BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE ALASKA BOARD OF NURSING

In the Matter of	)	
	)	
DEBRA RENA GRACIANI	)	OAH No. 20-0083-NUR
	)	Agency No. 2016-000744

DECISION

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I. Introduction

In this licensing action, the Division of Corporations, Business and Professional Licensing asks the Board of Nursing to revoke Rena Graciani's nursing license. The allegations against Ms. Graciani can be roughly categorized as allegations that:

(1) Ms. Graciani intentionally falsified patient records;

(2) Ms. Graciani ignored written orders or substituted her own judgment for that of independent practitioners as to matters outside the scope of her license;

(3) Ms. Graciani engaged in such hostile behavior towards colleagues as to implicate the Board's definition of unprofessional conduct; and

(4) Ms. Graciani improperly accessed, kept, and stored confidential patient health information.

Following a lengthy hearing and extensive post-hearing briefing, this decision concludes that the Division met its burden of proving significant unprofessional conduct across all four areas

identified above. Particularly in light of her repeated dishonesty and repeated failure in multiple contexts to acknowledge missteps or mistakes, the Division has met its burden of showing that revocation of Ms. Graciani's nursing license is appropriate here.

II. Background and Hearing

A. Overview

Rena Graciani received her nursing degree from the University of Alaska – Anchorage and was licensed as a registered nurse in July 2011. She began working as a dialysis nurse shortly after graduating, first at Fresenius Medical Care, then at Denali Dialysis, and finally at Providence Alaska Medical Center.

Providence terminated her in November 2016 for issues surrounding the transfer of care of a critically ill dialysis patient who died a few hours after the transfer. In 2018, following a successful grievance and arbitration of the termination, she returned to Providence as an ICU nurse. She continues to hold that position, although she was on a medical leave at the time of the hearing.

Ms. Graciani came to the Division's attention in 2016 following a colleague's complaint, and then through a mandated report to the Board from Providence upon her termination.[1] After her reinstatement, the Division received another complaint, described in detail below, that Ms. Graciani had falsified an order for a lab test.[2] These complaints led to the investigation and accusation described next.

B. Investigation and Accusation

The Division began receiving complaints against Ms. Graciani six months before her November 2016 termination. The initial complaint, submitted by a coworker, alleged medication errors and failure to follow physician orders.[3]

The matter was initially assigned to and investigated by Joanna Williamson, who conducted witness interviews in the fall of 2016. Those interviews of Providence dialysis nurses, the dialysis unit patient care technician, and the manager of the dialysis unit revealed that Ms. Graciani's colleagues had numerous concerns about disrespectful workplace behavior with other

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1 Ex. 16; Ex. 18; Bautista test.; Tracey test.

2 Ex. 98.

3 Ex. 18; Ex. 13; Tracey test.; Bautista test; Ex. 54.

nurses as well as hospital staff, and about whether she had failed to act in her patients' best interests or had countermanded physicians' orders.[4]

In November 2016, while the Division's investigation was ongoing, Providence terminated Ms. Graciani after a handoff communication incident that will be discussed in detail below. Ms. Graciani's union grieved her termination, and she was later ordered reinstated. In December 2019, the Division received a new complaint about Ms. Graciani, alleging she had falsified a doctor's order for a lab test.[5]

The Division filed an Accusation on January 7, 2020. After amendments during the pre-hearing and hearing phase of this case, the operative Third Amended Accusation alleges six counts of misconduct across four broad subjects – patient care/nursing decisionmaking, falsification of a patient record, hostile and disruptive behavior, and improper access and/or handling of confidential patient records.

C. Hearing

After the Division filed its original accusation, Ms. Graciani timely filed a notice of defense. Thereafter, however, the administrative proceeding was stayed for more than a year as the parties attempted to resolve the case without a hearing. Those efforts were unsuccessful, and in July 2021 the parties agreed to set the matter for hearing in October 2021.

The hearing began as scheduled, but after five days of hearing the parties agreed to continue the matter to do additional discovery on claims pertaining to Ms. Graciani's time at Providence after her reinstatement. The hearing then resumed in February 2022. In all, nineteen days of hearing were held at which, in addition to Ms. Graciani, 31 witnesses testified.

The hearing concluded on February 24, 2022. The parties submitted post-hearing briefs on March 29, 2022, and the matter was submitted for decision.[6]

III. Facts

As noted at the outset, this case involves a number of factual allegations across a wide span of topics. For purposes of organization and clarity, the discussion below first addresses allegations involving patient care (including associated records falsification), then allegations

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4 Ex. 51, 52, 53, 54, 58, 59, 60, 61, 62, 63.

5 Ex. 98.

6 Both parties stipulated to extend the AS 44.64.060 proposed decision deadline in this matter in light of the factual complexity and extent of the record.

concerning disruptive and disrespectful workplace behavior, and, finally, allegations involving improper access to or handling of confidential patient records.

A. Allegations Involving Patient Care

1. October 2016 handoff incident (Patient M.L.)

Perhaps the most serious allegations against Ms. Graciani in this proceeding stem from the October 2016 incident that initially led to her termination by Providence. The termination itself concerned Ms. Graciani sending a critically ill dialysis patient back to the patient's home floor without first conducting a "handoff communication" with that patient's primary nurse. The patient coded shortly after returning to the home unit and died later that night.

What was unknown at the time of her termination and at the time of the arbitration, however, is that Ms. Graciani altered data in the patient's electronic medical record shortly after the patient coded. Both the handoff incident and the data alteration are described below.

a. M.L.'s status before and after October 8, 2016 dialysis

M.L. was a critically ill 66-year-old woman who had been hospitalized for nearly two weeks following a myocardial infarction, and who had begun dialysis for acute renal failure.[7] M.L. was housed in Providence's Intermediate Care Unit (IMCU).

Throughout her hospital stay her systolic blood pressure had dipped as low as 82 but usually ranged between 94 and 97, while her diastolic pressure dipped as low as 42, but more typically ranged between 54 and 62.[8]

The events in question occurred on October 8, 2016. Earlier in the day, M.L.'s blood pressure was recorded as ranging from 111/65 at 3:24 a.m., to 103/62 at 7:24 a.m., and to 97/61 at 11:29 a.m.[9] At noon, nurse Ben Jack, the IMCU nurse assigned to care for M.L. that day, had noted she was "lethargic" and "slightly drowsy [but] easily aroused."[10]

M.L. arrived at the Providence dialysis suite from the IMCU at 14:51, breathing room air and in no acute distress.[11] At 17:14, she became hypotensive, with blood pressure dipping to 93/37.[12] Ms. Graciani, assigned as her dialysis nurse for the day, infused albumin per the

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7 Ex. DN, p. 1; Ex. BP, p. 1; Ex. 92.

8 *See* Ex. DO (9/28/16 pressures over the course of the day as follows: 101/55, 110/54, 110/62, 82/58, 106/42, and 94/60).

9 Ex. BP, p. 1.

10 Ex. BP, pp. 14, 17.

11 Ex. BP, p. 12.

12 Ex. BP, p. 2.

patient's prescribed protocols.[13] M.L.'s blood pressure rose to 99/58 by 17:24, and was 95/66 at 17:45. At 18:08, the record reflects, the dialysis treatment ended.[14]

M.L. remained in the dialysis suite with her vitals being tracked by telemetry equipment for nearly 40 minutes.[15] At 18:42, she departed the dialysis suite in a wheelchair with a member of the hospital transport team.[16]

b. Handoff expectations

Both hospital policy and the standard of care require that a nurse returning a patient to the patient's home floor after a procedure communicate directly with the receiving floor nurse prior to ending oversight of the patient.[17] Ideally this takes the form of an "S-B-A-R" report – that is, a summary of the patient's situation, background, assessment, and recommendations.[18] The expectation to complete a handoff during patient care is taught as part of nursing education and is standard in the profession.[19] The nurse who is "sending" the patient (i.e. the nurse currently with the patient) is responsible for initiating handoff communication, and handoff communication should occur before the patient leaves that nurse's care.[20]

Although M.L. remained in the dialysis suite for nearly forty minutes after her treatment ended, Ms. Graciani did not make a handoff communication before turning over care of M.L. A preponderance of the evidence establishes that she did not call either Mr. Jack or the IMCU charge nurse before returning M.L. to the IMCU. Although Ms. Graciani testified that she called Jack's internal "SpectraLink" phone, he testified that his phone never rang. Given the many areas in which Ms. Graciani gave testimony that lacked credibility, her self-serving testimony on this issue is less credible than Mr. Jack's.[21] Moreover, it is undisputed that Ms. Graciani did not

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13 Ex. BP, p. 9.
14 Ex. BN, p. 1; BP, p. 9.
15 Graciani test.
16 Ex. BP, pp. 6-7.
17 Doyle test.; Franz test.; LeFleur test.; Ex. 27 (handoff policy); Ex. 20, p. 15 (arbitrator's findings).
18 Franz test.; Doyle test.
19 Jack test.; Doyle test.
20 Doyle test; Ex. 27: Handoff Policy.
21 Late in the hearing, Ms. Graciani introduced a copy of M.L.'s hemodialysis order sheet with her handwritten notes from October 8, including vital signs ("97/64/71") and "1856 Ben, RN – 2-4008." Ms. Graciani has suggested these notes are evidence that she called Mr. Jack around 1855 for a handoff. However, phone logs show that 1855 was the time of a SpectraLink phone call *into* the dialysis unit. Ex. 103; LeCrone test. This was more likely than not Mr. Jack's call to Ms. Graciani when the patient returned to IMCU. Another call was then made *from* the dialysis suite to the main IMCU desk phone (240008) at 18:57, but that call occurred after Mr. Jack's call to the dialysis suite. *Id.* As to the content of this record, while the handwritten notes, if accurate, may show what information Ms. Graciani intended to provide to Mr. Jack, or even what information she provided once he reached her, they do not explain or mitigate her failure to provide handoff communication before the patient left the

talk to Mr. Jack before sending the patient back, and that she never called the charge nurse (Emily Anderson), as would have been appropriate if unable to reach the assigned nurse.

c. M.L.'s decompensation and death

Mr. Jack was surprised to see his patient returned to the floor without notice or any report from the dialysis unit.[22] He observed that the patient appeared significantly worse than earlier in the day – she was weak and complaining of dizziness when he met her in the hallway. She was "noticeably more" lethargic than earlier in the day.[23] Mr. Jack and a CNA began transitioning M.L. to her bed, and the CNA took her vitals. While Mr. Jack was examining her, M.L. became unresponsive.[24]

Mr. Jack called the dialysis suite trying to understand what had happened to the patient in the intervening hours. He spoke briefly with Ms. Graciani before having to abruptly discontinue the call because M.L. coded.[25] When reached by Mr. Jack, Ms. Graciani reported how much fluid had been taken off in dialysis, that the patient was hypotensive and on oxygen, and that the patient's physician was aware of the hypotension.[26]

CPR was performed at 18:59 – seventeen minutes after the patient left the dialysis suite.[27] The patient was stabilized and transferred to the ICU but coded again and died a few hours after arriving to the ICU.[28]

d. Hospital investigation into handoff incident

Emily Anderson, the IMCU charge nurse and Mr. Jack's supervisor, submitted a safety incident report about the lack of handoff communication regarding this critically ill patient.[29] In Ms. Anderson's view, not having a proper handoff communication had impeded decisionmaking because there was a piece of the puzzle – information about the patient's condition during dialysis – missing during an evolving situation with a rapidly deteriorating patient.[30]

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dialysis suite – nor, as discussed below, her alteration of the patient's medical record to delete critically low vital signs recorded shortly before the patient left the dialysis unit.

22 Jack test.; Ex. BP, p. 4.

23 Jack test.

24 Jack test. and Ex. 68.

25 Jack test.

26 Ex. 31, p. 1.

27 Ex. BP, p. 4.

28 Anderson test.; Doyle test,; Ex. BP, p. 4.

29 Doyle test.

30 Anderson test.

Carrie Doyle, who in 2016 was Providence's Staff Director and Director for Clinical Practice and Research, investigated the incident along with Brenda Franz, Clinical Director of Medical Surgical Services, and Eirik McFerrin, the Dialysis Unit Manager. [31]

Three days after the incident, Ms. Doyle and Ms. Franz interviewed Ms. Graciani about the incident, as well as about her understanding of handoff procedures, and the steps she takes when handoff is called for.[32] Ms. Graciani was evasive during the interview, not answering the questions being asked and denying any recollection of recent conversations on similar topics.[33] (She would later display the same patterns in her testimony before this tribunal). However, after the meeting Ms. Doyle had "no doubt" that Ms. Graciani "understood the process for completing handoff communications" – namely, an SBAR report with at least blood pressure, how much fluid had been removed during dialysis, and whether anything had been given for low blood pressure.[34]

As to the incident with M.L., Ms. Graciani reported having difficulty reaching the patient's nurse, but also reported making no attempt to speak to the charge nurse to complete a proper handoff before returning the patient, even though the patient was returning with a lower systolic blood pressure than when she arrived. She also suggested that Mr. Jack's call to her after the patient was back on her home floor at the IMCU could be characterized as her handoff.[35]

Ms. Graciani informed the interviewers that she does not hold patients back in the dialysis suite until she is able to complete a handoff because holding patience can cause delays. She cited management pressure to keep the suite running efficiently.[36] Accordingly, Ms.

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31 Ms. Doyle was involved because she was the administrator on call at the time of Ms. Anderson's report. Ms. Doyle now goes by her married name of Carrie Peluso, but was Carrie Doyle at the time of the events in question and at the start of the hearing in this case, so is referred to thusly to avoid confusion.

32 Doyle test; Franz test.; Ex. 30-31.

33 Doyle test.; Ex. 31, pp. 1, 2 (Referencing a recent prior supervisory discussion on handoff communication: "RG did not appear to recall the conversation. The date was given to RG and the statements about handoff communication were read verbatim to her.").

34 Doyle test.

35 Ex. 30-31, p. 2.

36 Ms. Doyle recalls this statement being made in the context of holding a patient back until a handoff can be made was delaying Ms. Graciani from going home at the end of her shift. Ms. Graciani claims that she did not hold patients because of managerial pressure to avoid delays in the suite's workflow and treatment of subsequent patients.

Graciani's practice was to return patients to the home unit even if contact with the patient's nurse had not been made.[37]

Ms. Doyle's contemporaneous notes reflect, and both Ms. Franz and Ms. Doyle testified, that Ms. Graciani described the added handoff step of trying to track down a charge nurse as "a hassle," and something she no longer attempts to do.[38] Ms. Doyle testified that she remembers the statement even years later "because it was so egregious."[39] Additionally, Ms. Doyle was struck by what she saw as the willfulness of Ms. Graciani's violation of protocol, noting that while errors happen in healthcare, "in this case she knew what should happen with handoff communication and didn't do it."[40]

Providence placed Ms. Graciani on administrative leave after the interview. She was terminated on November 1, 2016, although, as discussed below, was later ordered reinstated.[41]

e. Belatedly-discovered evidence of medical record misconduct

Undiscovered at either the time of these events or during the labor arbitration that led to her reinstatement, the evidence at hearing established that – in addition to failing to conduct a handoff and entering "handoff given" to describe the call she received from Mr. Jack after the patient was back in his care – Ms. Graciani deleted the evidence of M.L.'s hypotensive status in the dialysis suite, replacing those vitals with figures that were not generated by the dialysis or telemetry equipment.[42]

Providence Hospital maintains patient medical records in electronic form in a software system called "Epic." Exhibit BP is M.L.'s October 8, 2016 medical records from Providence's Epic system. It documents vital signs recorded by Providence equipment and validated by nursing staff or others, including the vital signs recorded while M.L. was in dialysis under Ms.

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37 Doyle test.; Ex. 31, p. 1. In her post-hearing brief, Ms. Graciani claims that her union representative testified that he "works in a similar situation Ms. Graciani was working when she was in the dialysis unit since he works in oncology and he never does a full SBAR" handoff. However, Mr. Peacott, who works in radiation oncology, clarified that he does a handoff phone call 100% of the time when a patient under his care requires medical intervention, even administration of pain medication, and that he would do a "full SBAR" if an adverse event occurred. In other words, Mr. Peacott's testimony does not support the notion that pre-transfer handoff communication is not required in the dialysis setting, let alone where, as here, the patient had a significant change in vitals during the course of her time under Ms. Graciani's care.

38 Doyle test; Franz test.; Ex. 30-31.

39 Doyle test.; Ex. 30-31. Ms. Doyle's impression from the meeting was that Ms. Graciani admitted not performing handoff in M.L.'s case in the way she had described that one should be performed.

40 Doyle test.

41 Ex. 32.

42 Ex. 101 and Phillip Miller testimony.

Graciani's care.[43] As the chart below shows, between 17:10 and 18:08, five sets of vital signs are displayed. But in the 18:08 column, the recordings for pulse and blood pressure are empty, even though another entry – the Mean Arterial Pressure (MAP), which is automatically computed based on pulse and blood pressure – is reported.[44]

Devices Testing Template - Sat October 08, 2016

Row Name	1808	1744	1729	1714	1710
Device Data					
Pulse	—	70 -DG	71 -DG	70 -DG	62 -DG
BP	—	95/66 -DG	99/58 -DG	(!) 93/37 -DG	93/57 -DG
MAP	52 mmHg -DG	75 mmHg -DG	82 mmHg -DG	69 mmHg -DG	67 mmHg -DG
Recorded by	[DG] Debra Rena R Graciani, RN 10/08/16 1917	[DG] Debra Rena R Graciani, RN 10/08/16 1750	[DG] Debra Rena R Graciani, RN 10/08/16 1750	[DG] Debra Rena R Graciani, RN 10/08/16 1750	[DG] Debra Rena R Graciani, RN 10/08/16 1750
Post-Hemodialysis Assessment					

Reviewing Exhibit 92, a different exhibit consisting of screenshots from M.L.'s electronic medical records in Epic, Division expert Joseph LaFleur testified that a mark in certain cells of the vital signs flowsheet signified that the contents of those cells had been manually altered. Specifically, as to vital signs measured between 18:00 and 18:48, Mr. LaFleur testified that the triangular marks in the top corners of the pulse and blood pressure cells for the 18:08 entry (the second column in the screenshot below) signified that those entries had been manually altered:

		36.6 (97.9)	36.8 (98.2)
73	71	71	66
18	18	18	26
			98
94/65	97/64	97/64	92/64

[45]

Ms. Graciani's union representative, who had served as an Epic trainer, concurred with this interpretation.[46]

Ms. Graciani testified that she did not know why the 18:08 vital signs data in Exhibit BP was blank. When asked if it was blank because she had deleted the blood pressure numbers in that row, she responded: "You need a blood pressure and a pulse to calculate a MAP. Why that information is blank, I do not know." As to Exhibit 92, Ms. Graciani denied having any knowledge of the data being manually changed.[47]

On rebuttal, the Division presented the testimony of Phillip Miler, Providence's Alaska Region Executive Director for Clinical Informatics. In response to questions that had arisen

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43 Ex. BP.

44 Ex. BP, p. 2.

45 Ex. 92, p. 5. The screen shot reproduced here shows the entries for 18:00, 18:08, 18:42, and 18:48.

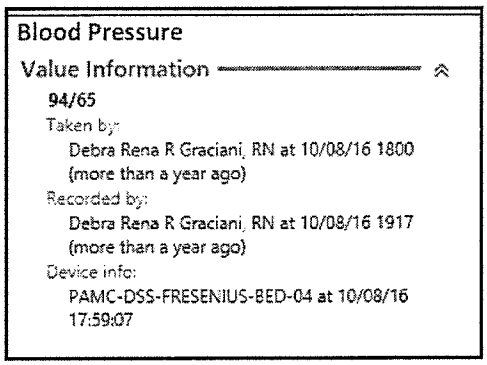
46 Peacott test.

47 Graciani test.

from Mr. LeFleur's observation about the triangular markings on the 18:08 entry, Mr. Miller accessed and reviewed the flowsheet's edit history, through which the software records data about all entries made. Mr. Miller offered persuasive testimony and documentary evidence establishing that Ms. Graciani had, in fact, manually edited the 18:08 vital sign readings, and had done so after the patient had coded.[48]

Mr. Miller explained that the patient's vitals were measured and automatically recorded by the dialysis bed at a set frequency (at least every few minutes). Those measurements are automatically transmitted into the Epic system. When charting for the patient, the nurse reviews the vitals that were recorded, and selects particular readings to validate for entry into the chart.[49] The data that was collected but not validated is discarded within a short period.

As to data that is validated, the Epic system records not only the reading that was validated, but also when and how it was measured, when it was validated, and who validated it. In the case of an unaltered piece of data, for example the blood pressure measured at 18:00, the edit history shows the following:


Blood Pressure
Value Information
94/65
Taken by:
Debra Rena R Graciani, RN at 10/08/16 1800 (more than a year ago)
Recorded by:
Debra Rena R Graciani, RN at 10/08/16 1917 (more than a year ago)
Device info:
PAMC-DSS-FRESENIUS-BED-04 at 10/08/16 17:59:07

This data tells future users that M.L.'s blood pressure of 94/65 was measured by Providence's Fresenius Bed No. 4 at 18:00, and that Ms. Graciani validated that measurement into M.L.'s electronic medical record at 19:17.

For the blood pressure measured at 18:08, however, the edit history shows both an original value measured by the machine, and a substitute value later entered by Ms. Graciani. In particular, the audit shows that at 18:08, the Fresenius Bed No. 4 measured M.L.'s blood pressure as 63/46 – a value displayed in red and with a warning marker in Epic. Ms. Graciani verified that reading in Epic at 19:17 – about twenty minutes *after* the call from Mr. Jack telling

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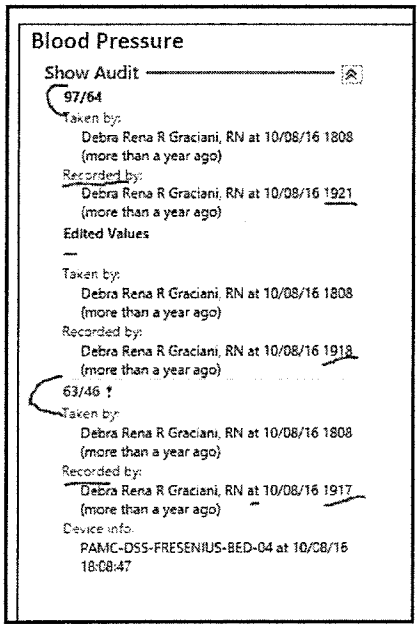
[48] Ms. Graciani would have been aware of the code because the announcement is audible throughout the hospital. Graciani test. Additionally, she was on the phone with Mr. Jack at the time the patient coded. Jack test.

[49] P. Miller test., and Ex. 101, pp. 21-22.

her the patient was nonresponsive. One minute later, she deleted the reading. And at 19:21, she replaced it with numbers that had not been recorded by the dialysis machine – replacing the patient's hypotensive reading of 63/46 with a normal blood pressure of 97/64. [50]

Also at 19:21, she added a note indicating that she had rechecked the patient's blood pressure after adjusting the BP cuff.[51] However, the 97/64 figure was not generated by the Fresenius machine.[52]


Blood Pressure
Show Audit
97/64
Taken by:
Debra Rena R Graciani, RN at 10/08/16 1808
(more than a year ago)
Recorded by:
Debra Rena R Graciani, RN at 10/08/16 1921
(more than a year ago)
Edited Values
—
Taken by:
Debra Rena R Graciani, RN at 10/08/16 1808
(more than a year ago)
Recorded by:
Debra Rena R Graciani, RN at 10/08/16 1918
(more than a year ago)
63/46 !
Taken by:
Debra Rena R Graciani, RN at 10/08/16 1808
(more than a year ago)
Recorded by:
Debra Rena R Graciani, RN at 10/08/16 1917
(more than a year ago)
Device info:
PAMC-DSS-FRESENIUS-BED-04 at 10/08/16 18:08:47

Additionally, the pulse and blood pressure Ms. Graciani entered into M.L.'s chart at 18:42 – the last measurement before the patient left the dialysis suite – were manually entered values, as opposed to values automatically derived from a machine and then validated by an Epic user.[53]

The Epic Audit trail reveals additional information as well. While M.L. was in dialysis, Ms. Graciani last accessed her chart at 17:53 – fifteen minutes before the hypotensive episode at 18:08.[54] After M.L. left the dialysis suite, Ms. Graciani accessed her chart from 18:43 – 19:30.[55]

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50 Ex. 101, p. 2; P. Miller test. Ms. Graciani also replaced the measured pulse (changing it from 70 to 71) but did not change the Mean Arterial Pressure automatically calculated by the dialysis machine. According to Mr. Miller, the formula used by that machine to calculate MAP is (systolic blood pressure + (2 x diastolic blood pressure)/3). Ex. 101, p. 4. As shown on Exhibit BP, ML's MAP of 52, based on calculations performed automatically using the machine's original readings, remained in the chart. Ex. 101, p. 2.

51 Ex. 101, p. 9 (The comment, entered at 19:21 but put into the comments section of the 18:08 record, reads: "tx ended, BP cuff adjusted/re-checked, pt NAD" – in other words, treatment ended, blood pressure cuff adjusted and rechecked, patient in no acute distress).

52 *See* Ex. 101, p. 2.

53 Ex. 101, p. 2.

54 Ex. 101, p. 17-20.

55 Ex. 101, pp. 11-17.

It was during this time that she was called by Ben Jack (at 18:55), and then at 19:18 deleted the 18:08 hypotensive blood pressure reading. At 19:23, she charted that Mr. Jack had not been available for handoff when she sent the patient back to her home floor.[56] She then accessed M.L.'s chart again from 20:00 – 20:37.[57]

Had the information presented by Mr. Miller been available at the time of the arbitration, the result of that proceeding, which is discussed in the next section, may well have been different.

f. Arbitration and Reinstatement

Ms. Graciani's union grieved her November 2016 termination, and the matter ultimately went to arbitration in August 2017. After a two-day arbitration hearing with both the hospital and the union represented by counsel, the arbitrator found:

- Effective, interactive handoff communications fulfill a critical hospital objective.[58]
- Ms. Graciani was on notice "of the hospital's expectation that she would engage in a handoff communication when sending a patient back to another unit," and, that that handoff "should precede the exchange of responsibility" for the patient.[59]
- While the hospital had been "lax in overseeing compliance with its expectations" regarding what to do in handoff communication if unable to reach the primary nurse, Ms. Graciani was aware of the requirement "to complete handoffs prior to releasing a patient to a receiving nurse."[60]

However, because of the hospital's historical disciplinary approach to handoff concerns, and because Ms. Graciani's disciplinary history only included one prior "handoff" concern – namely, a pair of January 2016 incidents, discussed below, in which Ms. Graciani did not notify her patients' assigned nurses that she had not administered a prescribed antibiotic – the arbitrator found that the hospital had not properly followed its progressive discipline policy in terminating her for the handoff failures with M.L.[61]

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56 Phillip Miller testimony.
57 Ex. 101, p. 10-11.
58 Ex. 20, p. 15.
59 Ex. 20, p. 15.
60 Ex. 20, pp. 15-16. The arbitrator also found that Ms. Graciani had "been a less than satisfactory employee" in terms of communication with her colleagues." Ex. 20, p. 14. These issues are discussed in Section III(B), below.
61 Ex. 20, p. 18.

Therefore, the arbitrator ordered Ms. Graciani reinstated. In doing so, however, he also declined to order an award of back-pay, concluding that Ms. Graciani had been dishonest in her testimony before him.[62] In particular, Ms. Graciani had testified that she attempted to reach Ben Jack by calling the main floor phone. She further testified that she reached a female at that desk four times, but that each time the transfer attempts failed. The hospital presented the testimony of its system administrator, Jody LeCrone, who also testified in the hearing in this case. Mr. LeCrone, System Administrator of Providence's Network and Telecommunications Operations, testified that internal hospital phone records record every connected call. While a call would not be logged if the caller hung up before the call was answered, a call that was answered and then dropped would show up on the log. Because the logs reflected no such calls, the arbitrator concluded that Ms. Graciani "provided dishonest testimony under oath, apparently in an effort to demonstrate she made substantial efforts before sending the patient to the primary floor."[63] The arbitrator therefore limited Ms. Graciani's remedy to "reinstatement but no backpay."[64]

Of note, Mr. LeCrone gave essentially the same testimony at the hearing in this case, although Ms. Graciani's post-hearing briefing claims otherwise.[65] Mr. LeCrone testified that hospital records show a 54-second call from a SpectraLink phone into the dialysis suite at 18:55.[66] Very shortly thereafter, at 18:57, someone in the dialysis suite called the IMCU desk phone for a 36-second call. There is no record of any other calls between dialysis and the IMCU between 17:46 and 18:57.[67] This means that Ms. Graciani's arbitration testimony about four calls to an unknown woman at the IMCU front desk, and which were then dropped while transferring to Mr. Jack, was more likely than not false, as the arbitrator concluded.[68]

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62 Ex. 20, pp. 18-19.

63 Ex. 20, p. 19 ("I consider this issue appropriate for consideration as grievant's fabrication under oath raises legitimate concerns about whether she can be trusted with the sober responsibilities of overseeing the care of vulnerable patients.").

64 Ex. 20, p. 20.

65 Graciani Post-hearing briefing at p. 47.

66 LeCrone test.; Ex. 103.

67 LeCrone test; Ex. 103. The only other outgoing call from the dialysis suite during this timeframe was to a supply store, not to a medical floor or a provider's SpectraLink phone. *Id.*

68 At the hearing in this case, Ms. Graciani testified that she attempted to call Mr. Jack at 18:42, and then reached him at 18:56 and gave her report. To the extent Ms. Graciani was suggesting that the 18:41 phone call on the phone log was an attempt to call Mr. Jack, Mr. LeCrone's testimony, and provision of a more detailed phone log in Exhibit 103, establish that the 18:41 phone call was (1) a call into the dialysis suite, not an outgoing call, and (2) originated from the renal care unit, not the IMCU. Additionally, Ms. Graciani's shifting narrative ignores the phone log evidence showing the 18:55 SpectraLink call preceded her 18:57 call to the IMCU desk phone.

After the arbitration result, Ms. Graciani returned to work at PAMC. She became an ICU nurse.

2. October 2019 Arterial sheath removal/ACT test incident

The next serious patient care incident at issue in the Accusation arose more than a year after Ms. Graciani's reinstatement. Specifically, the Division alleges that Ms. Graciani engaged in multiple forms of unprofessional conduct during an October 2019 incident in which she was tasked with removing a patient's arterial sheath after a cardiac catheterization procedure.[69]

The previous month Ms. Graciani had received a Written Warning about a July 2019 incident with another arterial sheath patient.[70] At that time, Providence concluded that Ms. Graciani had committed multiple errors during a sheath removal procedure, including failing to check an activated clotting time (ACT) to determine whether the sheath could safely be removed.[71] Pulling an arterial sheath when the Activated Clotting Time is too high can lead to serious, even fatal, consequences.[72] Ms. Graciani, who claimed to have been previously unaware of Providence's Arterial Sheath Removal policy, was provided a copy of that policy as part of the September 2019 Corrective Action.[73]

On October 21, 2019, however, Ms. Graciani again ran into trouble with an arterial sheath removal. In that incident, the patient's physician, Dr. April Rodriguez, had ordered that the patient's arterial sheath be pulled when the patient's ACT was within appropriate limits.[74] Implicit in this order was a requirement to check the patient's ACT. However, Ms. Graciani could not figure out how to order the ACT test in Epic, Providence's electronic medical record system.[75] Rather than access any number of resources she might have consulted or steps she might have taken to learn the procedure, she instead inputted an order for an entirely different lab

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69 A sheath is a protective casing used to assist with catheter insertion and advancement; the sheath is removed after the catheterization procedure once the patient is sufficiently stable to tolerate its removal. Doyle test.

70 Ex.46; Peacott test.

71 Ex. 46. *See also*, Peacott test. The September 2019 Written Warning indicated that Ms. Graciani's actions "placed the patient at high risk for significant harm," noting that the patient experienced "bleeding at the sheath site requiring additional manual pressure and fem[o]stop" and, eventually, "blood products." Ex. 46, p. 1. Ms. Graciani wrote in the employee comments section of the Corrective Action: "I disagree with the details of this written warning and investigation of events." *Id.*, p. 3.

72 Ex. ET.

73 Ex. 89; Ex. 99; McDonald test.

74 Ex. 100, p. 1. The order was made in a "nursing communication" reflected in the patient's chart.

75 Hubbard test.; Doyle test.; McDonald test.

test – a thrombin time test. She recorded it in the medical record as having been ordered by Dr. Rodriguez.[76]

There were numerous serious problems with this course of action. First, as a medical matter, an ACT test was the test that was actually needed, not a thrombin time test.[77] Second, ACT is a point of care test, performed at bedside, while the thrombin time is done in the lab, so changing the order to a lab test caused a delay in patient care.[78] Because the ACT test was needed before the patient's arterial sheath could be removed, this delay created a significant risk of harm.[79] Third, changing the test from what was ordered was an act outside the scope of Ms. Graciani's license.[80] Fourth, Ms. Graciani charted that Dr. Rodriguez had ordered the thrombin time test, when in fact she had not.[81]

In addition to all of these concerns, Ms. Graciani was dishonest when interviewed about the incident.[82] In the first meeting, she told her supervisor that she had called Dr. Rodriguez and gotten a verbal order for the thrombin time test.[83] At a second meeting two weeks later, when told that Dr. Rodriguez denied ever ordering a thrombin test, Ms. Graciani retracted her earlier claim that Dr. Rodriguez had given her a verbal order for that test.[84] Instead, Ms. Graciani offered a different explanation. This time, she said that she had been unable to find an ACT test in Epic, and that the only clotting-related test she had found was for thrombin time, so she put in an order for that instead.[85]

Multiple managers found that Ms. Graciani was evasive during the investigation into this incident.[86] Additionally, both Critical Care and Nursing management were aghast at the notion that a nurse would substitute a test for the one ordered under these circumstances, with multiple witnesses noting the many resources available to a nurse needing to determine how to order a particular test, the obligation to continue reaching out until the problem is solved, and the

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76 See Ex. 105, p. 1.

77 Doyle test. A Thrombin time test measures fibrinogen levels; it is not the same as an ACT test and does not provide the information needed to safely remove the arterial sheath. *Id.*; Ex. 99, p. 3.

78 Hubbard test.

79 Hubbard test.

80 Doyle test; Hubbard test.

81 Ex. 105; McDonald test.; Hubbard test. When this incident was investigated, Dr. Rodriguez told the critical care managers that she "would have never written an order for the thrombin time." Hubbard test.

82 Hubbard test.; McDonald test,; Ex. 100; Ex. 105.

83 Ex. 105; McDonald test.; Hubbard test.

84 Hubbard test.

85 Ex. 100; McDonald test; Hubbard test.

86 Hubbard test.; Doyle test.

profound impropriety of instead ordering a completely different test – let alone doing so in the physician's name and without authorization.[87]

On November 20, 2019, Ms. Graciani was issued a Final Written Warning for this incident – specifically, for dishonesty and practicing outside the scope of her license as an RN.[88] Lorrie Hubbard, then the Director of Adult Critical Care Services, testified that the corrective action wasn't for ordering a wrong test, but for the admitted act of fabricating a verbal order that would not have made sense for the patient. Ms. Graciani's written response to the discipline was: "I disagree with the finding as it is unjust."[89]

3. Other patient care allegations

Above, this decision has made factual findings regarding two serious patient care allegations – the October 2016 handoff incident, and the October 2019 arterial sheath/ACT test matter. This decision now turns back to other allegations involving complaints and investigations of matters that occurred in 2016 before Ms. Graciani was terminated (and then reinstated).[90] As will be seen, the evidence supports the allegations about two incidents that occurred in January 2016 regarding administration of the medication vancomycin. For the other two matters—the February 2016 magnesium sulfate incident and the March 2016 dialysis order – however, the evidence is inconclusive.

a. January 2016 vancomycin incidents (Patients G.R. and K.A.)

In early 2016 – roughly ten months before her termination – Ms. Graciani was disciplined by Providence for two different January 2016 incidents in which she failed to administer the antibiotic vancomycin to dialysis patients as ordered. Both incidents were summarized in a February 15, 2016 Letter of Counseling/Documented Warning issued by Clinical Nursing Director Brenda Franz, who explained that the letter arose from complaints by pharmacy staff,

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87 Hubbard test.; J. McDonald test.; Doyle test.

88 Ex. 105, p. 2. The Corrective Action also addressed an overtime rule not at issue in this nursing board disciplinary matter.

89 Ex. 105, p. 3.

90 Some testimony was also given about additional potentially serious issues that have arisen more recently – including a reported failure, while working as a telemetry nurse, to promptly contact a provider whose patient was desaturating – but as to which investigations have not been completed either by Ms. Graciani's employer or by the Division. Ms. Graciani has been on medical leave from Providence since the fall of 2021. Carrie Doyle testified that Ms. Graciani's ongoing absence from the workplace is the reason that no further steps have been taken regarding the telemetry incident. Because of the lack of a complete factual record on those incidents they are not addressed in this decision and are given no weight.

and as well as by dialysis, renal care and intensive care nurses, about these incidents and the related lack of communication that led to them.[91]

The first incident, on January 13, 2016, involved vancomycin prescribed to patient G.R., a 42-year-old man with hospital-acquired pneumonia. On the day in question, Ms. Graciani was G.R.'s assigned dialysis nurse. The prescription was entered into the patient's electronic medical record just before 10:00 a.m. that day by Dr. Ryan Webb.[92] The instructions called for the Vancomycin to be administered "during last hour of dialysis."[93] A pharmacist's note entered at 10:11 a.m. reflected that Pharmacist Ryan Friesen was "assisting with Vancomycin dosing," and that the patient should receive a dose of vancomycin "with dialysis today."[94]

According to a complaint he submitted the following day, Mr. Friesen had notified Ms. Graciani that he was preparing the vancomycin, after which he brought it to the dialysis suite to be administered. But Ms. Graciani did not administer the medication, nor did she inform the patient's primary nurse – i.e., the floor nurse assigned to the patient – that she had not done so. Instead, she entered a note in the medication administration record (MAR) section of the patient's chart stating that the medication was "not available."[95]

vancomycin 1 g in sodium chloride 0.9% 250 mL IVPB [49310781]

Ordering Provider: Ryan Gabriel Webb, MD	Status: Discontinued (Past End Date/Time)
Ordered On: 01/13/16 0959	Starts/Ends: 01/13/16 0959 - 01/14/16 0840
Dose (Remaining/Total): 1 g (1/1)	Route: Intravenous
Frequency: AFTER EACH DIALYSIS	Rate/Duration: 250 mL/hr / 60 Minutes
Admin Instructions: Please give vanco during last hour of dialysis.	Activate system and mix before use.

Timestamps	Action / Reason	Dose / Rate / Duration	Route	Other Information
Performed 01/13/16 1057 Documented: 01/13/16 1058	Not Given Medication not available	1 g 250 mL/hr 60 Minutes	Intravenous	Performed by: Debra Rena R Graciani, RN

Entering the note in this manner prevented the MAR from displaying the warning indicator that would have alerted the patient's providers that the dose had not been given.[96] Instead, as is apparent from the screenshot above, the note recorded the medication task as "performed."

Because Ms. Graciani had neither administered the medication as prescribed nor communicated that fact to the primary nurse, while also entering a note that marked the task as

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91 Ex. 50; Franz test.

92 Ex. BY; Ex. CD, p. 287.

93 Ex. CD, p. 287. Vancomycin is administered during the last hour of dialysis to prevent it from being "dialyzed out" during the treatment process.

94 Ex. CD, p. 150.

95 Ex. CD, p. 287; Franz test.

96 Franz test. *See also,* Ex. 50, p. 1 (Explaining that Graciani's entry in the MAR "prevented the red banner to appear as an overdue med so the primary nurse caring for the patient didn't know the med had been missed.").

"performed" in the medical record, G.R. did not receive the medication until the following day, when Friesen saw in the MAR that it had not been administered.[97]

When asked about the incident at the time, Ms. Graciani reported that the medication had not shown up in the unit until the end of treatment, and that she had later brought it to the patient's home unit and handed it to a technician.[98] But Pharmacist Friesen disputed this account of the medication's availability, and concerns remained about the lack of communication with the primary nurse.[99]

At the hearing, Ms. Graciani testified that she did not give the vancomycin because she would have had to hold the patient in the suite after dialysis was complete, and she understood there to be a management directive not to hold patients in the suite once dialysis was complete. But the basis for the pharmacist's complaint was that the medication had been delivered with sufficient time for it to be administered *during* dialysis, and, furthermore, that Ms. Graciani's communication failures after not giving the medication put the patient at risk.[100]

The second missed vancomycin incident was just a few days later, on January 18, 2016, and involved K.A., an "outrun patient," i.e., a patient receiving dialysis in their assigned unit because they are too sick to travel to the dialysis unit.[101] Brenda Franz's "documented warning" letter concerning this event recounted that the pharmacist had specifically "timed" K.A.'s vancomycin dose in the patient's MAR so that the medicine would be given during dialysis, making administration of the Vancomycin the responsibility of the dialysis nurse.[102] As with

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97 Franz test.

98 Franz test., Peacott test. The description of Mr. Friesen's version of these events is hearsay, recounted chiefly by Brenda Franz. However, it may be used to explain the hospital's decision to discipline Ms. Graciani for this incident, and to supplement the existing evidence surrounding the underlying incident and the discipline that followed.

99 *Id.* The pharmacist reported to Providence management that he had called the dialysis unit to find out when the patient was coming, and that the medication was ready. Peacott test.

100 Ms. Graciani's post-hearing briefing now suggests that she *intentionally* withheld the vancomycin because the order stated to give it "after each dialysis." In her post-hearing brief, she claims: "Ms. Graciani did the dialysis but did not administer vancomycin because Dr. Webb wanted the vancomycin to be administered 'AFTER EACH DIALYSIS.'" See post-hearing brief, p. 18. But (1) as shown above, Dr. Webb's administration instructions for January 13 say to administer the medication "during last hour of dialysis," and (2) this shifting explanation is not the explanation Ms. Graciani offered either during the disciplinary process or in her own hearing testimony, when she claimed that she had not given the medication because it was unavailable.

101 Ex. 50. While the only testimony on this incident came from Ms. Franz, she was directly involved in the disciplinary process that arose out of the incident, and met with Ms. Graciani's supervisors, Ms. Graciani, and her union representative to understand the incident before disciplinary decisions were made.

102 Ex. 50, Franz test. For outrun patients, the dialysis nurse is responsible for dialysis-related medications, including those to be administered during dialysis, while the primary nurse is responsible for other aspects of patient care. Franz test.

G.R. a few days earlier, Ms. Graciani had failed to administer the vancomycin, and failed to inform the patient's primary nurse it had not been given.[103]

Ms. Franz met with Ms. Graciani and her union representative during her investigation of this incident.[104] As to both incidents, Ms. Franz felt that Ms. Graciani failed to accept responsibility for her actions. Instead, as in other settings, she deflected or denied.[105] Ms. Franz testified that Ms. Graciani "never discounted that the events happened, but never took accountability for her piece or her parts," variously denying having been trained on the vancomycin protocol for dialysis patients, denying talking to the pharmacist, or defending her actions by saying she had given the medication to a patient care technician.[106]

In both of these incidents, the patient's course of vancomycin was disrupted long enough to interrupt the therapeutic level of the antibiotic; in G.R.'s case, the delay was a full 24 hours.[107] Ms. Graciani received a letter of counseling about the two incidents.[108] The letter noted a failure on both occasions to communicate with colleagues about critical matters of patient care, and that also on both occasions Ms. Graciani failed to conduct handoff communication to the patient's primary nurse, which could have avoided the delay in care.[109]

A preponderance of the evidence as to both vancomycin incidents supports a finding that, as to both patients, Ms. Graciani failed to administer the prescribed antibiotic during dialysis as directed, and then failed to conduct appropriate handoff communication to inform the patient's primary nurse that the medication had not been given.

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103 Ex. 50; Franz test. According to her union representative, Ms. Graciani's response to this accusation was that the medication "showed up as a PRN so she didn't know he was supposed to get it." Peacott test.

There is also an allegation that Ms. Graciani administered Ativan to patient K.A. without authorization or patient consent. Dr. Gittomer credibly testified that *he* ordered the Ativan for K.A. and did so in the context of the patient being (appropriately) tearful and upset about the possible need to amputate his leg that night. Gittomer test.

104 Franz test.; Peacott test.

105 Franz test. Ms. Franz also concluded that Ms. Graciani was dishonest in denying speaking to the pharmacist and denying that the medication was available.

106 Franz test.; Peacott test.

107 Franz test.

108 As noted above, the February 15, 2016 letter of counseling was the product of a disciplinary grievance brought by Ms. Graciani's union after an earlier (unidentified) initial disciplinary action about these incidents.

109 Ex. 50, pp. 1-2. At the hearing in this matter, Ms. Graciani deflected responsibility for these incidents by focusing on whether she had received sufficient details from Providence to defend against the related disciplinary action. But no documentation was submitted to support that Ms. Graciani was somehow unclear about which patients' care was at issue in the disciplinary matter, and her objections to Providence's internal disciplinary processes are irrelevant to the Board's inquiry into whether she fulfilled her professional obligations vis-à-vis these patients. There can be no doubt that by the time of the hearing in this case, Ms. Graciani had had ample opportunity – between the contemporaneous disciplinary meetings, the employment arbitration, her federal lawsuit, and this case – to understand the factual basis for this allegation. Nonetheless, Ms. Graciani testified that she *still* doesn't know the identity of the second vancomycin patient; this testimony was not credible.

b. February 11, 2016 magnesium sulfate incident (Patient P.F.)

The February 15 letter of counseling also addressed an incident that occurred on February 11, 2016, in which Ms. Graciani did not administer magnesium sulfate to her dialysis patient, P.F., as prescribed by the patient's cardiovascular surgeon, Pedro Valdes. The Division now alleges that Ms. Graciani overstepped the bounds of appropriate nursing judgment in withholding the magnesium sulfate, which Dr. Valdes had ordered be given during dialysis due to recent arrythmias.[110]

It is undisputed that:

- P.F., in the hospital for a coronary bypass, was being treated both by a cardiovascular surgeon (Dr. Valdes) and a nephrologist (Dr. Andrzej Maciejewski, generally known in the hospital as Dr. Mac).[111]
- On February 11, 2016, the patient's cardiovascular surgeon ordered magnesium sulfate be given during dialysis that day because of ventricular tachycardia symptoms.[112]
- Dr. Valdes's February 11 magnesium sulfate order was posted to the patient's chart.
- An IV bag of magnesium sulfate was brought to the dialysis suite and given to Ms. Graciani, his assigned dialysis nurse.[113]
- Ms. Graciani did not contact the cardiovascular surgeon who had ordered the magnesium sulfate.
- Ms. Graciani did not give the patient the magnesium sulfate.
- Ms. Graciani entered a notation in the patient's electronic medical record reflecting the magnesium sulfate had been held "per Dr. Maciejewski."[114]
- When P.F. returned to his home unit, Ms. Graciani did not inform the patient's primary nurse about having withheld the magnesium sulfate.
- Roughly three hours later, after learning that the magnesium sulfate had not been administered, the patient's primary nurse administered it "per cv surgeon as originally ordered for v-tach."[115]

Beyond this skeletal outline of known facts, the evidence on this incident was very conflicted, with numerous licensed professionals giving different versions of events.

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110 Ex. 50. This incident was also addressed in the same February 15, 2016 letter of counseling/documented warning that addressed the vancomycin incidents.

111 Ex. CC, Mac testimony. P.F.'s coronary bypass was being done in preparation for a kidney transplant. *Id.*

112 Ex. CC, p. 89-90.

113 Tracey test.

114 Ex. EI, p. 17. This notation also referenced the patient's normal lab level of 2.3. *Id.*

115 Ex. EI, p. 17.

Ms. Franz's letter of counseling, written within days of the incident, described the incident as follows:

> It was communicated to you by a fellow dialysis nurse that the magnesium infusion was to be administered due to patient having runs of VT. You communicated with the Nephrologist and not the ordering physician for clarification to administer when you did not see your patient in VT on the monitor. You also failed to communicate with the patients' primary nurse about the situation, which would have informed you of the run of VT and the need to administer the magnesium as ordered by the CV surgeon. Failure to administer the Magnesium as initially ordered resulted in the patient having a twenty-beat run of VT and the primary nurse calling you to verify if the administration of the magnesium had occurred or not. The primary nurse had to contact the CV Surgeon to receive further orders and administer Magnesium.[116]

At the hearing in this matter, Ms. Graciani testified that she was handed the magnesium sulfate just as Dr. Mac was rounding in the dialysis suite, that she did not know or inquire who had ordered the medication, and that she asked Dr. Mac whether the medication should be given or held.

But Ms. Graciani gave a different version of events to Division investigator Joanna Williamson in October 2016. At that time, she told Inv. Williamson that because she had questions about why the medicine was being given, she waited until the rounding doctor was there and then asked him.[117] This is a different sequence of events from serendipitously happening upon Dr. Mac just as the medication was delivered – and raises questions along the lines addressed in Ms. Franz's disciplinary memo, namely, why Ms. Graciani had not contacted the prescribing doctor if she had questions about why the medication was being given.[118]

Dialysis nurses Joanie Tracey and Terrie DuBois were present when these events occurred, and both testified that the patient's ICU nurse delivered the medication to Ms.

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116 Ex. 50, p. 2. P.F.'s medical records in this case do not appear to show a twenty-beat run of v-tach post-dialysis.

117 Ex. 56, p. 57-60. *Note:* While both parties had this exhibit since the distribution of the agency record, if not earlier, and the exhibit was identified as an exhibit for the entire length of the hearing, the Division ultimately did not offer the exhibit during the hearing and then withdrew it along with various other unused exhibits after the close of testimony. However, as Exhibit 56 contains an actual recording of Ms. Graciani's interview with the Division's investigator, it is highly probative in this matter, and unimpeachably authentic. Because there is no prejudice to either party of allowing the Board to consider Ms. Graciani's earlier interview with the Division investigator, Ex. 56 is admitted on motion of the ALJ.

118 Ms. Graciani also told Inv. Williamson that *Dr. Mac* had prescribed the magnesium sulfate which he then told her to hold. But the magnesium sulfate Ms. Graciani didn't administer was prescribed by the cardiovascular surgeon, not by Dr. Mac – which Ms. Graciani knew well before telling Inv. Williamson that Dr. Mac had prescribed it.. Ex. 56, pp. 59-60.

Graciani.[119] Ms. DuBois testified that she heard the ICU nurse tell Ms. Graciani to administer the magnesium sulfate "right now because of arrythmias the night before."[120] Ms. Tracey testified that, after the magnesium sulfate had been delivered, Ms. Graciani asked her (Ms. Tracey) whether she thought the patient's monitor indicated signs of V-Tach. While Ms. Graciani denies that this occurred – because she is "capable of determining that" herself – it is consistent with the Letter of Counseling's account that Ms. Graciani sought out the nephrologist instead of the ordering physician "when [she] did not see [her] patient in VT on the monitor."[121]

The evidence that most undermines Ms. Graciani's story of withholding the medication at the direction of the rounding physician is Brenda Franz's testimony, supported by contemporaneous notes from her investigation six years ago, that Dr. Mac had been unaware the magnesium sulfate was not given until Ms. Franz contacted him about the patient after the fact.[122] Ms. Franz's notes of that conversation recount that Dr. Mac had previously prescribed magnesium sulfate to this patient, and that he hadn't personally ordered magnesium on the day in question because it wasn't warranted from a nephrology standpoint, but that the cardiovascular surgeon had done so based on a cardiac concern.[123]

Ms. Franz credibly testified that Dr. Mac denied giving a direct order to hold the magnesium sulfate. This testimony is consistent with her February 2016 notes of her interview with Dr. Mac, in which she documented their conversation as follows:

> Dr. Mac: The [cardiovascular] surgeon ordered magnesium due to the patient having a run of five [beats of] ventricular tachycardia. Rena did ask if I wanted the magnesium administered on Thursday and I told her I was not opposed because I like my patient magnesium to be higher when they are having cardiac issues.
>
> **Brenda: Did you give an order to hold that Magnesium administration?**

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119 Tracey test.; DuBois test.

120 DuBois test.

121 Ex. 50, p. 2.

122 Franz testimony; Ex. 70.

123 Ex. 70 ("I gave an order on Wednesday night for a Mag Level around 1.8. That was given because I asked specifically if it was administered. On Thursday I did not order Magnesium for the patient as his level was above 2.0. The CV Surgeon ordered magnesium due to the patient having a run of 5 VT. Rena did ask if I wanted the magnesium administered on Thursday and I told her I was not opposed because I like my patient's magnesium to be higher when they are having cardiac issues.")

Dr. Mac: No, I told her I wasn't opposed to him getting it. Was it not given?[124]

Under oath at the hearing, however, Dr. Mac testified that Ms. Graciani had consulted him during rounds about whether to give the magnesium, and that he had told her to hold the magnesium sulfate given the patient's stable labs.[125] Ms. Graciani entered a note into the electronic medical record, noting that the patient's magnesium levels were within normal levels and the medication had been held "per Dr. Maciejewski."[126]

Both Ms. Tracey and Ms. DuBois testified that they were unaware until after the fact that Ms. Graciani had not administered the magnesium sulfate, and both recalled there being considerable internal fallout from the event. Ms. Tracey recalls that "the magnesium issue was a big deal," and that she discussed it after the fact with then-manager Kelly Rinas once she learned that the magnesium sulfate hadn't been given.[127] Ms. DuBois testified that "it looked bad on all of us" that Ms. Graciani did not administer the magnesium sulfate as prescribed by the cardiovascular surgeon.

Ms. Tracey and Ms. DuBois both believe that Dr. Mac had not actually ordered the magnesium sulfate be held, and the Division has argued that Dr. Mac's testimony at hearing was false. However, while it certainly is a close call, the available evidence is simply too equivocal to make a finding that Ms. Graciani withheld the magnesium sulfate without a physician's order to do so. On the one hand, Ms. Franz's contemporaneous notes reflect that Dr. Mac denied, at the time of the events, having directed Ms. Graciani not to administer the magnesium sulfate. To the contrary, he expressed surprise that it had not been administered. Yet, the prescribing physician did not testify, and Dr. Mac testified unequivocally that he had made a medical decision at bedside that the medicine be held. In light of Dr. Mac's sworn testimony and the doubts surrounding the events leading to the magnesium sulfate being withheld, the

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124 Ex. 70 (emphasis added). Ms. Graciani testified that she had been surprised when she first learned that Dr. Mac had made this statement. But she continued to maintain that Dr. Mac had ordered that the patient's magnesium sulfate be held.

125 Maciejewski test.

126 Ex. EI, p. 17.

127 Tracey test. Ms. Tracey recalls Ms. Rinas telling her that Dr. Mac had discontinued the magnesium, and that the cardiologist was "furious." This testimony, while hearsay, supports Ms. Graciani's narrative that Dr. Mac ordered the medication held.

preponderance of the evidence does not permit a factual finding that Ms. Graciani acted without a doctor's order.[128]

Separate from how it came to be that the magnesium sulfate was held was the failure to communicate about that course of action with the patient's primary nurse. As with the vancomycin incidents, the February 15 Letter of Counseling was critical of Ms. Graciani for "failing to communicate with the patient's primary nurse about the situation" with P.F. Indeed, although Dr. Mac took responsibility for the decision to withhold the magnesium sulfate, he also testified to his inaccurate belief that the magnesium had been ordered "prophylactically to prevent arrhythmias," and testified that it would be inappropriate to hold the magnesium sulfate if it were being used to treat arrhythmias. To the extent that Dr. Mac justified holding the magnesium sulfate based on his (mistaken) notion that "it was being used for prevention," Ms. Graciani, in failing to communicate with the patient's primary nurse, missed a significant opportunity to correct this misimpression and ensure prompt treatment of the patient's arrythmias. Noting that such communications "would have informed [her] of the run of VT and the need to administer the magnesium as ordered by the CV surgeon," Ms. Franz's letter of counseling instructed Ms. Graciani that "this is the second example of where your communication put a patient at risk for harm."[129]

Because the magnesium sulfate was ordered for an acute cardiac concern in a cardiac patient and was then withheld without either consulting the cardiovascular surgeon or informing the patient's primary nurse, the evidence supports a finding that Ms. Graciani's failure to communicate about the magnesium sulfate order with the patient's primary nurse either during dialysis or when the patient returned to his home unit placed the patient at risk of harm.[130]

c. March 3-4, 2016 Dr. Khan dialysis orders (Patient H.K.)

A few weeks after the magnesium sulfate incident came another allegation. Ms. Graciani was accused of entering dialysis orders for a new patient without physician approval – that is,

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128 The Division also argues that, even if Dr. Mac had told her to hold the magnesium sulfate, Ms. Graciani should not have done so without consulting the physician who prescribed it (or someone from his service). Multiple Providence managers and nurses as well as the Division's experts testified in support of this argument, but Dr. Mac disagreed. Calling it "practical hospital life," Dr. Mac testified that it would be appropriate for a nurse to consult with either physician about this issue, and that "the fastest and most practical way" in this situation was to talk to him.

129 Ex. 50, p. 2.

130 *See* Franz test.; Tracey test.; Ex. 50, p. 2.

that she entered the orders on her own initiative, rather than at the request of a nephrologist.[131] Again, however, the evidence is inconclusive.

H.K., the patient in question, was admitted late in the night of March 3, 2016. That night, Ms. Graciani entered a set of dialysis orders into H.K.'s chart, along with a notation that the orders were "verbal telephone orders" from the patient's nephrologist, Dr. Mahmud Khan.[132] The following morning Dr. Khan placed initial dialysis orders for H.K., at which point it was discovered that a set of orders was already in the chart.[133] An investigation followed.

Three different witnesses – Jim Blankenship, Brenda Franz, and Joanie Tracey – testified that Dr. Khan had denied placing the first set of orders in the patient's chart. Ms. Tracey testified that she was working in the dialysis suite that morning and called Dr. Khan about the patient's orders, to which he replied that he had not given any orders for H.K. the previous night.[134] Mr. Blankenship testified that Dr. Khan approached him on the morning of March 4, "very, very upset" at H.K. having dialysis orders entered that were not his orders.

The record also includes multiple emails exchanged within the dialysis and nursing management teams the day of the incident and shortly thereafter. In an email to Ms. Franz just after noon on March 4, Mr. Blankenship reported the following:

> I was able to speak with Dr. Khan this afternoon regarding the patient with two sets of dialysis orders. One set was entered last night with different settings and run times. Dr. Khan advised that he did not put in any orders or give verbal orders to anyone for this patient."[135]

Mr. Blankenship sent Ms. Franz a follow-up email on March 7, 2016, as follows: "Just finished speaking with Dr. Khan. He did not speak with any RN that night 3/3 regarding any patients. He did not give any telephone orders nor did he place any orders himself."[136]

Six months later, when discussing this incident with Division Investigator Williamson, Mr. Blankenship reported that on the morning of March 4, Dr. Kahn had called in orders for a patient admitted the previous night, and that, when it was revealed that dialysis orders were

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131 Franz test.; Blankenship test. Of note, Mr. Blankenship was also interviewed by a Division investigator in October 2016. Ex. 58. To the extent that his version of events differs between the two accounts, the events as described in the interview are more credible because it occurred so much closer in time to the events in question.

132 Ex. U, p. 2.

133 Franz test.; Blankenship test. The orders entered by Ms. Graciani on March 3 were different than the orders entered by Dr. Khan on March 4.

134 Tracey test.

135 Ex. 79.

136 Ex. 80.

already in the patient's chart under his name, he denied giving those orders.[137] Mr. Blankenship described Dr. Kahn as "very upset." Mr. Blankenship further reported that when asked about the first set of orders, Ms. Graciani had not denied entering them into the patient's chart but had said she was using the orders "as a placeholder" to ensure the patient was on the schedule for dialysis the following day.[138]

Mr. Blankenship testified, and told Investigator Williamson in 2016, that Ms. Graciani had explained that she enters temporary "placeholder" orders so that dialysis staff and doctors are aware that a particular patient will be occupying a dialysis bed on a given day.

Ms. Graciani, in the meantime, now denies the incident with Dr. Kahn's patient occurred. She denies using the term "placeholder" orders and denies ever entering orders for Dr. Kahn's patients without his express direction to do so.

At the hearing, Mr. Blankenship testified that Dr. Khan had followed up later the same day – March 4th – to retract his complaint, saying there had been a misunderstanding, that perhaps he had spoken with Ms. Graciani, and that he did not want to complain because Ms. Graciani "scared" him. This testimony is inconsistent with both the emails from the time of the event, and Mr. Blankenship's 2016 interview with Division investigator Williamson, which occurred after the alleged retraction, and at which Mr. Blankenship made no mention of Dr. Kahn having a change of heart. This could be because the retraction did not occur, or because Mr. Blankenship did not believe Dr. Khan and so did not mention the retraction to the investigator. Certainly, the contemporaneous evidence of Dr. Kahn's complaint is more credible than the story, years later, of a fearful retraction. Yet, clearly, something must have occurred in 2016 to weaken the hospital's case against Ms. Graciani, because Providence took no disciplinary action.

In short, the evidence is inconclusive. The emails on the day of and shortly following H.K.'s dialysis orders, along with the two different sets of dialysis orders in the patient's medication administration record, support the conclusion that Ms. Graciani may have entered dialysis orders under Dr. Khan's name for patient H.K. before or without speaking to Dr. Khan. However, the fact that Providence neither disciplined Ms. Graciani for this incident nor even memorialized findings in a non-disciplinary letter makes it difficult to conclude with any

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137 Ex. 59, pp. 28-29.
138 Ex. 59, p. 30.

certainty what occurred. Further compounding this difficulty is that neither party called Dr. Kahn to testify. Without either evidence of action taken by the hospital or testimony from the provider, this decision cannot find by a preponderance of evidence that Ms. Graciani entered dialysis orders for H.K. without direction from Dr. Kahn.

B. Unprofessional workplace interactions

Separate from the patient care issues described above, but occurring contemporaneously, Ms. Graciani has been the subject of extensive complaints relating to combativeness, disrespect, and disruptiveness in the workplace. While Ms. Graciani apparently has strong technical skills in at least some areas of nursing, there is overwhelming evidence that she can be very difficult to work with, frequently behaving in a rude and standoffish manner towards coworkers. Numerous witnesses from multiple workplaces testified that Ms. Graciani displayed hostility toward other caregivers, particularly towards (but not limited to) unlicensed personnel such as patient care technicians and patient transporters. Multiple prior supervisors from three different employers described Ms. Graciani's workplace behavior as requiring an enormous amount of management time due to the volume of complaints generated by her interactions with other caregivers.

1. Behavioral concerns at Fresenius and Denali Dialysis

While the Division's Accusation concerns events that took place during Ms. Graciani's time at Providence, her outright denials of these events eventually brought out evidence of similar allegations against her at both Fresenius, where she worked from 2011 until 2013, and Denali Dialysis, where she worked in 2013 and 2014.[139]

During her time at Fresenius, Ms. Graciani experienced conflict with coworkers, particularly patient care technicians.[140] These exchanges included arguments on the treatment floor, in front of patients. Former Charge Nurse and Manager Stacy Catania testified credibly that she observed Ms. Graciani being disrespectful in front of patients, and that several patients and coworkers complained about her, leading to disciplinary action.[141]

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139 As discussed further below, evidence of these events is considered not as an independent basis to find a violation under the accusation. These events are relevant for impeachment, credibility determinations, and as to the remedy.

140 Catania testimony.

141 Catania testimony. In addition to complaints about rudeness and disrespect, Ms. Catania recalled complaints from patient care technicians about Ms. Graciani not using the dialysis machine settings ordered by physicians, and instead using settings that differed from what had been ordered for particular patients.

Ms. Graciani was written up multiple times at Fresenius for rude, discourteous, and disrespectful behavior towards coworkers, including on the treatment floor and in front of patients.[142] She received a "Documented Counseling" in June 2012 for "discourteous and disrespectful behavior" towards a coworker in the treatment area, and then a "Written Warning" in October 2012 for "verbally attacking another coworker and putting her finger in her face."[143] A January 2013 "Final Written Warning" then documented seven separate incidents in a single month, including several patient complaints about Ms. Graciani's attitude and demeanor towards them, along with several incidents in which Ms. Graciani had changed patient treatment settings or medication dosages from what had been prescribed.[144] Ms. Graciani was terminated from Fresenius.[145]

When she began working at Denali Dialysis, Ms. Graciani was again the subject of "complaints and concerns from staff members and patients."[146] These concerns arose early in Ms. Graciani's time at Denali, with numerous complaints by the second week of orientation. As at Fresenius, and as would later occur at Providence, there were issues about rudeness towards patient care technicians, refusal to respond to direct questions, and hostile volume and tone of voice when responding to questions.[147] Ms. Graciani rebuffed attempts to implement a professional improvement plan.[148] Clinic Administrators believed that Ms. Graciani's behavior had an overall negative effect on the workplace.[149] Denali ended Ms. Graciani's employment in April 2014, but she testified that she "has no idea" why.[150]

2. Behavioral concerns at Providence

Ms. Graciani began working at Providence as a per diem dialysis nurse in 2014 and converted to a full-time position in the dialysis suite in May 2015. While she maintained positive relationships with the nephrologists whose patients were being treated there, Ms. Graciani's time in Providence's dialysis unit, like her time at Denali and Fresenius, was notable

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142 Ex. 106.

143 *See* Ex. 106, p. 1.

144 Ex. 106, p. 2.

145 Catania testimony; Tracey testimony; Graciani testimony. Ms. Graciani testified that she doesn't "recall the specifics" of why she was terminated, or whether or why she was counseled.

146 MaryCarol Miller testimony.

147 M. Miller test.

148 M. Miller test.

149 M. Miller test.

150 M. Miller test.; Graciani test. It is unclear from the record whether Ms. Graciani was formally fired, as Ms. Miller believed (and as Ms. Graciani appeared to concede at one point in her testimony), or if she was removed from the schedule without a formal letter of termination. The distinction is irrelevant to the Board inquiry.

for numerous complaints and workplace investigations regarding unprofessional communications and interactions – mostly with coworkers but some with or in front of patients.

a. Managers' perspective: an "extraordinary number" of complaints and concerns

Multiple former managers testified that during her employment in the dialysis suite Ms. Graciani generated an exceptionally very high volume of complaints and conflict from other caregivers. These were notable for the volume of complaints, their internal consistency (i.e., similar complaints from multiple unrelated sources), and their similarities to incidents at Denali and Fresenius.

Brenda Franz, the Clinical Nursing Director of Providence's Medical-Surgical Division since 2013, recounted "fielding an extraordinary number of concerns about this one nurse" – specifically, "multiple complaints by multiple caregivers," with a "continued pattern" of "complaints that would come in about communication." Ms. Franz described "getting complaints from transport/lift, Emergency, pharmacy, nurses in the renal care unit, and then of course care-givers within the dialysis suite." In her testimony, Ms. Franz described dozens of individual complaints she had received about Ms. Graciani's interactions with fellow nurses and care givers. "This wasn't one or two complaints; it was every caregiver inside dialysis, and multiple people from other departments." Ms. Franz was unable to recall such a "complex communication issue" arising during her thirty years in nursing.[151] Ms. Franz viewed the poor communication and lack of trust as a potential patient care issue, explaining that delays in care can "absolutely" result "if other team members can't approach you, don't trust you," and also that Ms. Graciani's failures to communicate would sometimes cause colleagues to repeat work she had already completed.[152]

Ms. Franz also testified that she witnessed unprofessional interactions with Ms. Graciani's colleagues, stating that, at times, Ms. Graciani was "very short" in communicating with colleagues, and at other times did not communicate at all. Although with physicians Ms. Graciani "seemed ready and willing to be part of the team," her conduct "with her nursing peers" was often rude and dismissive instead. Ms. Franz described the atmosphere in the dialysis unit while Ms. Graciani was present as noticeably tense, and testified credibly about receiving

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151 Franz test.
152 Franz test.

voluminous complaints, from within and outside the dialysis unit, arising from interactions with Ms. Graciani.[153]

Jim Blankenship, who served as the Interim Manager of Renal Nursing Services from February through September 2016, was "unable to count" the number of complaints he received about Ms. Graciani "from other departments and from coworkers," but estimated he spent 1-2 hours per day on issues relating to complaints about or by Ms. Graciani.[154] Having managed hundreds of nurses in the course of his career, he testified he had "never had to invest that much time in any one nurse as far as following up on complaints, trying to be fair to everyone, following up on her charting, treatment, communications with everyone."[155]

Ms. Graciani's union representative, Joey Peacott, attended multiple meetings between Ms. Graciani and Providence management to discuss complaints about Ms. Graciani being perceived by coworkers and others in the hospital as "loud, condescending, and dismissive;" "rude and condescending;" "condescending, non-collegial and not a team player;" and "bossy, territorial, rude, and condescending."[156]

b. Specific behavior-related complaints

In addition to the managers' perspective described above, numerous coworkers from the dialysis suite, as well as other hospital employees, complained to Providence management, and eventually to the Board, about Ms. Graciani's behavior. Testimony at hearing centered on behaviors variously described as rude, argumentative, aloof, and mercurial.

1. Complaints from within the dialysis suite

The first documented complaints were in September and October 2015, when multiple coworkers complained about tension in the unit, a "hostile, bullying work environment," and both general rudeness and occasional explosive anger from Ms. Graciani.[157] Dialysis nurses were coming to multiple leaders about coworker treatment by Ms. Graciani, including how they were talked to, eye rolling, lack of communication (not answering questions directly posed to her), and causing colleagues to duplicate efforts because she would not tell them whether she had

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153 Franz test.
154 Blankenship testimony.
155 Blankenship test.
156 Peacott test. Mr. Peacott testified to his belief that these complaints were blown out of proportion because Ms. Graciani is African American.
157 Franz test. re: complaints submitted by Joanie Tracey (9/17/15), Hazel Swenko (9/30/15), and Dawn Bennett (10/5/15).

done work.[158] In addition, there were multiple caregiver complaints about hostile communications. One such complaint described Ms. Graciani as belittling an employee who had made a mistake, then variously ignoring or rebuffing the employee in a "loud and rude" tone when asked questions.[159]

By early 2016, some of Ms. Graciani's dialysis coworkers were complaining that her lack of communication with other caregivers and short, disrespectful demeanor was putting patients at risk.[160]

Several witnesses described an uncomfortable incident in front of patients between Ms. Graciani and a Patient Care Technician (PCT).[161] The incident occurred during care of a frequent patient. The patient needed labs drawn before each treatment. Ms. DuBois had requested the PCT do the labs, but after the PCT started doing so, Ms. Graciani abruptly and aggressively directed her to stop. The patient and her mother described Ms. Graciani as slamming supplies down on the table and "angrily" declaring she would do the labs herself.[162] Ms. Graciani then drew the labs but "left kind of a mess," including blood on the equipment and the floor. When PCT Whitworth – standing less than an arms-length away – asked Ms. Graciani a question, Ms. Graciani first acted as if Ms. Whitworth wasn't there, ignoring her repeated questions, then reprimanded her with instructions to address Ms. Graciani "by name" if she wanted to ask a question.[163] Several nursing colleagues who witnessed the incident described Ms. Graciani's behavior as argumentative and unprofessional, particularly in front of a patient.[164] The patient's mother, who also witnessed the incident, described Ms. Graciani ignoring Ms. Whitworth when she was obviously speaking to her, and then reprimanding Ms. Whitworth in a "demeaning" manner right in front of her daughter, all of which she described as an "very unprofessional" and "childish" encounter to have in front of a very sick patient.[165] The patient

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158 Franz test.
159 Franz test. (re: 10/15/15 Dawn Bennett complaint).
160 Franz test. re: complaints from Terrie DuBois and Ms. Tracey.
161 Whitworth test.; Saturnino test.; Tracey test.; Hallstrom test. More broadly and by way of context, multiple witnesses also described Ms. Graciani as frequently hostile and unprofessional towards PCT Whitworth. Blankenship test.; Tracey test.; Whitworth test.
162 Hallstrom test.; Ex. 10.
163 Whitworth test; Hallstrom test.; Ex. 10.
164 Tracey test.; Whitworth test.
165 Hallstrom test.

herself submitted a written complaint, describing the encounter as "very uncomfortable and very unprofessional."[166]

The patient's mother, Becky Hallstrom, submitted her own written complaint in April 2016 about a separate incident involving Ms. Graciani's interactions with an elderly patient. Because of the intensive treatment her daughter required, Ms. Hallstrom was in the dialysis suite for about 12 hours per week for more than a year and had significant time to observe the interactions there. While Ms. Graciani was initially one of her daughter's nurses and was professional and proficient in that role, Ms. Hallstrom reported witnessing Ms. Graciani acting rudely towards and "snapping" at an elderly patient. After seeing Ms. Graciani be "very sharp" and "lose her temper" at the elderly patient, she did not want her treating her daughter. Ms. Hallstrom was sufficiently concerned to report the interaction to Mr. Blankenship, and later filed a written complaint.[167] Ms. Hallstrom's written complaint described that, while Ms. Graciani can behave appropriately and be charming "when there are people present to hold her accountable," she can also be "very rude," and had been "very impatient and rude" with an elderly dialysis patient.[168] Ms. Hallstrom testified that what she saw "made me wonder about her character as far as how well she takes care of people when there isn't someone watching."[169]

In addition to specific incidents, many former dialysis suite employees testified about a general pattern of behavior in which Ms. Graciani would ignore colleagues asking her direct questions,[170] speak to colleagues and other Providence staff in a curt and dismissive manner,[171] be argumentative by default,[172] and respond to colleagues with terse inflection, negative body language and exasperated sighs.[173] Ms. Graciani presented the contrasting testimony of another former dialysis nurse, Dyan Dyer, who denied that Ms. Graciani behaved inappropriately, and

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166 Ex. 10.

167 Hallstrom test; Ex. 9; Ex. CZ.

168 Ex. 9. Ms. Hallstrom's complaint also mentioned an initial reluctance to report this incident based on a concern "that Renee (sic) would retaliate if she finds out that I complained." At hearing, this statement was discussed and debated at length. This decision finds that the retaliation statement was intended to convey a concern that Ms. Graciani might act unkindly to Ms. Hallstrom's daughter (the patient) or that the atmosphere in the dialysis suite might otherwise become even more uncomfortable.

169 Hallstrom test. In addition to Ms. Hallstrom and her daughter, at least two other patients or patient family members also complained about what they perceived as "caustic," "judgmental," or otherwise unkind treatment by Ms. Graciani. Franz test.; Blankenship test. While Ms. Graciani brushed off such concerns as misunderstandings, Blankenship concluded that was she excusing disrespectful behavior as "businesslike." Blankenship test.

170 Whitworth test; Tracey test.

171 DuBois test.; Whitworth test.; Tracey test; Saturnino test..

172 Whitworth test.; Saturnino test..

173 Whitworth test.

opined that this was a communication style issue: "Rena is direct and to the point, which I appreciated and they did not." But the testimony about Ms. Graciani's workplace behavior went well beyond communication differences.[174]

Former dialysis nursing colleague Joanie Tracey described a general pattern of poor communication and mercurial behavior, creating an "atmosphere of never knowing how Rena was going to respond." Ms. Tracey also recounted witnessing more than one incident in which Ms. Graciani would directly block the path of a transporter who was trying to maneuver a patient bed out of the dialysis suite, not respond to the transporter's requests that she move, and then "accuse the transport people of trying to run her over."[175] While Ms. Graciani denied that this ever occurred, Ms. Franz received multiple complaints from transport staff and their supervisor about Ms. Graciani being uncooperative and disrespectful.[176]

Ms. Whitworth, who is now a nurse but was a PCT at the time she worked with Ms. Graciani, described her as "so frequently unkind and uncivil" and elaborated that "you had to walk on eggshells when she was in the suite" due to Ms. Graciani's rapidly shifting mood. Ms. Whitworth recounted several incidents in which Ms. Graciani treated her in a "dismissive and demeaning" manner, noting that this "always" occurred in front of patients, and created obvious discomfort for patients. Other witnesses corroborated these accounts.[177] Ms. Whitworth also recalled witnessing Ms. Graciani be confrontational with different staff members in front of patients on numerous occasions, characterizing this as "a regular pattern of disrespect and hostility."[178]

Dialysis nurse Mario Saturnino testified that Ms. Graciani was a disruptive influence, explaining that "when you have someone who fights with you, with other people, raising [their]

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174 In addition to the specific incidents described above, there was also testimony about numerous other conduct-related incidents which are not detailed herein because of a lack of sufficient evidence to determine what more likely than not occurred. These include: an incident in which Ms. DuBois recalled Ms. Graciani engaging in obstreperous and uncollaborative conduct regarding dialysis of a pediatric patient, and various conflicts between Ms. Graciani and PCT Kelly Whitworth regarding the dialysis unit "water room." DuBois test.; Whitworth test. This decision concludes it is unnecessary to delve into these incidents as to which the record is insufficiently clear. No conclusion is reached as to whether the testimony about these incidents fully characterized the events that occurred; many of the events at issue took place more than six years before the hearing, and a reality is that memories fade as time passes.

175 Tracey testimony.

176 Franz test. Ms. DuBois also told Division Investigator Williamson about transporter and other conflicts when she was interviewed in 2016. Ex. 63, p. 38 ("She talks down like to the house cleaner; she talks down to the transport people. She talks down to just the nurses on the floor.").

177 Saturnino test.; DuBois test.

178 Whitworth test.

voice, that's not the way to work with people in a hospital." Mr. Saturnino described Ms. Graciani as uncollaborative, needing to be "always right," and acting unprofessionally and confrontationally if challenged, corrected, or otherwise displeased.[179]

Now-retired dialysis nurse Terrie DuBois described Ms. Graciani's day-to-day behavior in the dialysis suite as "bossy" and "argumentative," saying that she talked down to colleagues in front of patients, and that this behavior made the dialysis suite an inhospitable environment for patients. DuBois described Ms. Graciani as inflexible: "Rena has a point of view, and if you don't do it that way, it's not right." Moreover, "no criticism went well. Once you said anything she didn't like, the rest of the day she didn't talk to you." Responding to the notion that people were just misunderstanding Ms. Graciani's communication style, Ms. DuBois countered: "That's not 'straightforward;' it's unprofessional."[180]

2. Allegations of retaliatory complaints by Ms. Graciani

Multiple witnesses also testified that Ms. Graciani would respond to coworker complaints by filing complaints about those coworkers,[181] but there was a lack of specific evidence at hearing to reach a conclusion as to this broad allegation. One particular incident was discussed at length during the hearing: a Mother's Day 2016 encounter in the dialysis suite in which Mr. Saturnino "side-hugged" each of his three female coworkers (including Ms. Graciani) and wished each a happy Mother's Day. Ms. Graciani filed a sexual harassment complaint with Providence about this encounter. The Division alleges that this complaint was made in bad faith, and both parties expended considerable time and energy at hearing exploring the events of the Mother's Day hug, as well as, more generally, questions of who was hugging whom in the dialysis suite during that period.

It appears that Ms. Graciani's complaint followed very shortly on the heels of a disciplinary action based, in part, on a complaint by Mr. Saturnino about Ms. Graciani's

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179 Saturnino test.

180 DuBois test. Ms. DuBois also testified credibly about a December 2015 incident in which she and Ms. Graciani disagreed about appropriate treatment protocols for a pediatric patient, with Ms. Graciani wanting set blood flow rates at a level higher than what the pediatric protocol provides. While the overall evidence was insufficient to clearly establish what occurred in terms of patient care, Ms. DuBois was credible in recalling this incident as another situation in which Ms. Graciani refused to consider other points of view, even when acting in a trainee capacity, and argued with her colleague in front of patients. This testimony supports other witnesses' recollection of Ms. Graciani being argumentative in front of patients. *See e.g.* Tracey test., Watsjold test., M. Miller test.

181 DuBois test.; Franz test; Blankenship test.

interaction with the elderly patient referenced in Ms. Hallstrom's complaint.[182] Nonetheless, the evidentiary value of this incident and Ms. Graciani's complaint are slim to none. Unquestionably, Ms. Graciani was within her rights to complain about unwanted workplace touching. Employees have the right to be free from unwanted workplace touching, and the law errs on the side of protecting those who raise concerns, even if the concerns cannot be substantiated. Indeed, Providence responded to this incident by reinforcing rules about even well-intended workplace touching.

On the other hand, Ms. Graciani's complaint alleged specific physical events that were not corroborated by any other witness – that Mr. Saturnino had kissed her face and run his hand down her back. Thus, there was sufficient evidence from which to infer that these allegations were false and that their falsity increased tension and stress within the dialysis workplace. Yet, although it is possible that Ms. Graciani's complaint was motivated by retaliatory animus as opposed to a genuine belief that Mr. Saturnino had engaged in sexual harassment, it is not necessary to decide those questions in this forum, and this decision places no weight on the fact that Ms. Graciani filed complaints about coworkers.

3. Complaints from outside the dialysis suite

In addition to complaints within the dialysis suite, Ms. Franz and Mr. Blankenship credibly testified that they fielded frequent and numerous complaints about Ms. Graciani from various hospital employees outside the dialysis suite. These included separate complaints from members of the transportation and lift staff, the housekeeping staff, pharmacists, emergency department providers, and ICU and Renal Care Unit nurses, all about perceived rudeness from Ms. Graciani.[183]

The complaints concerned Ms. Graciani speaking in a very short, directive tone; failing to communicate effectively and respectfully; hanging up on or abruptly discontinuing conversations; refusing to allow housekeeping staff into the suite; and other behavior that was perceived as disrespectful.[184]

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182 Ms. Graciani was disciplined on May 4, 2016 concerning the patient interaction about which both Ms. Halstrom and Mr. Saturnino had complained. Ex. 29. In 2016, Mother Day occurred on May 8 – four days after Ms. Graciani received the Written Warning. *See* Ex. 29, p. 3.

183 Franz test.; Blankenship test.

184 Franz test.; Blankenship test; Ex. 59, p. 20-23 (describing to Div. Investigator complaints about Ms. Graciani being "very demanding, very overbearing" with transport staff and "abrasive, a little belligerent" with housekeeping staff). Ms. Tracey also testified that a member of the housekeeping staff complained to her about Ms. Graciani's behavior. Tracey test. Ms. DuBois likewise told Division Investigator Williamson about complaints

4. Nephrologists' perspective

While the vast majority of former coworkers and supervisors who testified depicted Ms. Graciani as exceedingly difficult to work with, the three physicians who testified at the hearing in this matter all shared positive assessments of her skills and abilities.[185] Drs. Jeremy Gitomer, David Lefler, and Andrew Maciejewski variously described Ms. Graciani as an "exceedingly competent" dialysis nurse, able to draw upon a "broad fund of knowledge," "very, very knowledgeable," and a "very, very good nurse."[186]

Dr. Lefler described Ms. Graciani as proactive, professional, and forward thinking, and Dr. Gitomer opined that he would love to have a unit full of people with her skill and knowledge. All three testified they would have no concerns about Ms. Graciani providing care to their patients and denied ever having heard a complaint about her from a patient or another nephrologist.[187]

c. Behavior-related disciplinary history

As they had at Denali and Fresenius, Ms. Graciani's pattern of curt and dismissive interactions with coworkers at Providence eventually led to multiple disciplinary issues. In the arbitration award arising out of her termination, the arbitrator summarized:

> Throughout her relatively brief career, [Ms. Graciani] has been a less than satisfactory employee. Thus, in fairly rapid succession, she received repeated counseling and warnings, primarily directed at her shortcomings in communicating with her colleagues, a skill that is critical to support the hospital's mission of creating a safe environment for its patients.[188]

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housekeeping and transport staff made to her about Ms. Graciani's behavior towards them. Ex. 63, p. 38 ("She talks down like to the house cleaner; she talks down to the transport people. She talks down to just the nurses on the floor"), pp. 50-51 (describing incident with housecleaner); p. 53 ("ICU, IMCU – I don't know that there's [a] department in the hospital that hasn't wrote her up (sic) ... because of her behavior.").

185 At the same time, multiple former coworkers testified that Ms. Graciani's behavior around physicians was "night and day different" from her behavior at other times. Whitworth test.; Tracey test.; DuBois test.

186 At least one testifying nephrologist, Dr. Gitomer, admitted on rebuttal that his belief about Ms. Graciani's skills and knowledge was based at least in part on a misconception about her length of time working in the dialysis field, although he "found her font of knowledge very high."

187 In addition to the three nephrologists, Ms. Graciani submitted affidavits from two current colleagues in the ICU. Laura Crawford, ANP, testified by affidavit that she was Ms. Graciani's preceptor in the ICU, that Ms. Graciani was "a competent, entry level Intensive Care Unit Nurse," and that Ms. Graciani "always took [her] feedback and improved upon herself and got much better as a critical care nurse." Ex. BJ. RN Paula Rogers, another ICU colleague, described Ms. Graciani as "a team player" upon whom she felt she could rely to "keep [her] patients safe." Ex. BK.

188 Arbitration Award, Ex. 20, p. 14. The findings of the arbitrator are neither evidence nor authority. The quoted material, however, is a good summary of the findings independently arrived at in this decision.

1. June 2015 Letter of Counseling

On June 24, 2015, less than a month after her position converted to full time, Ms. Graciani received a non-disciplinary "letter of counseling" from Providence about "offensive and demeaning" statements made to other employees.[189] This letter was motivated by concerns around hostility and negativity on Ms. Graciani's part.[190] Ms. Graciani responded with a written rebuttal, arguing that her "mannerisms and directness" had "likely" been "misunderstood," and stating (falsely), "I have never been accused of harassment or hostility of any kind in any way."[191] Ms. Graciani expressed a willingness to "engage with others" so that, "through open, frank, honest discussion, the allegations about [her] may be understood to be mistaken." She also professed a "willingness to engage in instruction and training intended to help [her] be an employee who is never again thought of by anyone to be harassing or hostile."[192]

2. February 2016 Corrective Action and Letter of Counseling

Despite a stated intent to address her communication shortcomings, in February 2016 Ms. Graciani received a disciplinary "Corrective Action" about a "lack of goodwill and lack of teamwork,"[193] and a separate "Letter of Counseling/Documented Warning" about "inappropriate communication/conduct."[194]

The Letter of Counseling concerned, in part, Ms. Graciani's behavior during an educational presentation to dialysis staff about "Code Readiness."[195] Multiple witnesses recalled Ms. Graciani acting rudely towards the presenter, not making eye contact, rolling her eyes, sighing, and not responding when he attempted to engage her.[196] The letter of counseling asserted that "those attending as well as the presenter" found her "communication and behavior to be disruptive and unprofessional," and that the presenter had stopped his presentation at least

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189 Ex. 26.

190 Tucker test.

191 Ex. 26, p. 3. The most charitable interpretation of this statement is that Ms. Graciani intended it to cover only her time at PAMC.

192 Ex. 26, p. 3.

193 Ex. 28. The February 15, 2016 Corrective Action was a "documented verbal," the first step in Providence's progressive discipline process. Tucker test.

194 Ex. 50. The simultaneous issuance of these two separate Corrective Actions on February 15, 2016 was the result of a resolution of several disciplinary grievances filed by Ms. Graciani's union following what was initially more serious discipline for the events described. Franz test.; Tucker test.

195 The February 15, 2016 Letter of Warning also addressed the vancomycin and magnesium sulfate incidents discussed in Section III(A)(3), above.

196 Whitworth test.; Blankenship test.; Franz test. While Ms. Franz was not present for the meeting and learned about the conduct from the presenter as well as then-manager Kelly Rinas, the hearsay in her testimony is used to supplement the testimony of first-hand witnesses and to explain the disciplinary letter that followed.

twice as a result.[197] Observing that "[t]he common theme of your performance deficiencies and conduct concerns center around communication, and interpersonal skills in the workplace," the letter offered various suggestions on improving those skills.[198]

The same day's Corrective Action was precipitated by multiple complaints about lack of collaboration with and a rude and disrespectful tone and behavior towards coworkers, including issues with rude tone, curt/discourteous interactions, and a lack of communication/response when asked questions.[199] The Action referenced prior supervisory discussions with Ms. Graciani "on a number of occasions" about her being perceived by "others on the kidney dialysis team and within the hospital" as being "not collaborative, rude, [not] communicat[ing] effectively, and unwilling to make [her]self part of the team." Nonetheless, the Action asserted, Ms. Graciani continued to "communicate/act" contrary to the expectations of "working well with others" and "communicating effectively," and instead engaging in "behavior [that] puts the patient at a high risk for safety issues related to care."[200] Ms. Graciani was directed to complete a communication skills training, which she did.[201]

Ms. Graciani responded to the Corrective Action by noting that she disagreed with it, and writing: "I don't think my directness should be perceived as rudeness."[202] But multiple witnesses testified convincingly that the behaviors that led to the Corrective Action were not "directness,"[203] but hostile tones, eye rolls, and poor communication.[204] From a hospital management perspective, these behavioral concerns – reflected in complaints from multiple providers within the dialysis suite and multiple caregivers from other departments – threatened patient care because of the need for teamwork in providing care, and the inability to work as a team without the ability to disagree respectfully.[205] There was also a concern among management that Ms. Graciani did not take responsibility for her actions, and instead deflected

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197 Ex. 50, p. 2.
198 Ex. 50, pp. 2-3.
199 Franz test. The Corrective Action notice also acknowledged Ms. Graciani's denial of these accusations, observing that, "although you did not acknowledge such behavior, the situations and caregivers varied, the feedback about your attitude and behavior have been consistent[.]" Ex. 28, p. 1.
200 Ex. 28.
201 Ex. 49, p. 2; Franz test.; Graciani test.
202 Ex. 28, p. 3.
203 Franz test.
204 Franz test.
205 Franz test.

and blamed others' perceptions – traits that might translate into poor nursing judgment or a failure to admit errors.[206]

3. May 2016 Written Warning

Two months later, on May 4, 2016, Ms. Graciani received another Corrective Action, a written warning, regarding unprofessional behavior.[207] The subject of the warning was two-fold, (1) generally, numerous conversations since Mr. Blankenship assumed management of the dialysis suite in February 2016, and (2) specifically, the April 19, 2016 patient treatment incident addressed in Becky Hallstrom's complaint.[208] In addition to Ms. Hallstrom's written complaint, another dialysis nurse had complained to Mr. Blankenship about that incident, and reported that Ms. Graciani had addressed him "in a mad and argumentative tone" when he offered to provide care for the patient.[209]

The written warning addressed Ms. Graciani speaking "to patients and other staff in a frustrated, angry, and condescending voice," and expressed concern about Ms. Graciani's perceived "refusal and/or unwillingness [to] improve" an ongoing "lack of effective communications, collaboration, and empathy for our patients[.]"[210]

4. Post-reinstatement behavior-related discipline

The May 2016 Corrective Action was the last behavior-related disciplinary action before Ms. Graciani's termination in November 2016. Since returning to Providence in 2018, however, she has had at least two additional workplace communication issues that have risen to the level of documentation in her personnel file. A May 2019 non-disciplinary Letter of Counseling found that she had "raised [her] voice in a patient care area" and then "interrupted a meeting" to raise her specific concerns with the assistant clinical manager.[211]

And a June 2019 documented verbal Corrective Action found that Ms. Graciani interacted negatively with a phlebotomist, leading another nurse to report the incident.[212] At the hearing, the complaining nurse, Sasha Watsjold credibly described the April 2019 incident in which Ms. Graciani inappropriately raised her voice and yelled at a hospital phlebotomist who

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206 Franz test.

207 A written warning is the step after documented verbal counseling in Providence's corrective action paradigm.

208 Ex. 29, Blankenship test., Tucker test.

209 Blankenship test.; Ex. CZ, p. 2.

210 Ex. CZ; Blankenship test.; Ex. 29.

211 Ex. 41.

212 Ex. 44; Ex. CP.

had come to the ICU to draw a lab on Ms. Graciani's patient. Ms. Graciani was agitated by how long it took for a phlebotomist to arrive and spoke loudly and rudely to the phlebotomist when she arrived. In a conversation that occurred right outside an ICU patient's room, with "a lot of nurses and other providers" easily within earshot, Ms. Graciani was heard yelling at the phlebotomist.[213] The phlebotomist, Ms. Watsjold observed, was "getting red," "tearful," "having trouble responding," "stammering," and "looked like she was going cry."

It was a sufficiently inappropriate interaction that Ms. Watsjold later (1) apologized herself to the phlebotomist for the interaction, and (2) reported the incident – namely, Ms. Graciani's "harsh" and "inappropriate" behavior – to her manager. While Ms. Graciani denies that this incident occurred, the preponderance of the evidence supports a finding that it did.[214]

C. Protected health information violations

The final set of allegations in this case involve Ms. Graciani's handling of patients' protected health information (PHI). These include both her possession of hundreds of pages of PHI at the time of her termination, as well as allegations about accessing two specific patient charts.

1. Records in cubby (and false statements about them)

The most significant PHI issue by far concerns documents found in Ms. Graciani's dialysis suite cubby at the time of her termination in 2016, and about which she was interviewed when she returned to Providence in January 2018. Specifically, when escorted to the dialysis suite to clean out her locker on the day of her termination, Ms. Graciani was found to have roughly 400 pages of various patient records in her cubby.[215] While Ms. Graciani now denies that these documents were in her cubby, her denials are not credible in light of the evidence presented.

After the meeting at which she learned of her termination, Ms. Graciani was escorted to the dialysis suite by union representative Donna Phillips, Nursing Staff Director Carrie Doyle, and Renal Care Unit Nursing Manager Eirik McFerrin.[216]

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213 Ex. CP, Watsjold test. Ms. Watsjold also confirmed that the account of the incident in the June 29, 2019 "documented verbal" corrective action, Ex. 44, accurately described the situation as she observed it.

214 Ms. Graciani's written response to the Corrective Action was: "I do not recall this event and I don't believe such event occurred." Ex. 44, p. 3.

215 McFerrin test.; Doyle test.

216 Doyle test., McFerrin test., Phillips test., Graciani test.

In addition to locked lockers, the dialysis nurses also had open cubbies. The cubbies were mailbox shaped – wide enough to hold letter paper, and about three inches tall – and were open/unlocked, making their contents potentially accessible to anyone who passed through the dialysis unit. On the date in question, Ms. Graciani's cubby had a large volume of documents stuffed inside it.[217]

At some point during the locker clean out, both Ms. Doyle and Mr. McFerrin saw Ms. Graciani approach the cubby area, remove a stack of paper from her cubby, and begin to take the papers towards the trash or shred bin. They asked to look at the documents and could see "almost instantly" that at least some contained protected patient health information, including patient names and dates of birth, treatment records, and medical chart printouts. Ms. Doyle and Mr. McFerrin confiscated the documents at that time.

When tasked with reviewing the documents to determine their contents, Mr. McFerrin found that 359 separate pages contained protected health information.[218] While the discovery of these documents after it had already terminated Ms. Graciani limited Providence's recourse in terms of employment actions, it did report the discovery to the Board when reporting the termination.[219]

Later, after Ms. Graciani was ordered to be reinstated, the topic of the cubby documents was addressed in a meeting with Providence Human Resources personnel on her first day back.[220] At the start of that meeting, which was recorded, Human Resources Consultant Dar'Shon Tucker summarized that "on 11/1/2016 while gathering your personal belongings from your cubby, it was discovered that you had several hundred pages of documents containing PHI in your cubby."[221] When Ms. Tucker asked Ms. Graciani to identify the documents, her initial response was that she couldn't remember the events of that day, but then, when looking at individual records, she was able to identify the records.[222]

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217 Doyle test., McFerrin test. There is considerable disputed testimony about almost every aspect of this incident, including the location of the cubbies within the suite, the size of the cubbies, and the actions of the various participants. The testimony of Ms. Doyle and Mr. McFerrin was more credible than the testimony of Ms. Graciani, whose denials now conflict with earlier admissions, or Ms. Phillips, whose memory of the events is limited.

218 McFerrin test; Ex. 91. Some of these individual pages contained information on up to a dozen patients.

219 Tucker test.; Ex. AU; Ex. 16. Providence's November 15, 2016 report to the Board asserted that Ms. Graciani's possession of these records "is a violation of the Rights of Individuals with Respect to Protected Health Information policy, PROV-PSC-807, the same policy Ms. Graciani was previously disciplined for violating in August 2014." Ex. 16.

220 Tucker test.; Ex. AJ.

221 Ex. AU, p. 2.

222 *Id.*, pp. 3-4.

When Ms. Tucker then asked, "so why did you have them in your cubby?", Ms. Graciani responded, "For later review, I guess."[223] Later, Ms. Tucker returned to this threshold question: "So help me understand, why did you hold on to the documents?" Ms. Graciani responded: "I have no response. I don't know. I just put the information in if I needed to go back and look at something for reference[.]"[224] When asked about the appropriateness of keeping "patient records [or] documents once a patient is no longer in your care," Ms. Graciani responded, "I wasn't told I was not allowed to."[225]

At no point in the January 24, 2016 transcribed meeting did Ms. Graciani deny that the documents had been in her cubby.[226] At the hearing in this case, however, she took the position that the documents had never been in her cubby. She denied that her answers to Ms. Tucker constituted an admission otherwise. Instead, she insisted, she had been answering "theoretically." That is, she claims to have understood Ms. Tucker to be asking why she might have had such documents in her cubby, and further claims that her answers were simply hypothetical musings on why she *might* have done so *if* she had done so – which, she now claims, she did not. Ms. Graciani's denials on this issue are not only uncredible but bizarre in the face of the interview transcript.

Still more incredible is that Ms. Graciani then changed her story again when confronted with more statements from her meeting with Ms. Tucker. On recross, she conceded having told Ms. Tucker that the documents were in her cubby for later review and for use by other staff, and testified that she intended to tell Ms. Tucker "that the reason [she] had those documents in [her] cubby was because nobody told [her] not to."

On redirect after recross, Ms. Graciani changed her story yet again, testifying that as to the "cubby documents" presented to her at the January 24 meeting, "I don't know where those documents came from."

The Division has proved beyond a preponderance of the evidence that at the time of her termination in 2016, Ms. Graciani was in possession of hundreds of pages of PHI, relating to

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223 Ex. AU, p. 4.
224 Ex. AU, p. 6.
225 Ex. AU, pp. 6-7.
226 To the contrary, she stated that it must have been widely known, because "they were in my cubby, I mean, staff could go and see because it's beside other staff's cubbies." Ex. AU, p. 8.

many dozens if not more individual patients, and that she was storing those documents in an unsecured open cubby in the dialysis suite.

2. Specific patient chart access issues (August 2014 and March 2016)

In addition to the PHI in the cubby, two other PHI-related incidents were discussed at hearing and are raised in the Division's accusation. First, it is undisputed that early in her employment at Providence, Ms. Graciani accessed her ex-husband's medical records.[227] She received a written reprimand in August 2014 and was provided a copy of the hospital's privacy policy.[228]

Second, in the course of the Division's investigation of complaints against Ms. Graciani, it determined that Ms. Graciani had accessed patient records of D.F., a patient whose care team she was not on.[229] At the time in question, D.F. was a nephrology patient, but not a dialysis patient.[230] In March 2016, while still working as a dialysis nurse, Ms. Graciani accessed D.F.'s chart – and multiple sections of the chart -- on multiple days over a several day period.

Ms. Graciani has justified this access as saying that nephrologists would sometimes ask her or other dialysis nurses to look in advance at records for a patient who might potentially start dialysis in the future. Although disputed by Providence management and some of the nurses, this testimony was borne out by several nephrologists—who would be the source of such instructions—as well as a key Division nurse witness, Terrie DuBois. No other motive was suggested or proven for Ms. Graciani to access these records.

Thus, while the evidence is disputed, and while the existing practice may well be significantly out of step with the hospital's expectations, the evidence supports that there was a practice of nephrologists requesting and expecting dialysis nurses to sometimes access nephrology patient charts outside of an existing nurse-patient relationship, as part of the dynamic planning and scheduling process within the dialysis suite. It is more likely true than not true that Ms. Graciani's access of D.F.'s chart occurred in accordance with that practice, and not for a reason other than a request by the patient's physician.

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227 Ex. 25; Tucker test.

228 Tucker test.; Ex. 24.

229 Ex. 48; Stephanie Tasker test; Maureen Shaw test.

230 Ex. 48; Shaw test; Graciani test., Lefler test.

IV. Procedural and Evidentiary Issues

A. Providence's role in this case

Ms. Graciani has argued in this case that the Division's claims against her have been orchestrated by Providence Hospital, essentially as an effort to achieve through the licensing process what Providence was unable to achieve through its employee discipline process. Thus Ms. Graciani's post-hearing briefs argues that "Providence managers arbitrarily disciplined Ms. Graciani and accused Ms. Graciani of abusive behavior, and then used the discipline and unsubstantiated allegations to advocate for sanctions against Ms. Graciani's license." Relatedly, Ms. Graciani's counsel was critical of the various investigations conducted by Providence and attempted to introduce evidence of alleged shortcomings both in those investigations and in Providence's human relations/disciplinary grievance processes. And lurking in the background of these assertions is a federal lawsuit that Ms. Graciani is pursuing against Providence and former supervisors Jim Blankenship, Brenda Franz, Kelly Rinas, and James Effrid.

Ms. Graciani's arguments about Providence's role in this matter miss the mark at several levels. First, there is sufficient credible testimony of disruptive behavior by Ms. Graciani – at Providence and elsewhere -- to belie the suggestion that she was arbitrarily and unfairly accused of such behavior. Further, the evidence does not support a finding that the complaints filed about Ms. Graciani were part of some coordinated effort by Providence to impugn her. Dialysis nurse Joanie Tracey, the first complainant to the Division, complained individually because of her individual belief that Ms. Graciani was violating various professional responsibilities.[231] Another complaint was submitted by Providence Director of Nursing Deb Hansen at the time of Ms. Graciani's termination, as specifically required by employers under AS 08.68.277.[232] Lastly, Carrie Doyle submitted a complaint after it came to light, as detailed above, that Ms. Graciani had fabricated a physician order for a lab test.[233]

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231 Tracey test.

232 AS 08.68.277 ("Duty of employers to report. (a) An employer of a nurse licensed under this chapter or a nurse aide certified under this chapter practicing within the scope of that license or certification that discharges or suspends a nurse or nurse aide or conditions or restricts the practice of a nurse or nurse aide shall, within seven working days after the action, report to the board the name and address of the person and the reason for the action. An employer shall report to the board the name and address of a nurse or nurse aide who resigns while under investigation by the employer. The requirement of an employer to report under this section applies only to a discharge, suspension, or restriction of practice that is based on a ground allowing action by the board under AS 08.68.270 or 08.68.334 or for conduct prohibited under AS 08.68.340.")

233 Ex. 98.

While Ms. Doyle's testimony supports an inference that the decision to submit the complaint was made by a management team, rather than by Ms. Doyle alone, her testimony also supports the conclusion that the decision was based on a consensus that Ms. Graciani had clearly breached her professional responsibilities and created a serious risk of harm to the patient. Public policy requires that licensees – in management positions and elsewhere – err on the side of reporting such concerns so that the Board can carry out its statutory obligation to regulate the profession. Nothing in the events as presented at hearing support a conclusion that Providence either directed its employees to complain to the Board or otherwise orchestrated or interfered in this process.

Ms. Graciani has also suggested that the presence of a Providence attorney at the hearing should be taken as evidence of Providence playing some sort of behind-the-scenes role in this licensing matter. But this argument ignores the procedural history that led to Providence's presence at the hearing. Ms. Graciani's lawyer in her federal lawsuit entered an appearance in this matter very shortly before the hearing was scheduled to begin. Providence's attorney in that case (also representing the individual defendants in that case, including several witnesses in this matter) then made a limited entry of appearance to raise concerns that Ms. Graciani was using confidential documents from the federal case as exhibits in this case. Ultimately, Providence's attorney attended the entire hearing, and was extremely helpful to the parties and the tribunal in coordinating the availability and scheduling of the dozens of Providence-associated witnesses, as well as the production of certain documents whose relevance became apparent as the proceedings unfolded.

While Ms. Graciani now argues that the presence of Providence's attorney shows that Providence is the driving force in this case, Providence's lawyer did not get involved in this case until Ms. Graciani's employment lawyer did (and until Ms. Graciani submitted confidential documents from the federal case in this matter), and nothing about Providence counsel's presence at the hearing supported an inference that Providence was steering or attempting to steer the Division's pursuit of this licensing matter.

B. Criticism of Division's investigation

Ms. Graciani criticizes the Division's investigation, including the limits of documents collected by the Division, the fact that Division investigators did not interview any physicians, and other perceived shortcomings. But these criticisms misapprehend the Division investigators'

role in the licensing process. The Division's investigators are tasked with gathering information about complaints that are forwarded to the Division, and then presenting that information to reviewing Board members to determine whether there is a reasonable basis on which to conclude that a violation of the Board's statutes or regulations has occurred.[234] While there are always additional documents that could be requested, or additional witnesses who could be interviewed, the Division's investigator is not required to conduct an exhaustive proof-beyond-a-reasonable-doubt inquiry before filing an accusation. The hearing process itself affords a licensee the opportunity to come forward with information the investigator may not have had access to or otherwise may not have uncovered. At the hearing, the Division must freshly prove every element of the alleged violations, a process that largely moots any gaps in the Division's preliminary review.

Ms. Graciani also criticizes the Division's reliance on Providence's internal investigations to form the basis for its accusation. In particular, Ms. Graciani spent considerable time during the hearing critiquing Providence's internal human relations processes and investigations and attempted to use the proceedings in this case to showcase what she contends are shortcomings in those processes.

But this Board's concerns are with the underlying conduct, and the existence of numerous complaints and concerns regarding this licensee. As to those issues, this decision finds that the Providence documentation of Ms. Graciani's various disciplinary encounters is reliable evidence of the events described therein. As described below, the Division presented testimony of administrators involved in investigating the underlying incidents and fielding an array of complaints and concerns surrounding Ms. Graciani. Whether and to what extent Ms. Graciani has labor and employment grievances with Providence is largely irrelevant to the Board's inquiry into whether she engaged in the conduct at issue in the Division's Accusation. In short, Ms. Graciani's criticism of the Division's reliance on documentation from Providence to understand the concerns about her conduct in these events is not well taken.

C. Ms. Graciani's credibility

The witness whose hearing testimony was least credible in this case was Ms. Graciani herself. At multiple points in her testimony, particularly on cross examination, Ms. Graciani failed to answer direct questions and engaged in painful degrees of wordsmithing and attempts to

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234 Bautista test.

avoid taking responsibility for past actions or statements. Notably, this conduct during her testimony was similar to the evasiveness that multiple managers reported during workplace investigations and disciplinary meetings, and made those accounts more credible.[235]

The most obvious example of her lack of credibility at hearing involved the hundreds of pages of old patient records Ms. Graciani was storing in her dialysis suite cubby. The evidence includes two different transcripts of earlier proceedings in which she never denied that the materials in question were in her cubby. Yet in this proceeding, she – at times – took the position that she never had patient records in her cubby.

When shown an arbitration transcript in which she testified that she had kept documents in her cubby because she had "kind of been told" she could keep documents in her cubby to review later, and then asked whether that testimony refreshed her recollection about having documents in her cubby, she answered: "From the information presented before me, that's what I was told at the time." Ms. Graciani was extremely reluctant to acknowledge her prior inconsistent statements, even when they were in writing, only acknowledging those statements with phrases like, "I see the information that I said there, yes;" "looking at this page, that appears to be what I'm saying;" and "[t]hat's the information written before me." Ms. Graciani's failure to be forthright even when confronted with her own prior statements cast severe doubt on her overall credibility.

Ms. Graciani's shifting stories about the cubby documents during the hearing itself were damning to her credibility as a witness. In the course of her testimony, she denied having documents in her cubby at all, saying anyone who said otherwise was lying. Shortly thereafter, she changed her story, now saying that she had the documents in her cubby because she hadn't been told she couldn't. She later switched her story again to say she didn't know where the cubby documents came from. Her testimony about most of the incidents in this case was marked by shifting explanations, and explanations that differed from her prior statements about the

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235 Franz test. (explaining that finding Ms. Graciani trustworthy "was getting to be very, very difficult with the amount of complaints and then her discounting every single one"; describing response during Vancomycin investigation as "self-contradictory" and "another example of her not taking responsibility, denying, and deflecting"); Doyle test. (when asked whether Ms. Graciani was evasive during handoff incident investigation: "She wasn't answering the questions we were asking"); Blankenship test. ("anytime you have an issue, you get a twenty-minute explanation of why she wasn't supposed to follow the standard rules").

events – a pattern described by her former managers in their testimony about workplace investigations.[236]

Ms. Graciani's evasiveness was also apparent during testimony about her workplace behavior. As described above, the evidence shows that Ms. Graciani was disciplined and eventually terminated or otherwise non-retained by two prior employers for similar types of behavior she is then alleged to have engaged in while at Providence, and that she was counseled repeatedly at Providence throughout her time in the dialysis unit for concerns about rudeness towards coworkers. Ms. Graciani's testimony professing surprise that she had been seen in a negative light by her dialysis coworkers was not credible in light of her lengthy disciplinary history for such conduct over three separate employers.[237]

Ms. Graciani also failed to remember certain events in their entirety – such as ever being counseled about behavior issues at a prior employer, despite evidence of repeated issues and counseling; as well as multiple incidents for which she was disciplined at Providence.[238] She also made other claims that were both difficult to believe and impossible to square with others' testimony, such as claiming to have "no idea" why she was terminated by an earlier employer.

Ms. Graciani's credibility as a witness was also impaired by her insistence that most other witnesses were lying about their experiences with her. At various points, she insisted that staff who deny accessing documents from her cubby would be lying, and that numerous dialysis staff members did so. (This was after her earlier testimony that she had "no documents" in her cubby). Ms. Graciani insisted that various incidents about which multiple witnesses testified did not occur, and that multiple people who complained to management about these incidents were all lying, as were the management employees who investigated the complaints. She also insisted that the stories about her disruptive behavior were untrue, despite testimony from former colleagues, former and current supervisors, and even a former patient's parent – all of whom would have to be lying in order for Ms. Graciani's version of events to be accurate.

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236 For example, when Providence was investigating Ms. Graciani having ordered the thrombin time test instead of the ACT test, she first claimed to have conferred with the patient's physician about the matter, and then later denied having made that statement after the physician was contacted.

237 Ms. Graciani testified that she believed up until the hearing that she had a collaborative relationship with the other nurses in dialysis, but that she no longer believes so in light of the testimony in this case. This testimony is not credible in light of the numerous disciplinary meetings and documentation around Ms. Graciani's workplace behavior.

238 Ms. Graciani claimed not to recall any incident involving a phlebotomist (although she was disciplined for this incident and credible testimony at the hearing established that it occurred), and also professed confusion at hearing about there having been two separate vancomycin incidents (again, despite a written disciplinary history).

Ultimately, Ms. Graciani's credibility was severely undermined by the sheer number of people who would have to have been mistaken or outright lying – and the number of contemporaneously written documents that would have to be false – in order for her narrative to be accurate.[239]

D. Hearsay evidence

When a hearing is held under the Administrative Procedure Act (APA), the technical rules of evidence do not apply.

> Relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of a common law or statutory rule that makes improper the admission of the evidence over objection in a civil action.[240]

In hearings such as this one that are conducted under the Administrative Procedures Act (APA), a specific rule governs the use of hearsay – that is, statements that were made outside of the hearing being offered at the hearing to prove the truth of the matter asserted in the statement. Hearsay that is not admissible in court is still admissible in APA proceedings, but its use is restricted based on whether or not it is corroborated by other evidence. The restriction, known as the *residiuum* rule, is that "[h]earsay evidence may be used to supplement or explain direct evidence but is not sufficient by itself to support a finding unless it would be admissible over objection in a civil action."[241]

Here, as Ms. Graciani's counsel noted, the record contains a significant volume of hearsay statements. All of Providence's disciplinary memoranda, for example, are hearsay to the extent that they are offered to prove that the events at issue happened as described in those memoranda (although some might well be admissible in court by virtue of falling within an exception to the hearsay rule). Likewise, complaints that managers received about Ms. Graciani, or complaints shared between coworkers, are hearsay to the extent offered to prove that events occurred as described in those complaints.

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239 These include but are not limited to testimony – as well as records and prior transcripts – regarding the patient records that were in her cubby; notes and testimony that she said she talked to Dr. Rodriguez during the Thrombin time test incident; the testimony of all the witnesses to the infamous hug incident; multiple former supervisors' testimony and documentation about behavior complaints they received from numerous facets of hospital staff; Ms. Tracey's testimony about looking at the monitors for the patient in V-tach; Ms. Graciani's former (Fresenius) supervisor's testimony about workplace conflict there; a pharmacist's complaint (conveyed through Ms. Franz) that he had spoken with Ms. Graciani and she failed to administer vancomycin as they discussed; and Ms. Watsjold's contemporaneous complaint and hearing testimony about Ms. Graciani berating a phlebotomist.

240 AS 44.62.460(d).

241 AS 44.62.460(d)

There was significant non-hearsay evidence that Ms. Graciani was disciplined repeatedly by Providence. Given the non-hearsay evidence that Ms. Graciani was counseled and disciplined on multiple occasions, the hearsay descriptions of the underlying conduct supplement and explain the evidence of the discipline.

Multiple former coworkers offered credible testimony about firsthand experiences with Ms. Graciani. Likewise, multiple former managers offered credible testimony both about their own firsthand experiences with Ms. Graciani, and about the voluminous complaints they fielded – not just from immediate coworkers but from various parts of the hospital. To the extent hearsay statements by other complainants were presented, those may be used to supplement the firsthand testimony of witnesses who personally experienced unprofessional behavior, or who fielded complaints about such behavior.

It is also noteworthy that Ms. Graciani's counsel elicited a significant volume of hearsay testimony – particularly from Ms. Franz, who was asked during her testimony to take numerous breaks for the purpose of gathering her notes about the specific complaints that gave rise to various disciplinary and non-disciplinary memoranda in evidence in this case. That Ms. Franz then provided information from those notes – such as who from different departments had complained, when they had done so, and the stated basis for those complaints – could not have been a surprise to counsel. It was these notes that filled in many of the blanks on the behavioral evidence, with Ms. Franz detailing (based on her notes, as requested by Ms. Graciani's counsel) the range of complaints that had been received. In any event, even if Ms. Graciani did not waive her objection to this evidence, and even if not separately admissible under exceptions to the hearsay rule, this testimony supplements and explains non-hearsay evidence that includes both firsthand testimony and the evidence of multiple disciplinary actions.

E. Character/propensity evidence

As described above, evidence of Ms. Graciani's workplace difficulties at prior employers was admitted in the Division's rebuttal case. Ms. Graciani's counsel had argued that the conduct-related claims against her were at best misunderstandings of a straightforward communication style or at worst the fabrications of a discriminatory work environment. Ms. Graciani herself had downplayed and minimized if not denied any possibility that the complaints regarding her behavior might be based on valid concerns about her actual conduct. When the Division sought to introduce evidence that she had engaged in the same types of behavior at her

prior two places of employment, Ms. Graciani argued that this was improper character evidence.[242]

As a preliminary matter, the evidentiary rule on prior bad acts does not apply in this administrative proceeding.[243] To the extent that the Rules of Evidence are used in these proceedings "as a guide," Ms. Graciani's objection is still not well taken. The testimony establishing that Ms. Graciani previously engaged in similar conduct is relevant to rebut her assertion that these complaints were either fabricated or based on misunderstandings of her self-described "businesslike" communication style. Further, the evidence of ongoing behavioral issues across multiple workplaces is directly relevant to the Board's determination of whether the conduct at issue in the Division's Accusation rises to the level of actionable unprofessional conduct and, if so, what sanction might be appropriate.

V. Discussion

A. General legal principles

The Board of Nursing has been charged by the legislature to develop reasonable and uniform standards for nursing practice.[244] Those standards, set out in the Board's regulations, establish the requirements for licensure, the standards for ongoing practice, and the scope of what constitutes unprofessional conduct.[245]

The legislature has also empowered the Board with disciplinary authority to enforce its standards, and AS 08.68.275 identifies the range of disciplinary sanctions that the Board may take, singly or in combination, in exercising those disciplinary powers.[246] These range from imposition of probation to permanent license revocation. The Board may suspend or revoke the license of a person who:

- "has intentionally or negligently engaged in conduct that has resulted in a significant risk to the health or safety of a client or in injury to a client;"[247]

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242 *See* Alaska R. Evid. 404(b)(1) (evidence of other wrongs or acts "is not admissible if the sole purpose for offering the evidence is to prove the character of a person in order to show that the person acted in conformity therewith. It is, however, admissible for other purposes, including, but not limited to, proof of motive, opportunity, intent, preparation, plan, knowledge, identity, or absence of mistake or accident.").

243 *See* AS 44.62.460(d); 2 AAC 64.290(b).

244 AS 08.68.100(a)(8), (b).

245 *See* 12 AAC 44.400 (Requirements for licensure); 12 AAC 44.770 (Unprofessional conduct).

246 *See* AS 08.01.075 (Disciplinary Powers of Boards).

247 AS 08.68.270(5).

- "is guilty of unprofessional conduct as defined by regulations adopted by the board."[248]
- "has willfully or repeatedly violated a provision of this chapter or regulations adopted under this chapter or AS 08.01."[249]

The Board's regulations broadly define unprofessional conduct as "nursing conduct that could adversely affect the health and welfare of the public," and identify 42 specific examples included within that definition.[250] Of relevance here, these include:

- "failing to use sufficient knowledge, skills, or nursing judgment in the practice of nursing as defined by the level of licensure" (12 AAC 44.770(1));
- "failing to perform acts within the nurse's scope of practice which are necessary to prevent substantial risk or harm to a client" (12 AAC 44.770(5));
- "violating the confidentiality of information ... concerning a client"[251] (12 AAC 44.770(6));
- "falsifying a client's records or intentionally making an incorrect entry in a client's chart" (12 AAC 44.770(10));
- "harassing, disruptive, or abusive behavior by a licensee directed at staff or a client, a client's relative, or a client's guardian" (12 AAC 44.770(29)); and
- "disruptive behavior by a licensee at the workplace that interferes with the provision of client care" (12 AAC 44.770(30)).

As the party seeking to invoke disciplinary sanctions, the Division has the burden of proving, by a preponderance of the evidence, that Ms. Graciani committed the alleged violations.[252] Additionally, to the extent the Board finds violations and chooses to impose disciplinary sanctions, AS 08.68.270(f) requires the Board to "seek consistency in the application of disciplinary sanctions." Accordingly, "a significant departure from prior decisions involving similar situations shall be explained in the findings of fact or order."

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248 AS 08.68.270(7).

249 AS 08.68.270(8).

250 12 AAC 44.770.

251 Unprofessional conduct also includes "failure to maintain patient documentation in compliance with HIPAA" (2 AAC 44.770(42)), but the Division did not expressly allege a violation of this provision.

252 AS 44.62.360; *Odom v. State*, 421 P.3d 1, 7 (Alaska 2018).

B. The Division's allegations

With regard to patient care, Count I alleges that Ms. Graciani engaged in conduct that resulted in a significant risk to patient health or safety and constituted unprofessional conduct under 12 AAC 44.770(1) by substituting a test of her choosing for a test that was ordered by a physician, failing to acknowledge and correct medication errors, failing to follow hand-off protocols, falsifying physician orders, failing to administer medication as ordered, and failing to communicate patient needs appropriately. Count III alleges that Ms. Graciani failed "to perform acts within her scope of practice which were necessary to prevent a substantial risk or harm to a client" and that this was unprofessional conduct under 12 AAC 44.770(5). The specific conduct alleged is: "repeated failure to follow hand-off protocols, failure to follow physician orders, failure to communicate patient needs appropriately, withholding ordered medication, administering medication without proper charting, and failure to follow appropriate procedures."

With regard to hostile and disruptive behavior, Counts II and V both allege that Ms. Graciani's behavior was so disruptive and inappropriate as to give rise to disciplinary violations. Count II alleges that Ms. Graciani was "rude, disruptive, argumentative, and hostile with coworkers, staff, patients, and patients' families," and that this was unprofessional conduct under 12 AAC 44.770(1). Count V alleges that Ms. Graciani engaged in "repeated disruptive behavior in the workplace" that "interfered with the provision of patient care," and that this was unprofessional conduct under 12 AAC 44.770(30). Count I also alleges that Ms. Graciani was "argumentative and uncollaborative with staff and coworkers" in a manner "that resulted in a significant risk" to patient health or safety under 12 AAC 44.770(1).

As to PHI, Count IV alleged that Ms. Graciani repeatedly gained "unauthorized access and personal possession of protected patient information, and violat[ed] confidentiality of information concerning a patient," and that this is unprofessional conduct under 12 AAC 44.770(6).

Lastly, Count VI alleges that Ms. Graciani's "intentional deletion of valid and properly entered vital signs data from a patient's medical record and replacement of that data with other data which she knew did not reflect the patient's true condition for the time the original data were entered" constituted intentionally making an incorrect entry and falsification of a patient's record, and that this was unprofessional conduct under 12 AAC 44.770(10).

C. Did the Division meet its burden of proving violations of the nursing statutes or regulations?

1. Falsifying physician orders

Only one allegation was proven as to falsification of physician orders, but it is an extraordinarily serious one. This was the entry of a thrombin time test under Dr. Rodriguez's name for the patient needing an Activated Clotting Time test. As discussed above, the evidence was clear that Ms. Graciani entered an order for a Thrombin time test under Dr. Rodriguez's name, when Dr. Rodriguez did not (and would not have) ordered a thrombin time test for that patient. The Division met its burden of showing that Ms. Graciani, in fabricating the order of a physician, falsified records in violation of 2 AAC 44.770 (10).

2. Substituting a test of her choice for the test ordered by a physician

In addition to having falsified a physician order for a thrombin time test, Ms. Graciani's conduct in this incident – in failing to order the correct test and instead falsifying an order for an unrelated and unnecessary test – unduly prolonged the time before the sheath could be removed and created a risk of significant harm.

Ms. Graciani's then-supervisors noted in their testimony the many resources available to a nurse facing this situation, observing that Ms. Graciani could and should have reached out to peers, the charge nurse, or the leadership team. Her solution – to fail to administer the ACT test and to make up an order for a different test – was massively inconsistent with nursing standards and with the scope of her license, and created a substantial risk of harm to the patient.

The Division met its burden of showing that this was unprofessional conduct in violation of 12 AAC 44.770(1) and represents practice beyond the scope of a nursing license in violation of 12 AAC 440.770(5).

3. Falsification of a patient's medical record

In addition to falsifying physician orders, Count VI alleges that Ms. Graciani's "intentional deletion of valid and properly entered vital signs data from a patient's medical record and replacement of that data with other data which she knew did not reflect the patient's true condition for the time the original data were entered" constituted intentionally making an incorrect entry and falsification of a patient's record, and that this was unprofessional conduct under 12 AAC 44.770(10).

The evidence at hearing established without question that Ms. Graciani altered vital sign data in M.L.'s electronic medical record after learning that the patient had coded. The Division established this count by far more than a preponderance of the evidence.

4. Medication errors

As to allegations that Ms. Graciani failed to administer medication as ordered, failed to acknowledge and correct medication errors, and/or failed to properly chart when administering medication, the evidence supports a finding that Ms. Graciani failed to administer vancomycin to patients G.R. and K.A. in January 2016, and failed to properly communicate with those patients' primary nurses to ensure that the medication was timely administered.

As to G.R., the departure from nursing standards is quite profound, encompassing not only a failure to follow a physician's order that it was her responsibility to carry out, but also the entry of incorrect data in the patient's record (that the medication was "not available"), resulting in a wholly missed day of treatment.

As to K.A., the "outrun" patient, the evidence on this situation is thinner and less profound, but the Division presented evidence that Ms. Graciani was responsible for the administration of vancomycin to this patient, and neither administered the vancomycin nor communicated this omission to the primary nurse. While a simple or isolated medication error may not, in and of itself, be a violation of licensing standards, the failure to take responsibility for the error was unprofessional conduct.

In short, the evidence supports that Ms. Graciani's conduct in failing to administer vancomycin to patients G.R. and K.A. violated, at a minimum, 12 AAC 44.770(1).[253]

5. Hand-off protocols and communicating patient needs

The evidence established that Ms. Graciani failed to follow appropriate hand off protocols as to patients G.R. and K.A. in January 2016, as to P.F. in February 2016, and as to M.L. in October 2016. In each incident, Ms. Graciani withheld or failed to communicate time-sensitive information about a critically ill patient when transferring care of that patient back to the patient's main nurse.

In failing to follow procedures as to G.R., the result was the patient not receiving the ordered medication for more than 24 hours. The undisputed testimony is that this can cause the

[253] Conduct related to patient G.R. may well have violated 12 AAC 44.770(10) as well, but it is not necessary to reach this issue.

patient's level of the antibiotic to fall below the therapeutic range. In the context of a patient hospitalized in the renal care unit and experiencing hospital-acquired pneumonia, this certainly creates a risk to patient health or safety (although the extent of the risk was not established). As to patient K.A, likewise, the patient did not receive the scheduled dose, and Providence concluded he was without the medication for a sufficient time to fall below the therapeutic range.

As to patient P.F., the magnesium sulfate patient, even accepting that Ms. Graciani appropriately withheld the magnesium sulfate at Dr. Mac's direction,[254] she failed to timely communicate to the patient's nurse that the medication had not been administered. Given that the medication had been ordered that day for acute cardiovascular symptoms, this communication failure created an unreasonable risk of harm.

As to patient M.L., there can be no doubt that the failure to follow handoff procedures created a significant risk to patient health or safety. The patient was critically ill and had multiple hypotensive incidents during her time in dialysis. She coded shortly after returning to the IMCU. Not timely communicating these facts to M.L.'s care team before her return to the IMCU created a significant risk to the patient's health.

It is unprofessional conduct for a nurse to fail to perform acts within the nurse's scope of practice which are necessary to prevent substantial risk of harm.[255] The nurse's scope of practice includes hand off communication, including but not limited to clear communication about the withholding of ordered medication.

As to the vancomycin and magnesium sulfate incidents, the record clearly establishes that Ms. Graciani failed to communicate a medication change or a failure to administer medication that was prescribed to be given during dialysis. At least as to G.R. and P.F., the record supports a finding that this communication failure created a substantial risk of harm, and therefore constitutes unprofessional conduct under 12 AAC 44.770(5).

As to M.L., the record clearly establishes a complete failure to conduct handoff communication before the patient was returned to her home unit, and that this failure created a

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254 To the extent that the Division alleges that it was unprofessional conduct to withhold a medication ordered by one physician at the direction of another, this decision cannot make that finding. Such a holding would place too high a burden on nurses to referee physician interactions in the fast-paced hospital inpatient setting and could potentially create an impossible situation in which a nurse whose patient is jointly managed by multiple providers would be guilty of unprofessional conduct for either administering *or* withholding the patient's prescribed medication.

255 12 AAC 44.770(5).

substantial risk of harm to the patient. Ms. Graciani's failure to conduct handoff communication for M.L. constituted unprofessional conduct under 12 AAC 44.770(1) and (5).

6. Workplace behavior rising to the level of unprofessional conduct

While a significant amount of hearing time was spent on testimony about Ms. Graciani's workplace behavior, Ms. Graciani's counsel attempted to dismiss the Division's concerns about these issues out of hand, arguing that they were personnel matters and not within the purview of the Board of Nursing. Ms. Graciani also argues in her post-hearing brief that the evidence established only "isolated instances involving personality conflicts between Ms. Graciani and co-workers."[256]

But standards of professional conduct in the nursing profession expressly include cooperative, non-disruptive behavior.[257] In 2008, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued Sentinel Event Alert 40, entitled "Behaviors that Undermine a Culture of Safety." Sentinel Event Alert 40 identified disruptive behavioral patterns including overt actions, such as verbal outbursts, as well as passive activities, such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities; reluctance or refusal to answer questions; condescending language or voice intonation; and impatience with questions.[258] In the Code of Ethics of the American Nurses Association (ANA), nurses pledge to treat others with respect, and profess their commitment to keeping patients safe through compassionate, caring, collegial relationships.[259]

Of course, "disruptive" behavior must be something significantly more than a bad day, an occasional error, or a personality conflict. Division expert Denise Valentine pointed to behavior

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256 Graciani Post-hearing brief, p. 20.

257 Valentine test.; LeFleur test.; Doyle test.

258 The Joint Commission. Behaviors that undermine a culture of safety. Joint Commission Sentinel Event Alert. 2008; Issue 40. July 9, 2008; updated June 18, 2021. Available online at https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-40-intimidating-disruptive-behaviors-final2.pdf (last retrieved June 7, 2022).

259 Code of Ethics with Annotations, § 1.5 (Relationships with Colleagues and Others: Respect for persons extends to all individuals with whom the nurse interacts. Nurses maintain professional, respectful, and caring relationships with colleagues and are committed to fair treatment, transparency, integrity-preserving compromise, and the best resolution of conflicts. … The nurse creates an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect. This standard of conduct includes an affirmative duty to act to prevent harm. Disregard for the effects of one's actions on others, bullying harassment, intimidation, manipulation, threats, or violence are always morally unacceptable behaviors. Nurses … collaborate to meet the shared goals of providing compassionate, transparent, and effective health services."

that is "consistent and significant," such as, as alleged in this case, a broad scope of complaints and a history of attempts to work with the licensee to improve the work atmosphere.[260]

At least one other state nursing board has addressed the issue of disruptive behavior as a licensing issue. The Louisiana State Board of Nursing revoked the license of a nurse that it found to have engaged in disruptive and abusive conduct similar in many ways to the workplace interaction allegations in this case. There, as here, the evidence at hearing consisted of supervisors' testimony about complaints received about the licensee – including that those complaints "resulted in others refusing to work with [the licensee] and patients becoming insecure regarding staff and the care they were providing" – and the employment discipline that resulted, as well as coworkers' testimony "that [the licensee] was difficult to work with and that [her] behavior disrupted the entire floor on which [she] worked."[261]

Here, the Board's regulations define unprofessional conduct to include both "harassing, disruptive, or abusive behavior by a licensee directed at staff or a client, a client's relative, or a client's guardian;"[262] and "disruptive behavior by a licensee at the workplace that interferes with the provision of client care."[263] Counts II and V of the Accusation both allege that Ms. Graciani's workplace behavior was so disruptive and inappropriate as to give rise to disciplinary violations under these provisions.[264]

The evidence at hearing established that Ms. Graciani's presence on the dialysis team at Providence negatively impacted the overall working environment. It is unprofessional conduct for a nurse to engage in harassing, disruptive, or abusive behavior directed at staff, a client, or a

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260 Valentine test. *Cf.* Reynolds, Norman T. *Disruptive Physician Behavior: Use and Misuse of the Label.* Journal of Medical Regulation, Vol. 98, Issue 1, 8-19, pp. 18-19. ("Physicians, like all human beings, manifest with a wide range of behaviors and means of relating to others stemming from their individual personalities and environmental influences. Anyone can have an occasional expression of inappropriate behavior. The disruptive physician differs from peer physicians in the sense that manifestations of inappropriate behavior represent an ongoing pattern that is pervasive, deep-seated, and resistant to change.")

261 *Holmes v. Louisiana State Bd. of Nursing*, 2013-2154, 156 So. 3d 183, 191 (La. Ct. App. 2014), writ denied, 152 So. 3d 885. In *Holmes*, unlike here, the disruptive behavior had escalated on one occasion to physically pushing a coworker. But the decision in that case was based on disruptive behavior alone, without any allegations of nursing misconduct in patient care.

262 12 AAC 44.770(29).

263 12 AAC 44.770(30).

264 Count I of the Accusation also alleges that Ms. Graciani was "argumentative and uncollaborative with staff and coworkers" in a manner "that resulted in a significant risk" to patient health or safety under 12 AAC 44.770(1). While Ms. Graciani's uncollaborative and disruptive behavior may have had negative implications in the workplace and may have negatively impacted patients who were exposed to workplace conflict, the Division did not show that this behavior was so severe as to have "resulted in a significant risk" to patient health or safety.

client's relative or guardian.[265] The evidence here establishes that Ms. Graciani engaged in extensive disrespectful and otherwise disruptive behavior towards dialysis coworkers and other hospital staff. The evidence further establishes that this behavior occurred with sufficient frequency and severity to implicate the rules of professional conduct. The Division thus met its burden of establishing a violation of 12 AAC 44.770(29).

It is separately unprofessional conduct for a licensee to engage in disruptive workplace behavior that interferes with the provision of client care.[266] Here, it is more likely true than not true that on at least some occasions, Ms. Graciani's disruptive behavior had a negative impact on patient care. The PCT argument that occurred in front of Ms. Hallstrom's daughter, the incident with the elderly dialysis patient, and the incident with the phlebotomist all occurred in front of patients. In all three of these instances, the patients themselves or other caregivers nearby raised concerns that this disruptive behavior was negatively impacting patient well-being. The Division met its burden of establishing that Ms. Graciani engaged in unprofessional conduct in violation of 12 AAC 44.770(30).

7. Patient confidentiality violations

Lastly, the Division met its burden of proving that Ms. Graciani violated her obligations towards patient confidentiality. 12 AAC 44.770(6) defines unprofessional conduct to include "violating the confidentiality of information or knowledge concerning a patient." Ms. Graciani has admitted this conduct as far as accessing her ex-husband's record in 2014, but denies both that her access of nephrology patient D.F.'s chart was inappropriate, and that she had PHI in her cubby.

As discussed above, the allegation as to D.F. was unproven. As to the cubby documents, however, the Division met its burden of establishing that more than 350 pages of those documents containing patient names and private medical information were in Ms. Graciani's unsecured cubby. Her possession and storage of these patient records in an open cubby was a significant patient confidentiality violation and constituted unprofessional conduct under the Board's regulations.

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265 12 AAC 44.770(29).
266 12 AAC 44.770(30).

D. What sanction, if any, is appropriate?

Having found that Ms. Graciani committed the violations described above, the Board must determine what disciplinary sanctions, if any, are appropriate for these violations.

1. Framework

The disciplinary powers of this board range from reprimand to permanent revocation, and include the power to suspend for an identified period of time, and to impose practice conditions or limitations, probation, peer review, fines, and educational requirements.[267]

By regulation, the board has established disciplinary guidelines "[t]o ensure that the board's disciplinary policies are known and are administered consistently and fairly."[268] The guidelines provide direction and guidance on when the board should choose revocation over suspension as a sanction, and on the length of a suspension, but do not address imposition of the other available sanctions such as reprimands, fines, additional education requirements, or placing conditions on the license.[269] The board is not prohibited from imposing greater or lesser sanctions than suggested by the guidelines.[270] However, the board must seek consistency in the application of disciplinary sanctions and must explain significant departures from prior decisions involving similar facts.[271]

Under the guidelines, license revocation is reserved for the most serious violations. The guidelines suggest that the board may exercise its discretion to revoke a license under nine circumstances, three of which may be pertinent to Ms. Graciani's situation.

> The board will, in its discretion, revoke a license if the licensee
> (6) impersonates another health care provider;
> (7) intentionally or negligently engages in conduct that results in a significant risk to the health or safety of a client or injury to a client; or
> (8) engages in unprofessional conduct, as described in 12 AAC 44.770, if the health, safety, or welfare of another person is placed at risk[.][272]

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267 AS 08.68.275(a)(2), (5)-(9); AS 08.01.075(a).

268 12 AAC 44.700.

269 12 AAC 44.720.

270 12 AAC 44.710(b). A board's choice of disciplinary sanctions typically will be upheld if reasonable and explained with reference to evidence in the record. *Wendte v. Alaska Board of Real Estate Appraisers*, 70 P.3d 1089, 1094-1096 (Alaska 2003) (explaining that a licensing board "must exercise its discretion reasonably" and upholding a board's exercise of its discretion to impose sanctions because the decision was based on relevant and current information contained in the record and cited in the decision).

271 AS 08.01.075(f); AS 08.68.275(f) ("The board shall seek consistency in the application of disciplinary sanctions. A significant departure from prior decisions involving similar situations shall be explained in the findings of fact or order.").

272 12 AAC 44.720(a).

The guidelines also contain some overlap between revocation and suspension, in that unprofessional conduct (as well as repeat violations) can be the basis for either sanction.[273]

2. Severity of violations

While the board must seek consistency in the application of disciplinary sanctions, the sheer number and breadth of Ms. Graciani's violations makes it difficult to locate directly comparable prior cases.[274] At the same time, the number and breadth of violations here is somewhat of a distraction to the bottom line, which is the severity of the most significant violations. If this were *only* a case about unprofessional workplace interactions, the recommended sanction would likely consist of a reprimand, additional training, and a period of probation or other supervision. If this were *only* a case about improper handling and storage of PHI, the recommended sanction might rise to include a short suspension. Even as to the patient care violations, if this were a case about the missed administration of vancomycin or about communication between nurses about medication timing, those incidents alone would be unlikely to warrant revocation.

But this case involves – in addition to the workplace violations, the PHI violations, and the medication handoff incidents – several additional violations so severe as to compel the result. The most glaring violations in this case were revealed relatively late in the hearing and are far more severe than some of the other violations found above. In particular, Ms. Graciani's falsification of the thrombin time test, failure to conduct a handoff communication for M.L., and falsification of M.L.'s chart – as well as her dishonesty about all three events – are extremely serious violations of her license. These incidents showcase both a callous disregard for patient well-being and a fundamentally dishonest character inconsistent with the most basic obligations of the profession.

The board has revoked RN licenses for unprofessional conduct that places patient health and safety at risk. In 2007, the board revoked the license of an RN who failed to do necessary

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273 Unprofessional conduct that does not place another person at risk can trigger a one-year suspension under the guidelines, while unprofessional conduct that creates such a risk can warrant a two-year suspension or revocation.

274 None of the Board's prior cases are sufficiently similar to the wide range of violations here to serve as a benchmark, although the Board has revoked RN licenses in other wide-ranging cases that involved practice outside the scope of licensure (*In re Ronald S. Medley*, Case Nos. 2300-93-008, 2300-96-004, final decision Nov. 17, 2000), entering false vital signs ((*In re Rene Fields Kruzie*, Case No. 2300-89-2, final decision Dec. 7, 1989), and disruptive behavior alongside records falsification and other patient care violations (*In re Cory D. Polon*, Case Nos. 2304-03-005, 006, 010, 011, 012, 016, and 017, final decision Sept. 22, 2004).

follow up and failed to maintain appropriate chart notes regarding disease treatment for communicable diseases.[275] In 2004 the board revoked RN and ANP licenses of a nurse who engaged in misconduct involving prescriptions as well as dishonesty.[276] Both cases are relevant not only to Ms. Graciani's intentional conduct that put patients at risk, but also to her deceptive charting to disguise her errors.

Both the M.L. non-handoff and the unilateral replacement of an ACT test with the Thrombin time test were unprofessional conduct that created a significant risk of harm to the patient. In both cases, the willfulness of the conduct is a significant added concern. Ms. Graciani did not contact the patient's charge nurse because it was too much of a hassle. She could not figure out how to order an ACT test, so she ordered something different instead. Importantly, neither situation involved a simple good faith mistake. Rather, both involved at least some level of intentional decisionmaking that failed to prioritize patient safety

3. Significance of deceptive conduct

The intentional misconduct would be concerning enough without the fact that here, the significant risks created by her conduct were then further compounded by Ms. Graciani's dishonesty – which in both instances extended to entering false information into the medical record. Concerning the missed handoff incident with M.L., Ms. Graciani failed to conduct a handoff before sending the patient back to her home floor, falsely documented that the receiving nurse had been unavailable, and then falsified the patient's vital signs in Epic after the patient coded. As to her falsification of the thrombin time test order, Ms. Graciani failed to ensure that the needed and time-sensitive lab test was performed, instead falsifying an order for a different test and then lying about it. In both instances, Ms. Graciani displayed a profound lack of concern for her patient's safety, coupled with a disturbing willingness to exceed her scope of practice and lie – including falsifying patient records – to cover it up.

Above and beyond the inherent severity of these two violations, both the intentionality of Ms. Graciani's conduct, and her dishonesty are significant factors for the board's inquiry into what level of sanction is warranted here. "The board's prior decisions reflect an understandable intolerance for deception and dishonesty."[277] The board has previously considered deception and dishonesty in decisions to revoke a license, as well as denying licensure where an applicant had

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275 *In re Hamshar*, OAH No. 06-0555-NUR at 20 (Alaska Board of Nursing 2007).
276 *In re Polon*, Case Nos. 2304-03-005, 006, 010, 011, 012, 016, and 017 (Alaska Board of Nursing 2004).
277 *In re Small*, OAH No. 09-0396-NUR & 10-0057-NUR, at 48 (Alaska Board of Nursing 2010).

been dishonest about work history and then failed to demonstrate that she was "fully rehabilitated from this misconduct."[278] The reason for this focus on honesty is not simply blind devotion to an ethical ideal, but rather the critical need for honesty in the nurse's day-to-day practice. The board explained this linkage in its 2006 *Kimble* decision, where a nurse sought licensure after forging records relating to prior professional experience.

> Honesty is a key trait in nursing. Nurses administer medication. In the course of a career, it is common for a nurse to make a number of medication errors. Even though the errors reflect poorly on the nurse, the nurse must accurately chart the dosages and times the medications were actually given and bring the errors to the attention of supervisors or physicians.[279]

In Ms. Kimble's situation – in striking parallel to Ms. Graciani's – the Board noted that her "deceptions involved a sustained and premeditated cover up of her past actions, including the forgery of records," and that this was all done "in circumstances where the conduct could put patients at risk."[280] Accordingly, the board concluded, "the dishonesty went to the core of the attributes that are required of a nurse, indicating that she could not be trusted to own up to errors she might commit in patient care."[281]

The board has not limited its honesty discussions to outright lies and forgery (although those are present in this case). Noting the well-established principle that "it is critically important for nurses to be honest, forthright and willing to acknowledge the errors they make," this board has also refused to license applicants who have "shown a pattern of concealing or minimizing [their] conduct."[282] Here, the evidence establishes not just rank dishonesty in the falsification of the Thrombin time test and the alteration of M.L.'s vital signs in Epic, but also a widespread pattern of deflecting and minimizing responsibility for errors. Multiple witnesses testified that, as the board has observed in other cases, this behavior leads them to believe that Ms. Graciani cannot be trusted to self-report errors or seek out guidance when she needs it.[283]

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278 *In re Kimble,* OAH No. 06-0032-NUR, at 12 (Alaska Board of Nursing 2006).

279 *Id.*, at 10.

280 *Id.*, at 10.

281 *Id.*, at 10.

282 *In re Acha*, OAH No. 17-0906-NUR, at 1 (Alaska Board of Nursing 2018) ("Mr. Acha has shown a pattern of concealing or minimizing that conduct that continued through his Alaska application process and his Alaska hearing in 2017. As this Board has held in prior decisions, it is critically important for nurses to be honest, forthright and willing to acknowledge the errors they make.").

283 Doyle test. (noting she was unaware of Ms. Graciani "ever acknowledging a mistake"); Franz test. (noting importance of nurses being "reflective" in order to learn from mistakes and prevent future recurrences and stating she does not believe Ms. Graciani "can be counted on to own up to her own errors," including medication errors).

Her conduct in the M.L. and Thrombin test incidents are direct evidence of this untrustworthiness; her habit of deflecting and denying responsibility is further evidence of Ms. Graciani not being reliable to self-report an error.

Ms. Graciani's own hearing testimony highlighted these same concerns; her inability to admit wrongdoing or even acknowledge adverse facts casts further doubt on whether she possesses the necessary honesty nurses require.[284] Likewise, Ms. Graciani's purported reflections on lessons supposedly learned during the disciplinary process focused on others' actions, never her own, and rang hollow.[285]

4. Scope of violations

Even without the other violations, this decision would invoke license revocation for the violations surrounding the non-handoff and the falsified Thrombin test (including the falsification of records and other dishonesty present in both events). As it is, the intentionality and deception that underlie these violations also inform the board's assessment of Ms. Graciani's culpability as to both the disruptive workplace conduct and the PHI. In both of these areas, Ms. Graciani pervasively deflected responsibility for her actions, up to and including denying the words right in front of her.

All told, the violations present a series of problems that go to the heart of the nursing profession, and the expectations the board, other professionals, and the public hold for licensees. Ms. Graciani has:

- Falsified orders and medical records,
- Disregarded physician orders,
- Failed to communicate with other professionals about the care of shared patients,
- Treated colleagues throughout the care setting with disdain and disrespect, and
- Flagrantly ignored her obligation to safeguard confidential patient health records.

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284 *See In re Kimble*, OAH No. 06-0032-NUR, at 6 (Alaska Board of Nursing 2006) ("Ms. Kimble was a witness who had difficulty giving direct, accurate and fully coherent answers to the questions addressed to her. This impression was pervasive throughout her testimony.").

285 *See In re Small, supra*, pp. 49 ("The most telling thing about whether she would use better judgment as a result of this learning experience is that she does not seem to appreciate the risk she subjected her patients to and she does not take responsibility for the lapse in judgment.").

Particularly where the M.L. incident, the Thrombin time incident, and the data falsifications so clearly warrant revocation on their own, the compounding effect of the other violations is significant.[286] So too is Ms. Graciani's insistence on deflecting responsibility for every single violation and attempting to portray this licensing action as an employer's devious plot, rather than acknowledging her role in the many events that led to this action.

The evidence at hearing established multiple violations of the board's regulations, including multiple serious intentional acts that put patient safety at risk. The evidence further shows that Ms. Graciani has engaged in a pattern of deceptive conduct – in medical records, in disciplinary meetings, when confronted with mistakes, in her testimony before the arbitrator, and in her testimony in this case. She cannot be trusted to adhere to the standards of the profession. While not a decision made lightly, this decision concludes that the appropriate remedy here is revocation of Ms. Graciani's license.

VI. Conclusion

The Division met its burden of proof as to misconduct warranting the disciplinary sanction of revocation. Accordingly, Debra Rena Graciani's Registered Nurse License No. 33198 shall be revoked.

Dated: June 13, 2022.

Signed
Cheryl Mandala
Administrative Law Judge

[286] See *Matter of Small*, OAH No. 09-0396-NUR & 10-0057-NUR, at p. 47 (concluding that each of two proven violations would warrant revocation but "together they demand revocation because the deceit reflected in [the licensee's conduct] raises serious concerns about whether [the licensee] can be trusted to own up to errors in patient care.") (Alaska Board of Nursing 2010).

Adoption

The Alaska Board of Nursing adopts this decision as final under the authority of AS 44.64.060(e)(1). Pursuant to AS 44.62.520(a)(2), the Board's decision is effective immediately.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of distribution of this decision.

DATED this 5 day of August, 2022.

By: *Signed*
Danette M. Schloeder
Chair, Alaska Board of Nursing

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]