STATE OF MICHIGAN

COURT OF APPEALS

In re CAROLINE JOAN CICHOSKI, RN.

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES,

Petitioner-Appellee,

v

CAROLINE JOAN CICHOSKI, RN,

Respondent-Appellant.

UNPUBLISHED
November 4, 2004

No. 245932
Department of Consumer and Industry Services
LC No. 1999-004974

Before: Griffin, P.J., Wilder and Zahra, JJ.

PER CURIAM.

Respondent appeals as of right from an order of the Department of Consumer and Industry Services Board of Nursing Disciplinary Subcommittee (BNDS) placing respondent on probation as a practicing nurse. We affirm.

I. Basic Facts and Procedure

Respondent is a registered nurse licensed in Michigan. She was terminated from her position at St. John Hospital and Medical Center ("the Hospital") on November 23, 1998, because of a November 13, 1998 incident in which a patient under respondent's care died.

The hospital reported to petitioner that:

> a) On August 12, 1998, pursuant to the Hospital's Work Performance Plan and following a performance review, Respondent entered into a <u>Work Improvement Plan</u> due to Respondent's performance, which was below the minimal standards for the nursing profession.
>
> b) During October 1998, Respondent was cited for three incidents of substandard practice, which included Respondent's inability to evaluate the status and needs of patients, and her failure to administer a medication as ordered.

> c) On November 13, 1998, Respondent cared for Patient 1684442 (number used to protect privacy of patient) who underwent a tracheotomy and who was to be suctioned every 15 minutes. Hospital staff reported the following regarding Respondent's care of Patient 1684442:
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> > i. Respondent gave an update on Patient 1684442's status when she had not evaluated the patient;
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> > ii. Respondent failed to suction the Patient 1684442 every fifteen minutes;
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> > iii. Respondent was unable to determine Patient 1684442's status and failed to call appropriate code after Respondent found the patient to be unresponsive;
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> > iv. Respondent failed to assist staff in resuscitating Patient 1684442 after staff determined that Patient 1684442 was in cardiac arrest;
> >
> > [v]. Staff observed Respondent had not documented the Patient 1684442's ventilator checklist for a one-hour period prior to the patient's cardiac arrest and observed Respondent documenting the list after patient had expired; and,
> >
> > [vi]. Respondent failed to report the November 13, 1998 incident to appropriate staff as required by hospital policy.

Based upon the above report, petitioner then filed an administrative complaint alleging respondent violated MCL 333.16221(a) and (b)(i). MCL 333.16221 provides in relevant part:

> The department may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order relevant testimony to be taken and shall report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee shall proceed under section 16226 if it finds that 1 or more of the following grounds exist:
>
> (a) A violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition that impairs, or may impair, the ability to safely and skillfully practice the health profession.
>
> (b) Personal disqualifications, consisting of 1 or more of the following:
>
> (i) Incompetence.

After conducting hearings, the hearing referee issued a proposed decision recommending that the administrative complaint be dismissed. However, the BNDS rejected the hearing referee's proposed decision and concluded that respondent had violated the standard of care for nursing. On December 20, 2002, the BNDS issued its final order placing respondent on probation.

II. Argument

Respondent argues that the BNDS's decision was not supported by competent, material, and substantial record evidence, and that the BNDS's decision constitutes an abuse of discretion. We disagree.

A. Standard of Review

"Pursuant to Const 1963, art 6, § 28, a court that conducts a direct review of an administrative decision must determine whether the action was authorized by law and if the decision was supported by competent, material, and substantial record evidence." *Motycka v General Motors Corp*, 257 Mich App 578, 580-581; 669 NW2d 292 (2003). The reviewing court "considers the whole record – that is, both sides of the record – not just those portions of the record supporting the findings of the administrative agency." *Michigan Employment Relations Comm v Detroit Symphony Orchestra, Inc*, 393 Mich 116, 124; 223 NW2d 283 (1974). Review is of the agency's final decision, not of a hearing referee's proposal for decision or of the agency's decision to reject that proposal. *Dignan v Michigan Public School Employees Retirement Bd*, 253 Mich App 571, 578; 659 NW2d 629 (2002).

"Substantial evidence is any evidence that reasonable minds would accept as adequate to support the decision; it is more than a mere scintilla of evidence but may be less than a preponderance of the evidence." *Michigan Ed Ass'n Political Action Committee v Secretary of State*, 241 Mich App 432, 444; 616 NW2d 234 (2000). "When there is sufficient evidence, a reviewing court may not substitute its discretion for that of the administrative tribunal even if the court might have reached a different result." *In re Kurzyniec Estate*, 207 Mich App 531, 537; 526 NW2d 191 (1994). The reviewing court must "accord due deference to administrative expertise and not invade the province of exclusive administrative fact-finding." *Michigan Employment Relations Comm*, *supra*. Reversal of an agency's decision for an abuse of discretion requires a result "'so palpably and grossly violative of fact and logic that it evidences not the exercise of will but perversity of will, not the exercise of judgment but defiance thereof, not the exercise of reason but rather of passion or bias.'" *Marrs v Bd of Medicine*, 422 Mich 688, 694; 375 NW2d 321 (1985), quoting *Spalding v Spalding*, 355 Mich 382, 384-385; 94 NW2d 810 (1959).

B. Analysis

The BNDS found that respondent violated the standard of care in several ways on November 13, 1998. On November 13, 1998, respondent was caring for five patients, including an eighty-year-old man with chronic pneumonia and an upper respiratory infection. The patient required an enriched-oxygen tube to breathe. Respondent testified that at about 10:00 p.m., she walked into the patient's room and found him unresponsive. She told her supervisor, Veronica Lynn Joiner, that that she needed help, but Joiner replied she was too busy. Respondent then informed a nearby nurse, Steven M. Aldis, that she needed assistance. Aldis asked if it was "a stat," and respondent replied, "yes, that's a stat, stat, stat." Aldis ran into the room and respondent started suctioning the patient. Respondent testified that she told Aldis that the patient's pulse was weak. However, Aldis testified that he asked respondent for the patient's pulse, and she said, "I don't know." Aldis opined that a patient's pulse is "just one of the basic things that a nurse should do if you suspect that your patient is going into respiratory or cardiac distress." Respondent testified that Aldis yelled "full code" to the desk and, "almost immediately," a respiratory team came in, pushed respondent aside, and took over. "Full code" means that all measures should be taken to sustain a patient's life. Respondent testified that she knew the patient was full code because she only notes on her private records if a patient is not full code. However, Aldis testified that he asked respondent for the patient's code status, but respondent did not know and asked Aldis where to find it. To this Aldis replied, "[y]ou don't find it[,] [y]ou know that," and then told respondent that it should be on the patient's chart. According to Aldis, respondent did not tell him the code status even after being told where to find it. Rather Aldis testified that he asked Joiner for the patient's code status, and she told him that the patient was full code.

Also, the record reflects that there was no ambu bag[1] in the room. Aldis testified that after he started CPR, he asked respondent to get the ambu bag but she did not know where it was. There was testimony that the "nurse who was assigned to the patient has ultimate responsibility of how that room is set up to handle the patient that is in that room." An ambu bag was eventually obtained and Joiner administered the ambu bag. Aldis asked respondent to start an IV, but "she was just standing there saying, you know, 'Oh, my God. Oh, my God. Oh, my God.'" Respondent did not start an IV, but instead, a member of the IV team happened to be coming down the hall and started the IV. Respondent seemed "scared, frazzled, insure [sic] of what to do."

Further, there was evidence that respondent improperly filled out the patient's ventilator checklist. Respondent understood that the patient was supposed to be assessed every fifteen minutes to determine whether he needed a ventilator, and that she was to make entries on the checklist when she made the assessments. She testified that all but one entry were made before the code situation. The checklist indeed included respondent's initials at fifteen minute intervals from 9:00 p.m. to 10:00 p.m., the hour before the patient was found in distress. Joiner testified that she saw respondent writing on the checklist after the code had been completed. While Joiner's observation may only prove that respondent was updating the checklist for the time during the incident, nurse Kathleen Hempton testified that respondent informed her days after the code incident that respondent had filled in the information on the checklist for the period from 9:00 p.m. to 10:00 p.m.

In regard to the November 13, 1998 incident, the BNDS found that respondent (1) failed to communicate the emergency nature of her requests for help with the patient; (2) did not know the patient's "code status" or have that information readily available; (3) failed to ensure that an "ambu bag" was in the patient's room and did not know where to locate one; (4) was not sufficiently functional during the resuscitation attempts; and (5) inappropriately filled out the

[1] "A self-inflating bag (containing foam rubber in its walls), used to assist respiration during resuscitation." Schmidt, Attorneys' Dictionary of Medicine, p A-275.

patient's ventilator checklist after the patient died. We conclude these findings are supported by competent, material, and substantial evidence of record. *Motycka*, *supra*. Thus, even if this Court might have reached a different result, we must "accord due deference to administrative expertise and not invade the province of exclusive administrative fact-finding." *Michigan Employment Relations Comm*, *supra*. Accordingly, because expert testimony was presented indicating that respondent's conduct was substandard in regard to each of the above findings, we conclude that the BNDS did not abuse its discretion deciding that respondent violated MCL 333.16221(a) and (b)(i).

The BNDS's decision was also based on "three incidences of substandard practice" cited by Dr. Roopal E. Thakkar, a resident at the hospital where respondent was employed. Notably, this evidence was presented through deposition testimony, and respondent did not testify regarding these incidents. On one occasion, respondent called Dr. Thakkar because a patient's blood pressure was too high. When Dr. Thakkar returned the call and asked respondent for the specific pressure reading and the patient's medication, respondent did not know. Also, Dr. Thakkar testified that respondent called him four to five hours later and stated that she had forgotten to give the patient his blood pressure medication that evening.

The second incident involved respondent calling Dr. Thakkar and asking how to calm an agitated patient. Dr. Thakkar asked respondent what medication the patient was taking, and she did not know. Dr. Thakkar then went to check on the patient. He found the room had all its lights on and the television volume loud. After Dr. Thakkar turned off the lights and television, the patient was calm.

In the third incident, respondent informed Dr. Thakkar that she was going to send an obviously bloody stool sample for an occult blood test. This test determines whether the stool contains blood. Thus, Dr. Thakkar testified that the test was unnecessary, and that respondent improperly attempted to order the test without a doctor's authorization.

We conclude that reasonable minds would not accept as adequate *all* the above instances of substandard conduct as violative of the standard of care.[2] However, respondent's failure to timely administer blood pressure medication to a patient violates the standard of care. Thus, this finding of substandard practice is supported. Moreover, the record reflects that respondent was concerned about the patient's elevated blood pressure, but that this concern did not indicate to her that she had forgotten to medicate the patient. The record thus also supports a finding of incompetence. MCL 333.16221(b)(i).

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[2] First, the BNDS did not expressly find the second incident (the agitated patient) violative of the standard of care. Second, in regard to the first incident, there is evidence that Dr. Thakkar did not immediately return respondent's call, and for this reason, plaintiff's expert could not definitively state that respondent's failure to recall the patient's blood pressure or medications violated a standard of care. Third, respondent only requested that Dr. Thakkar give permission for a occult blood test. While ordering the test may have been improper, we cannot conclude that respondent acted improperly by merely requesting Dr. Thakkar order the test. Dr. Thakkar possessed sole control of whether the test was done, and respondent's request was merely ministerial.

Finally, we address respondent's argument that the BNDS abused its discretion by rejecting the hearing referee's proposal for decision in her favor that was supported by competent, material, and substantial evidence. This argument runs contrary to the understanding that review is of the agency's final decision, not of a hearing referee's proposal for decision or of the agency's decision to reject that proposal. *Dignan*, *supra*. And assuming, without deciding, that the hearing referee's proposal for decision is supported by competent, material, and substantial evidence, we cannot conclude that the BNDS committed error or abused its discretion. An agency is "free to accept, reject, or modify the referee's proposal." *Id*. "It does not matter that the contrary position is supported by more evidence, that is, which way the evidence preponderates, but only whether the position adopted by the agency is supported by evidence from which legitimate and supportable inferences were drawn." *McBride v Pontiac School Dist*, 218 Mich App 113, 123; 553 NW2d 646 (1996). Here, the disciplinary subcommittee's findings were sufficiently supported, *supra*, and regardless whether the hearing referee's proposed decision was likewise supported, we cannot conclude that the BNDS committed error or abused its discretion in disciplining respondent. MCL 333.16226(1).[3]

Affirmed.

/s/ Richard Allen Griffin
/s/ Brian K. Zahra
/s/ Kurtis T. Wilder

[3] Under MCL 333.16226(1), "probation, limitation, denial, suspension, revocation, restitution, community service, or fine" are appropriate sanctions for violation of MCL 333.16221(a) and (b)(i).