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

In the Matter of the Accusation Against: **CARLOS RAY KOTSAKOS** 452 Texas Avenue Gulfport, MS 39507 Registered Nurse License No. 636229 Respondent.	Case No. 2008-306 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about April 16, 2004, the Board issued Registered Nurse License Number 636229 to Carlos Ray Kotsakos (Respondent). The license expired on June 30, 2007, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

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

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

6. Code section 2811, subdivision (b) provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Code section 2761 states, in pertinent part:

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

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

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

. . ."

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

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

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

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

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

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

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

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

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

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

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

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

COST RECOVERY

11. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the case investigation and enforcement.

FACTUAL BACKGROUND

12. In August 2005, Respondent was assigned to Kaiser's Santa Teresa Medical Center in San Jose as a long-term travel nurse employed by Valley Healthcare Systems, Inc. He was on a 13-week contract, assigned to work in the Medical-Surgical Unit, when he made a medication error resulting in the death of a 21-year-old chemotherapy patient, as follows:

a. The patient, CW,[1] was diagnosed in July 2005 with T-cell non-Hodgkin's lymphoma[2] with positive cerebrospinal fluid cytology. He was being treated at Kaiser Santa Teresa.

b. On or about August 26, 2005, Respondent was working in the Medical-Surgical Unit and assigned to care for CW. Respondent noted an order by CW's oncologist for an injection into the spinal canal (intrathecal administration) of the chemotherapy agent Cytarabine.[3] A pharmacist delivered chemotherapy medication and Respondent notified the oncologist that the chemotherapy was available for administration. However, the drug delivered was not Cytarabine; it was the powerful neurotoxin, Vincristine, and was intended for another patient's chemotherapy.

c. Vincristine is extremely toxic to the central nervous system; it is never to be administered intrathecally and must only be administered by intravenous (IV) injection. Accidental intrathecal administration is exceedingly dangerous, with a mortality rate approaching 100 percent.[4]

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1. The patient is identified only by his initials to protect his and his family's privacy; his name will be disclosed in discovery, upon request.

2. Non-Hodgkin's lymphoma (NHL) describes a group of cancers which arise from lymphocytes, a type of white blood cell. These lymphomas are a diverse group of diseases with varying courses, treatments, and prognoses.

3. Cytarabine is a chemotherapy agent used mainly in the treatment of hematological malignancies such as leukemia and non-Hodgkin's lymphoma. It is also known as Ara C.

4. The medical literature documents cases of ascending paralysis due to massive encephalopathy and spinal nerve demyelination, accompanied by intractable pain, almost uniformly leading to death; a handful of survivors were left with devastating neurological damage with no hope of recovery.

d. When the oncologist arrived, Respondent removed and discarded the drug labeling identifying the medication and the patient for whom it was intended, without following the Five Rights of medication administration by verifying: 1) right patient; 2) right route; 3) right dose; 4) right time; and 5) right medication. Respondent did not verify with another licensed practitioner the right chemotherapy drug, dose and patient, nor did he perform an audible time-out with the administering physician prior to administration.

e. Without having verified the contents of the syringe containing Vincristine, or the patient for whom the drug was intended, Respondent handed the unlabeled syringe to the administering oncologist who injected its contents into CW's spinal canal. Cerebrospinal fluid (CSF) lavage was performed in an effort to dilute and remove the drug, thus limiting neural damage, but was unsuccessful.

f. As a result of the intrathecal administration of Vincristine, CW died on August 29, 2005.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence: Failure to Follow the Five Rights)

13. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that he failed to follow the Five Rights of medication administration resulting in a lethal administration to a patient of the wrong medication, as described in paragraph 12, above.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence: Removal of Medication Identifiers)

14. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that he removed medication labeling identifying the patient and drug prior to providing the medication to the administering physician, as described in paragraph 12, above.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence: Failure to Perform Verification)

15. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence and/or incompetence in that, prior to administration of chemotherapy, he failed to verify with another licensed practitioner the right drug, dose and patient, as described in paragraph 12, above.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence: Failure to Perform Audible Time-Out)

16. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that he failed to perform with the administering physician an audible time-out prior to administration of chemotherapy to a patient, as described in paragraph 12, above.

PRAYER

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

1. Revoking or suspending Registered Nurse License Number 636229, issued to Carlos Ray Kotsakos;

2. Ordering Carlos Ray Kotsakos to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: 4/29/08

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

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