BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **S. WHITNEY STEPHENSON** **10488 E. Alder Creek Road** **Truckee, CA 96161** **Registered Nurse License No. 458757** **Nurse Anesthetist Certificate No. 2623** RESPONDENT	Case No. 2017-228 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about September 27, 2016, Complainant Joseph L. Morris, PhD, MSN, RN, in his official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2017-228 against S. Whitney Stephenson (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about August 31, 1990, the Board of Registered Nursing (Board) issued Registered Nurse License No. 458757 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2017, unless renewed.

3. On or about April 7, 2000[1], the Board of Registered Nursing (Board) issued Nurse Anesthetist Certificate No. 2623 to Respondent. The Nurse Anesthetist Certificate will expire on October 31, 2017, unless renewed.

[1] "Pursuant to Government Code section 11515 and California Evidence Code section 452, the Board hereby takes official notice that the advanced practice certificate listed as Certified Registered Nurse Anesthetist Certificate No. 2623 throughout Accusation Case No. 2017-228 is inaccurate and should be Nurse Anesthetist Certificate No. 2623."

4. On or about September 27, 2016, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2017-228, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record which, pursuant to Business and Professions Code section 136 and/Title 16, California Code of Regulation, section 1409.1, is required to be reported and maintained with the Board, was and is:

10488 E. Alder Creek Road

Truckee, CA 96161.

5. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

6. On or about October 11, 2016, the Board of Registered Nursing received the signed Domestic Return Receipt for the Accusation served by Certified Mail acknowledging receipt on September 30, 2016.

7. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the Accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service of the Accusation upon her, and therefore waived her right to a hearing on the merits of Accusation No. 2017-228.

9. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board after having reviewed the proof of service dated September 27, 2016, signed by Christian Espiritu,

finds Respondent is in default. The Board will take action without further hearing and, based on Accusation No. 2017-228 and the documents contained in Default Decision Investigatory Evidence Packet in this matter which includes:

Exhibit 1: Pleadings offered for jurisdictional purposes; Accusation Case No. 2017-228, Statement to Respondent, Notice of Defense (two blank copies), Request for Discovery and Discovery Statutes (Government Code sections 11507.5, 11507.6 and 11507.7), proof of service, and mail receipt;

Exhibit 2: License History Certification for S. Whitney Stephenson, Registered Nurse License No. 458757, Nurse Anesthetist Certificate No. 2623;

Exhibit 3: Affidavit of Kyong Kim-Wong (Investigator);

Exhibit 4: Affidavit of Bryan Tune (Expert Witness).

The Board finds that the charges and allegations in Accusation No. 2017-228 are separately and severally true and correct by clear and convincing evidence.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent S. Whitney Stephenson has subjected her following license(s) to discipline:

   a. Registered Nurse License No. 458757

   b. Nurse Anesthetist Certificate No. 2623

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's license(s) based upon the following violations alleged in the Accusation, which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case.

   a. Violation of Business and Professions Code section 2761(a) - Unprofessional Conduct.

   b. Violation of Business and Professions Code section 2761(a)(1) - Unprofessional Conduct, Incompetence.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 458757, heretofore issued to Respondent S. Whitney Stephenson, is revoked.

IT IS SO ORDERED that Nurse Anesthetist Certificate No. 2623, heretofore issued to Respondent S. Whitney Stephenson, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on April 13, 2017.

It is so ORDERED March 14, 2017.

Michael D. Johnson

Board of Registered Nursing
Department of Consumer Affairs
State of California

Attachment:

Exhibit A: Accusation No. 2017-228

Exhibit A

Accusation No. 2017-228

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **S. WHITNEY STEPHENSON** **10488 E. Alder Creek Road** **Truckee, CA 96161** **Registered Nurse License No. 458757** **Certified Registered Nurse Anesthetist** **Certificate No. 2623** Respondent.	Case No. 2017-228 **ACCUSATION**

Complainant alleges:

PARTIES

1. Joseph L. Morris, PhD, MSN, RN ("Complainant") brings this Accusation solely in his official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1990, the Board of Registered Nursing issued Registered Nurse License Number 458757 to S. Whitney Stephenson, ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2017, unless renewed.

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3. On or about April 7, 2000, the Board of Registered Nursing issued Certified Registered Nurse Anesthetist Certificate Number 2623 to Respondent. The Certified Registered Nurse Anesthetist Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2017, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

DISCIPLINARY STATUES AND REGULATIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . ."

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care

before it is provided."

11. Section 2827 of the Code states: "The utilization of a nurse anesthetist to provide anesthesia services in an acute care facility shall be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist or podiatrist."

12. Section 2833.5 of the Code states: "Except as provided in Section 2725 and in this section, the practice of nurse anesthetist does not confer authority to practice medicine or surgery."

COST RECOVERY

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

GENERAL STATEMENT OF FACTS

14. On all relevant dates, Respondent was employed as a Certified Registered Nurse Anesthetist ("CRNA") at Kaiser Permanente, San Francisco Medical Center, San Francisco, California.

15. Respondent's practice was pursuant to the Anesthesia Care Delivery Policies and Procedures at Kaiser. (Policy Number: ANS-9001.) These policies included the following:

A. Each anesthesia care team member is expected to know their strengths and weaknesses and to seek consultation accordingly. (Provision 5.1.2)

B. A CRNA is responsible for his or her own professional conduct. (Provision 5.1.5.2)

C. A CRNA does not practice medicine. (Provision 5.1.5.3)

D. A CRNA may develop and implement an anesthetic plan; however, a physician must concur with the anesthetic plan prior to induction. (Provision 5.1.5.5)

E. A CRNA may administer anesthesia only upon the order of a physician, dentist,

podiatrist or clinical psychologist and not pursuant to a standardized procedure. (Provision 5.1.5.10)

F. A CRNA does not have legal authority to order drugs; therefore, a physician on site must place an order to authorize the CRNA to select and administer drugs and devices, and must concur with the Anesthesia Plan prior to induction. (Provision 5.1.5.11)

16. As a result of patient care issues, Respondent was terminated from her position as a CRNA at Kaiser, effective October 28, 2014.

STATEMENT OF FACTS REGARDING PATIENT 1

17. On May 21, 2014, Respondent was the assigned CRNA to Patient 1, a 50-year-old male who was admitted to Kaiser for removal of a pancreatic mass.

18. The surgery lasted for approximately 3.5 hours during which time Respondent administered 7 liters of a crystalloid intravenous solution. The rate of administration was approximately 1 liter per hour. The amount of fluid administered during surgery was excessive and contrary to the surgeon's orders.

19. In an interview with the Division of Investigation ("DOI") on October 27, 2015, Respondent admitted that she had given too much fluid during Patient 1's surgery and that 4 liters of intravenous fluids would have been sufficient.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Administration of Excessive IV Fluids)

20. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), in that on May 21, 2014, she administered excessive intra-operative fluids to Patient 1. The facts in support of this cause for discipline are set forth above in paragraphs 17 through 19.

STATEMENT OF FACTS REGARDING PATIENT 2

21. On July 13, 2014, at 4:53 a.m., Patient 2 delivered her second infant under epidural anesthesia. Post-delivery, Patient 2 experienced significant hemorrhage that was unable to be controlled with medication.

22. At approximately 7:20 a.m., Patient 2 was emergently transported to the operating room for a dilation and curettage. As the on-duty CRNA, Respondent responded to the operating

room. She did not contact the attending in-house anesthesiologist regarding Patient 2's condition, but assumed that he had already been informed.

23. In the operating room, Respondent was unable to administer medication through the existing epidural catheter, as she did not realize it had been capped off. She did not call for assistance from the attending anesthesiologist. Instead, without a physician order, Respondent administered intravenous sedation to Patient 2.

24. In an interview with DOI on October 27, 2015, Respondent admitted that she should not have assumed that the anesthesiologist was aware of the case and should have called for assistance when unable to administer medication through the epidural catheter.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Notify Attending Anesthesiologist)

25. Respondent is subject to discipline for unprofessional conduct pursuant to Code section 2761, subdivision (a), in that she failed to notify the attending anesthesiologist that Patient 2 had been emergently transferred to the operating room for an active post-partum hemorrhage. The facts in support of this cause for discipline are set forth above in paragraphs 20 through 24.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Call for Assistance)

26. Respondent is subject to discipline for unprofessional conduct pursuant to Code section 2761, subdivision (a), in that she failed to call for assistance from the attending anesthesiologist when she was unable to administer medication through Patient 2's existing epidural catheter. Respondent's failure to call for assistance, led her to administer intravenous sedation in an already compromised patient. The facts in support of this cause for discipline are set forth above in paragraphs 20 through 24.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Practice of Medicine)

27. Respondent is subject to discipline for unprofessional conduct pursuant to Code sections 2761, subdivision (a), and 2833.5, in that she administered intravenous sedation to

Patient 2, without physician authorization and in violation of Kaiser's Policy and Procedures. The facts in support of this cause for discipline are set forth above in paragraphs 15 and 23.

STATEMENT OF FACTS REGARDING PATIENT 3

28. On August 15, 2014, Patient 3, a 60-year old male was admitted to Kaiser for elective repair of a metatarsal fracture. Patient 3's medical condition was complicated by hypertension, a history of smoking and asthma. Respondent consulted with the attending anesthesiologist regarding the plan for anesthesia.

29. Patient 3 was intubated and placed under general anesthesia. The surgery was uneventful. Prior to extubation, Patient 3 had a documented bradycardia. Instead of treating the bradycardia, Respondent elected to extubate Patient 3, who then experienced a laryngospasm. Respondent administered a medication in an attempt to break the laryngospasm which led to a further bradycardia. She attempted to ventilate Patient 3, and declined assistance from the attending anesthesiologist, believing that she could handle the incident.

30. Respondent continued in her attempt to ventilate Patient 3 and relied on the monitors that displayed his oxygen saturation was normal. She failed to notice that Patient 3 was blue and cyanotic in appearance. When the attending anesthesiologist returned to the operating room on his own, he then discovered Patient 3's critical condition. He was able to re-intubate Patient 3 (21 minutes after Patient 3 had been extubated). Patient 3 experienced a cardiac arrest and was able to be resuscitated.

31. In an interview with DOI on October 27, 2015, Respondent admitted that she was in panic mode and had "tunnel vision" relying on the monitors for Patient 3's oxygenation. She also admitted that she should have asked for help from the attending anesthesiologist when she first encountered problems extubating Patient 3.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence – Failure to Recognize Signs of Respiratory Arrest)

32. Respondent is subject to disciplinary action for incompetence pursuant to Code section 2761, subdivision (a)(1), in that she failed to recognize the signs and symptoms of respiratory arrest when Patient 3 was extubated. The facts in support of this cause for discipline

are set forth above in paragraphs 28 through 31.

SIXTH CAUSE FOR DISCIPLINE

(Incompetence – Failure to Recognize Need for Assistance from Attending Anesthesiologist)

33. Respondent is subject to disciplinary action for incompetence pursuant to Code section 2761, subdivision (a)(1), in that she failed to recognize Patient 3's critical condition and therefore failed to timely call for assistance from the attending anesthesiologist. The facts in support of this cause for discipline are set forth above in paragraphs 28 through 31.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 458757, issued to S. Whitney Stephenson;

2. Revoking or suspending Certified Registered Nurse Anesthetist Certificate Number 2623, issued to S. Whitney Stephenson;

3. Ordering S. Whitney Stephenson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 27, 2016

for JOSEPH MORRIS, PHD, MSN, RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant