
## States Give Troubled Caregivers a Pass

By Charles Ornstein and Tracy Weber

ProPublica is a non-profit, investigative reporting newsroom founded in 2008 to fill a gap created by a decreased amount of investigative reporting at typical newspapers, which have been financially challenged in recent years. We have 19 reporters and partner with mainstream organizations both large and small on our articles. We make our data available for their own stories as well.

When the protection of the public is inconsistent, it will become suspect, and states will inevitably create more rules pertaining to public protection. This is why we decided to look at the underside of the health profession in California and around the country.

In 2004, we wrote a series of articles about a very troubled hospital in Los Angeles. It was started in 1965 to provide care to a minority population that did not have health resources easily available. Over the years, it had become one of the worst hospitals in the country, jeopardizing the very people that it was attempting to help. And we showed that by any variety of standards, this hospital was incredibly challenged. One of the key findings was that nurses were doing very harmful things, such as giving patients the wrong drugs and turning down cardiac monitors. Patients were dying without the cause being noted.

In 2007, a woman died at this hospital. She fell out of her wheelchair and rolled around on the floor for 45 minutes. People walked past her, but she was not treated. This scenario was captured on the hospital's video cameras. Two people did call 911 to say that the hospital was not caring for her, but ultimately nobody came to her aid and she died. As the district attorney and others were looking into the case, they determined that the triage nurse was the person who largely ignored things and tried to cover up after the fact. The woman was reckless and she would be liable for involuntary manslaughter due to her failure to perform her legal duty with a substantial factor of causing this woman's death. That's a pretty serious situation. But the woman continues to have a clear license to practice anywhere in California. There is no notation of the incident.

We began checking on a lot of nurses specifically named in our stories who were turning down monitors

or giving incorrect doses or incorrect medication. None of the nurses were disciplined even though they were turned in to the nursing board. Obviously, we had some pretty challenging questions.

We decided to look at 2,400 different records of nurses and to put them all in a database in order to track how long it takes to discipline a nurse. It allowed us to track the length of time from accusation to discipline, and it was something that board of nursing had never done. We found that it took an average of three years and five months to discipline a nurse, even if a patient had died and there was gross negligence. There was no prioritizing of cases.

We also found that the board was not tracking nurses who were on probation and were still getting in all sorts of trouble. Nurses would be fired by other state agencies for negligence and would still have clean licenses. Nurses had even lost other licenses and would still have their registered nurse licenses and be free to work.

In one particular case, a male nurse had got into trouble at one hospital for beating a patient, and the hospital reported him to the state nursing board. That was the end of it. At his next hospital, he beat up two patients and was criminally charged with felony. That hospital also reported him to the nursing board, but he was able to get another job at another hospital before the criminal case went through. He still had a clear license when we were doing our story, which was well after the fact. He subsequently said that he had gone through anger management courses as a part of his criminal case, but also said the nursing board is there to protect patients from people like him. He admitted he had a problem, but said he dealt with it - which was really an indictment of the fact that the board was supposed to be protecting patients.

We also found that some nurses did not believe that the charges against them were valid and because it took so long to go through their case, witnesses or paperwork at the hospital were gone or lost. They said they continued to have a cloud over their head. So it was bad for both the guilty and innocent nurses. At the core, we found was that the board was not protecting patients, and it was not good for nurses or patients.

We tracked a lot of cases in order to track sanctions on nurses and how many times they got into trouble before action was taken against them. After our story came out, the California governor took quick action to remove some members of the nursing board. The head of the nursing board resigned. What we found out then was that problems affecting the nursing board were affecting all of the state's health-related boards because they shared a pool of investigators. They were all relying on the same pool to investigate cases.

We found a case where a nurse was going from hospital to hospital injecting Propofol (a short-acting, intravenously administered hypnotic agent used to induce sleep or general anesthesia). She even posed as a nurse in a hospital where she wasn't working in order to get Propofol. We had to go to five

courthouses to find a criminal conviction - and she still had a clear license. Ultimately, she was able to endanger a lot more patients as the result of slow movement of the process.

We also found that nurses that had been disciplined in neighboring states were not disciplined in California. We started to track how nurses were able to move from place to place and state to state even after they were disciplined. Because these states were not uniform about relying on each other, nurses were able to get into trouble in one state and practice in another.

One nurse got in serious trouble in Florida where she neglected the care of a baby and the baby died. She lost her license in Florida. She still had a clear license in Connecticut. When we interviewed a Florida spokesperson, he said he “just figured Connecticut would find out.”

What people forget is that a nurse or a PT can be in another state in 20 minutes when the states are close. We found a lot of cases where nurses will lose a license in one state and travel 20 minutes to a neighboring state and have a clean license. The states are telling each other that they are always connected through a general database run by a nursing board. There are a lot of holes in that process.

Some states consider accusations to be public information and some states don't. From our perspective, the public is interested from the moment the complaint comes in the door. Boards have different standards when it comes to public exposure. And I would like to challenge everyone to put disciplinary actions online. Some states make a person file for freedom of information, pay $20 to see a disciplinary action and wait 30 days to see it. How is that protecting the public?

I think Arizona is one of the few states that we found that posted complaint information. We thought that was great because it led a potential employer to ask questions. But we know health care professions are immensely powerful in terms of getting a legislator to take a different point of view.

Eventually, we were led to a couple of federal databases that hospitals and other state and regulatory agencies can access to look for discipline against practitioners. We found there were major gaps in the database, and we wrote a story in February about how it appeared certain boards of pharmacy and boards of nursing were not reporting cases. One board had reported a single case since 1996 and we found that they were disciplining dozens of pharmacies a year. Four months after the story ran, states reported an additional 70,000 caregivers to this database that they hadn’t reported before. Reports are still coming in. Still, there is an unwarranted assumption on the part of regulators that providers will be honest when they renew their licenses.

We also found in California that discussion may have happened within the walls of the board offices, but it was never shared with the board at public meetings. Public meetings applauded people’s contributions in the field, but there was never discussion of tough issues such as why it took 41 months to discipline a practitioner. When California finally decided to take a look at discipline across its borders, it found 3,500

cases in which nurses with clean California licenses had been disciplined in other states. The estimate is that they would have to discipline 2,000 of those nurses in addition to its average disciplining of 300 nurses per year. That is a huge number.

As mentioned earlier, some states do not prioritize cases. However, in states where the best practices are employed, that's the first thing that is done. Cases where patients may be put in harm's way are addressed first. Other states evaluate their process on a regular basis. The Texas Board of Nursing has six pages of statistics it evaluates every quarter and it compares the information with previous quarters. Ultimately, boards must be asked, "Are you protecting your public?" "Are you putting the interest of the public first?" and most importantly, "Can you honestly say at the end of the day that the public is being put before the interest of the profession?"

*ProPublica's Charles Ornstein and Tracy Weber have focused their work on loopholes in the disciplinary process, particularly in nursing.*