EDMUND G. BROWN JR., Attorney General
of the State of California
WILBERT E. BENNETT
Supervising Deputy Attorney General
DIANN SOKOLOFF, State Bar No. 161082
Deputy Attorney General
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2212
Facsimile: (510) 622-2270

Attorneys for Complainant

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>AIMEE BETH GARRIS<br>1914 North Hoover Drive<br>Los Angeles, CA 90027<br>Registered Nurse License No. 565048<br><br>Respondent. | Case No. 2009-290<br><br>**ACCUSATION** |

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) is the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, and brings this Accusation solely in her official capacity.

2. On or about March 14, 2000, the Board of Registered Nursing ("Board") issued Registered Nurse License Number 565048 to Aimee Beth Garris (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2010, unless renewed.

JURISDICTION

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

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

5. 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.

6. Section 125.3 of the Code provides, in pertinent part, that the Board of Registered Nursing 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.

**DRUGS**

7. **"Tissue Plasminogen Activator (tPA)"** - is an enzyme that helps dissolve clots. It is a systemic thrombolytic (clot-busting) agent and is used in the treatment of heart attack and stroke. It is a dangerous drug pursuant to Section 4022 of the Business and Professions Code.

CAUSE FOR DISCIPLINE

(Gross Negligence)

8. On December 24, 2004, while employed as a registered nurse, and serving as a stroke patient's primary nurse, in the Emergency Department at the Kaiser Permanente Medical Center, in Santa Clara, California, respondent was grossly negligent in providing nursing care to the stroke patient, who died two days later. Included within this conduct is that respondent failed to follow Kaiser's policy and procedure for stroke patients that tPA medication must be calculated according to appropriate dose given and the remainder must be withdrawn from the vial and discarded prior to administration. As a result of respondent's failure to withdraw the excess medication (tPA 32.5 mg) from the vial, the patient died from medication

over dosage by another registered nurse, after receiving tPA 100 mg instead of tPA 67.5 mg, as ordered by the physician. The circumstances are hereinafter set forth. On the occasion in question, a physician at Kaiser-Santa Clara Emergency Department diagnosed a patient as having a stroke and ordered a total of tPA 67.5 mg. to be administered to the patient. Ten percent, or 6.75 mg., was to be administered as a bolus over one minute, and 60.75 mg. was to be given over fifty-nine minutes. Just before 1900 hours, respondent, who was the stroke patient's primary nurse, combined the tPA powder with 100 mls. water and hung the solution via intravenous piggy back. Respondent administered tPA 6.75 mg. as a bolus over one minute, and then programmed the pump to administer the remaining prescription dose of tPA over fifty-nine minutes. During the tPA infusion process, respondent turned care of the stroke patient over to Trushna Khatri, R.N. and then respondent went on a break. Prior to the completion of the tPA administration, the Charge Nurse, Kathleen Herring, re-assigned Khatri to another patient and Herring took over care of the stroke patient. After the sixty-minute infusion time elapsed, the alarm sounded to alert staff that the preset amount of tPA had infused. When the alarm sounded, Herring inappropriately responded to the alarm by re-starting the pump, and thereby increasing the amount of medication to be infused by approximately 32.5 mg (the amount remaining in the vial), without receiving a report on the patient, reviewing the physician's order, or checking with the primary nurse. By 2035 hours, the stroke patient's blood pressure became elevated, the patient began experiencing neurological deficits, was drowsy and unable to answer simple questions. The patient was transferred back to the Intensive Care Unit on December 25, 2004, and died on December 26, 2004. The cause of death was listed as, "Intracranial bleed due to Ischemic Stroke due to hypertension."

9. Respondent's conduct, in failing to follow hospital policy and procedure for tPA administration by discarding excess medication prior to administration, as set forth in paragraph 8 above, constitutes gross negligence and provides grounds for disciplinary action under Code section 2761(a)(1).

///

///

## 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 565048, issued to Aimee Beth Garris;

2. Ordering Aimee Beth Garris 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;

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

DATED: 5/11/09

RUTH ANN TERRY, M.P.H, R.N.
Executive Officer
Board of Registered Nursing
State of California
Complainant

SF2008402953

Garris Accusation.wpd