Clayton argues that the record does not contain any evidence that she uninterruptedly administered normal saline to Patient 1 during her shift. By her third assignment of error, Clayton argues that the record does not contain any evidence that she administered normal saline to Patient 1 without a physician's order.

{¶ 33} The Board did not find that Clayton uninterruptedly administered normal saline to Patient 1 during her shift. Although medical records established that Clayton gave Patient 1 a total of 1,097 milliliters of normal saline during her shift, the evidence was equivocal regarding the exact time, or times, that Patient 1 received the normal saline. Therefore, the Board made no findings tying the administration of normal saline to a particular period during Clayton's shift. Rather, the Board simply found that Clayton administered a total of 1,097 milliliters of normal saline to Patient 1 during her shift.

{¶ 34} Clayton explained her administration of normal saline to Patient 1, despite Dr. Bowers' order of a saline lock, by claiming that that Dr. Chaudhry ordered it. The question before the Board, therefore, was whether Dr. Chaudhry had authorized the administration of the 1,097 milliliters of normal saline, thus supplanting Dr. Bowers' earlier order of a saline lock.

{¶ 35} After considering the evidence, the Board found that Dr. Chaudhry only ordered Clayton to administer a 250 milliliter bolus of normal saline to Patient 1. Clayton, however, argues that the evidence shows that Dr. Chaudhry ordered Clayton to give Patient 1 a 1,097 milliliter saline bolus. Clayton's testimony was the only evidence in the record that Dr. Chaudhry authorized the administration of all 1,097 milliliters of normal saline to Patient 1. The Board did not believe that testimony. We cannot second-guess that credibility determination. *Applegate v. State Med. Bd.*, 10th Dist. No. 07AP-78, 2007-Ohio-6384, ¶ 21.

{¶ 36} Subtracting 250 milliliters (the amount of normal saline ordered by Dr. Chaudhry) from 1,097 milliliters (the total amount administered) yields the result of 847 milliliters. Therefore, Clayton administered 847 milliliters of normal saline to Patient 1 without a physician's order to do so and despite Dr. Bowers' prohibition against the administration of normal saline. We thus find no abuse of discretion in the trial court's

determination that reliable, probative, and substantial evidence supports the Board's conclusion that Clayton did not comply with the physician's orders regarding the administration of normal saline. Accordingly, we overrule Clayton's second and third assignments of error.

{¶ 37} By Clayton's fourth assignment of error, she argues that the trial court erred in affirming the Board's decision to discipline her for failing to follow the physician's order to administer a Cardizem drip to Patient 1 when that order did not appear in Mercy's computer system. We disagree.

{¶ 38} The Board concluded that the acceptable and prevailing standards of safe nursing care require an ICU nurse to locate and implement the physician's orders for a patient under the nurse's care. Clayton, admittedly, did not locate and implement the physician's orders for Patient 1. Instead, she relied on the information entered by a pharmacist into the hospital computer system to determine what kind of and how much medication to administer. The pharmacist failed to enter Dr. Bowers' order for an intravenous Cardizem drip titrated to reduce Patient 1's heart rate below 100 beats per minute.

{¶ 39} Clayton argues that the error in the pharmacist's computer entry justifies her failure to administer the intravenous Cardizem drip. We are not persuaded. The physician's orders, not the pharmacist's entry, dictated the course of Patient's 1 care. As the Board found, Clayton violated the standard of care and applicable administrative rules when she failed to locate and implement the physician's order. The pharmacist's error does not excuse this violation. Accordingly, we overrule Clayton's fourth assignment of error.

{¶ 40} By Clayton's fifth assignment of error, she argues that the trial court erred in affirming the Board's decision to discipline her for waiting too long to seek a physician's assistance with Patient 1. We disagree.

{¶ 41} Both Klenke and Dr. Bowers testified that Clayton should have contacted a hospitalist regarding Patient 1's condition when he did not respond to the medication administered at 10:16 p.m. and when his systolic blood pressure dropped below 100 at 2:00 a.m. Relying on this testimony, the Board concluded that Clayton did not timely recognize and notify a hospitalist of Patient 1's deteriorating condition, and, thus, she

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

violated the acceptable and prevailing standards of safe nursing care and the specified administrative rules.

{¶ 42} Clayton argues that the trial court should have rejected Klenke's and Dr. Bowers' testimony in favor of her testimony that a physician's intervention was not necessary until 4:00 a.m., when Patient 1 became unable to interact with her. Our role, however, is not to determine which testimony is more credible or worthy of greater weight. *Ressler v. Ohio Dept. of Transp.*, 10th Dist. No. 09AP-338, 2009-Ohio-5857, ¶ 13. Rather, we only determine whether the trial court abused its discretion in determining whether reliable, probative, and substantial evidence supported the administrative agency's order. *Id.* Here, we find no such abuse of discretion. Accordingly, we overrule Clayton's fifth assignment of error.

{¶ 43} By Clayton's sixth assignment of error, she argues that the Board erroneously shifted the burden of proof onto her. We disagree.

{¶ 44} In an administrative proceeding, the party asserting the affirmative of an issue bears the burden of proof. *Nucklos v. State Med. Bd.*, 10th Dist. No. 09AP-406, 2010-Ohio-2973, ¶ 17. A burden of proof is a composite burden requiring the party on whom it rests to go forward with the evidence (the burden of production) and to convince the trier of fact by some quantum of evidence (the burden of persuasion). *Chari v. Vore*, 91 Ohio St.3d 323, 326 (2001).

{¶ 45} Here, the Board had the burden of producing evidence and persuading the finder of fact that Clayton failed to provide nursing care to Patient 1 in accordance with the acceptable and prevailing standards of safe nursing care and the specified administrative rules. The hearing examiner recognized that the Board had that burden of proof, and he determined that the Board carried its burden. Report and Recommendation of the Hearing Examiner, at ¶ F of the Conclusions of Law.

{¶ 46} In the course of deciding whether the Board had satisfied its burden of proof, the hearing examiner resolved a conflict in the evidence over whether the physician's orders were contained in Patient 1's chart when he was admitted to the ICU. In relevant part, the hearing examiner stated:

> Respondent has contended that Dr. Bower[s'] Physician's Orders were not part of Patient 1's chart when he was admitted to the Hospital ICU from the [emergency

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

> department]. As noted in my Findings of Fact, I do not find that this contention is supported by the preponderance of the evidence. Respondent's main evidence to support this contention is Respondent's hearing testimony where she contends that Physician's Orders were not part of [ ] Patient 1's chart. (Tr. 95). I do not find this testimony credible in that in both the Hospital and Board investigation interviews shortly after this incident Respondent openly admitted that she did not look at the Physician's Orders during her shift and in neither interview did she contend that the Physician's Orders were not part of Patient 1's chart. The most direct and compelling testimony on this issue came from the author of the Physician's Orders, Dr. Bowers, who testified that, upon arriving at the end of the Respondent's shift on August 28 and seeing Patient 1 with an I.V. running in direct violation of one item in the Physician's Order[s], she "very easily" found the Physician's Orders in Patient 1's chart.

(Footnote omitted.) Report and Recommendation of the Hearing Examiner, at 35-36.

{¶ 47} The hearing examiner blundered when he used the phrase "preponderance of the evidence" in evaluating contradictory evidence. The hearing examiner was not determining whether Clayton's evidence satisfied a pre-set level of persuasiveness necessary to carry a burden of proof. Rather, the hearing examiner was comparing conflicting evidence and determining which evidence was more credible. Although erroneously expressed, read in context, the passage at issue communicates that Clayton's evidence is not as convincing as the Board's evidence. As the Board's evidence directly contradicted Clayton's evidence, the hearing examiner rejected Clayton's evidence and made a factual finding based on the Board's evidence.

{¶ 48} Although the hearing examiner inappropriately phrased his discussion of an evidentiary conflict, he correctly held the Board to the burden of proving Clayton's violation of the standard of care. Accordingly, we overrule Clayton's sixth assignment of error.

{¶ 49} By Clayton's seventh assignment of error, she argues that the trial court erred in affirming the Board's decision to allow Klenke to testify as an expert witness. She also argues that Klenke's participation as a witness biased the Board against her. We disagree with both arguments.

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

{¶ 50} During the trial, Clayton objected to Klenke testifying as an expert witness because Klenke was a member of the Board when the Board initiated its investigation into the complaint regarding Clayton's care of Patient 1. Klenke's term as a Board member ended approximately two years prior to her testimony at Clayton's hearing. Primarily, Clayton asserted that Klenke's prior service on the Board created a conflict of interest. The hearing examiner overruled the objection after Klenke testified that she was not involved in or even aware of the investigation while a Board member. Like the trial court, we perceive no error in this ruling.

{¶ 51} After the close of the hearing, Klenke was reappointed to the Board. Klenke was not present at the Board meeting when Clayton's attorney addressed the Board or when the Board voted to adopt the hearing examiner's report and recommendation with modifications. The Board added to its record a statement that it did "not give[ ] any deferential regard, or heightened weight, to Ms. Klenke's testimony, and accepts that testimony only to the extent that it was incorporated in the Findings of Fact and Conclusions of Law made by the Hearing Examiner." Adjudication Order, at 2. Despite the Board's explicit assurances of impartiality, Clayton now argues that Klenke's participation in the matter biased the Board against her.

{¶ 52} A reviewing court presumes that the decision of an administrative agency is valid and was reached in a sound manner. *West Virginia v. Ohio Hazardous Waste Facility Approval Bd.*, 28 Ohio St.3d 83, 86 (1986); *accord McRae v. State Med. Bd.*, 10th Dist. No. 13AP-526, 2014-Ohio-667, ¶ 42 (" '[A] presumption of honesty and integrity on the part of an administrative body exists, absent a showing to the contrary.' "). To overcome this presumption, an appellant must show that an administrative agency member was biased, partial, or prejudiced to such a degree that the member adversely affected the agency's decision. *ATS Inst. of Technology v. Ohio Bd. of Nursing*, 10th Dist. No. 12AP-385, 2012-Ohio-6030, ¶ 32.

{¶ 53} Here, the Board members explicitly repudiated Clayton's supposition that Klenke unduly influenced the Board's decision. We reject Clayton's argument that the Board's statement actually proves the Board's bias. We think it more likely that the Board definitively declared its impartiality to preempt the very argument that Clayton now

asserts. In any event, Clayton has not established any facts to overcome the presumption of validity. Accordingly, we overrule Clayton's seventh assignment of error.

{¶ 54} For the foregoing reasons, we overrule all of Clayton's seven assignments of error, and we affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

CONNOR and T. BRYANT, JJ., concur.

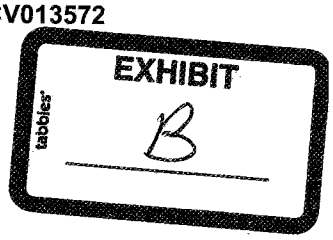
T. BRYANT, J., retired, of the Third Appellate District, assigned to active duty under authority of Ohio Constitution, Article IV, Section 6(C).

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 12:11 PM-13AP000726

Court of Appeals Judgment Entry

Exhibit B

Franklin County Ohio Clerk of Courts of the Common Pleas- 2014 May 23 4:07 PM-12CV013572



IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Beverly Clayton, C.N.P., R.N.,	:	
Appellant-Appellant,	:	
v.	:	No. 13AP-726 (C.P.C. No. 12CV-13572)
Ohio Board of Nursing,	:	(REGULAR CALENDAR)
Appellee-Appellee.	:	

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on May 15, 2014, appellant's assignments of error are overruled, and it is the judgment and order of this court that the judgment of the Franklin County Court of Common Plea is affirmed. Costs assessed against appellant.

KLATT, CONNOR and T. BRYANT, JJ.

T. BRYANT, J., retired, of the Third Appellate District, assigned to active duty under authority of Ohio Constitution, Article IV, Section 6(C).

/S/JUDGE

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 3:49 PM-13AP000726

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 15 3:49 PM-13AP000726

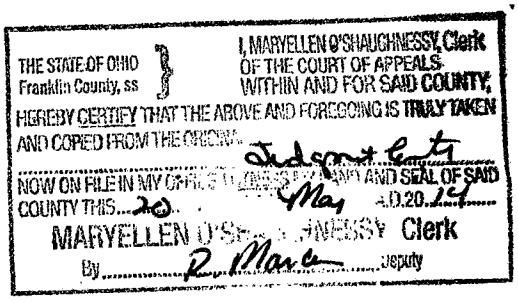
Tenth District Court of Appeals

Date: 05-15-2014

Case Title: BEVERLY CLAYTON CNP RN -VS- OHIO STATE BOARD NURSING

Case Number: 13AP000726

Type: JEJ - JUDGMENT ENTRY

So Ordered

/s/ Judge William A. Klatt