

1 **ARIZONA STATE BOARD OF NURSING**
2 **4747 North 7th Street Ste 200**
3 **Phoenix AZ 85014-3655**
4 **602-771-7800**

5 IN THE MATTER OF REGISTERED NURSE
6 LICENSE NO. RN137552

7 ISSUED TO:
8 AMANDA LUCIA TRUJILLO

9 Respondent.

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER NO. 13A-1311014-NUR**

10 A hearing was held before Diane Mihalsky, Administrative Law Judge (“ALJ”), at 1400 West
11 Washington Suite 101, Phoenix Arizona, on January 15, 2014 at 8:00 a.m. and February 3, 2014 at
12 10:00 a.m. Carrie H. Smith, Esq., Assistant Attorney General, appeared on behalf of the State.
13
14 Amanda Lucia Trujillo appeared in person on her own behalf.

15 On March 7, 2014, the ALJ issued Findings of Fact, Conclusions of Law and
16 Recommendations. On March 28, 2014, the Arizona State Board of Nursing met to consider the ALJ’s
17 recommendations. Based upon the ALJ’s recommendations and the administrative record in this
18 matter, the Board makes the following Findings of Fact and Conclusions of Law.
19

20 **FINDINGS OF FACT**

21 **BACKGROUND AND PROCEDURE**

22 1. The Arizona State Board of Nursing (“the Board”) has the authority to regulate and
23 control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1606, 1663, and 1664.
24 The Board also has the authority to impose disciplinary sanctions against the holders of nursing
25 licenses for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 through 1667.
26

27 2. The Board issued Registered Nurse License No. RN137552 to Amanda Lucia
28 Trujillo (“Respondent”).
29

1 3. On or about April 26, 2011, the Board received a complaint from a hospital in Arizona
2 (“the Hospital”) alleging that Respondent practiced beyond the scope of her license in April 2011, by
3 writing an order without the permission of the patient’s physician. Based on this information, the Board
4 opened an investigation.
5

6 4. After the Board issued a notice of charges, Respondent obtained the representation of
7 counsel. On or about December 17, 2012, the Board and Respondent entered into a Consent Agreement
8 in which Respondent admitted that the conduct and circumstances described in the Findings of Fact
9 constituted sufficient cause pursuant to A.R.S. § 32-1664(N) to revoke, suspend, or take other
10 disciplinary action against her license, that she agreed to the issuance of an order of probation, and that
11 she waived all rights to a hearing, rehearing, appeal, or judicial review relating to the Hospital’s
12 complaint.¹
13

14 5. In the Consent Agreement, Respondent admitted that the following events occurred
15 during her employment by the Hospital:
16

17 11. Hospital], Respondent provided more than 100 pages of
18 liver transplant education to [a patient], who had end stage
19 liver disease, but who had not been evaluated for liver
20 transplant surgery, was not on the liver transplant waiting
21 list, was not scheduled for liver transplant surgery, was not
22 scheduled for a liver transplant evaluation the following day,
23 and was not scheduled for any other “major invasive
24 surgery”. . . . [The patient’s] medical record indicated: “We
25 will bridge [the patient] through to see a hepatologist to see
26 if patient would qualify for a liver transplant, which seems to
27 be a viable option at this time. Short of that, [the patient]
28 may become hospice.” Respondent states that when she
29 assessed [the patient], she determined that [the patient]
lacked knowledge about her disease, her medications, home
care, and liver transplant. Respondent states that although
the medical records document that [the patient] was not
scheduled for a liver transplant evaluation at [the Hospital],
Respondent recalls receiving [a] report from the previous
nurse that [the patient] was scheduled for a liver transplant

¹ The Board’s Exhibit 1, Consent Agreement at 5.

1 the next day.

2 12. [In April] 2011, while working as a RN at [the
3 Hospital], the Respondent entered an order for a social
4 services case management consult to evaluate “patient for
5 home hospice or inpatient hospice per patient request”
6 under a physician’s name when she had not obtained a
7 verbal or written order from the physician for the consult.

8 15. Respondent has violated [the patient’s]
9 confidentiality and privacy in written correspondence, on
10 social media, and in interviews about [the patient] including
11 [the patient’s] dates of hospitalization, place of
12 hospitalization, purported diagnosis, purported knowledge
13 deficits, purported nursing care, and purported treatment
14 decisions. Respondent denies breaching [the patient’s]
15 confidentiality and privacy, but agrees that she will not
16 disclose confidential patient information learned in the
17 course of treatment in the future to anyone other than
18 members of the health care team for health care purposes.²

19 6. In the Consent Agreement, Respondent also admitted the charged violations of former
20 A.R.S. § 32-1601(18)(d) and (j) (effective September 30, 2009),³ including the following specific
21 sections of A.A.C. R4-19-403 (effective January 31, 2009) that further define unprofessional conduct
22 for a registered nurse:

23 1. A pattern of failure to maintain minimum standards of
24 acceptable and prevailing nursing practice;

25

26 3. Failing to maintain professional boundaries or engaging
27 in a dual relationship with a patient, resident, or any
28 family member of a patient or resident;

29

30 12. Assuming patient care responsibilities that the nurse
31 lacks the education to perform, for which the nurse has
32 failed to maintain nursing competence, or that are
33 outside the scope of practice of the nurse⁴

34 _____
35 ² Id. at 3-4.

36 ³ Former A.R.S. § 32-1601(18) defined “unprofessional conduct” to include the following:

37 (d) Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.

38

39 (j) Violating this chapter or a rule that is adopted by the board pursuant to this chapter.

40 ⁴ See the Board’s Exhibit 1, Consent Agreement at 4-5.

1 7. In the Consent Agreement, Respondent agreed that her license would be placed on
2 probation for a term of twelve months. Respondent agreed that the terms of her probation would
3 include the following:
4

5 2. Psychotherapy

6 Within thirty days of the effective date of this Order,
7 Respondent shall submit to the Board for approval the name
8 of a behavioral health professional with expertise in treating
9 persons with medical and psychiatric concerns to conduct
10 psychotherapy sessions twice a month for a minimum of six
11 months. Within seven days of receipt of approval from the
12 Board, Respondent shall make an appointment to begin
13 participation in psychotherapy. Respondent shall execute
14 the appropriate release of information form(s) to allow the
15 treating professional(s) to communicate information to the
16 Board or its designee, and Respondent shall immediately
17 provide a copy of the entire Consent Agreement to all
18 treating professional(s). . . . Respondent shall continue
19 undergoing treatment until the treating professional(s) notify
20 the Board, in writing on letterhead, that treatment is no
21 longer needed. . . .

22 3. Ethics Counseling

23 Within thirty days from the effective date of this
24 Order, Respondent shall make an appointment to begin
25 professional ethics counseling with a Board approved
26 Fellow from the Lincoln Center for Applied Ethics.
27 Respondent shall execute the appropriate release of
28 information form(s) to allow the ethics counselor to
29 communicate information to the Board or its designee
Prior to the beginning of counseling, Respondent shall
furnish a copy of this Consent Agreement and Order to
include Findings of Fact and Conclusions of Law to the
counselor. Respondent shall cause the counselor to notify
the Board in writing within fifteen days of entry into the
counseling, and to verify in that same letter receipt of the
Consent Agreement and Order to include Findings of Fact
and Conclusions of Law.

Respondent shall undergo and continue ethics
counseling at a minimum of twice per month for three
months (six sessions) or until the counselor determines and

1 reports to the Board in writing and on letterhead, that
2 treatment is no longer considered necessary or the
3 counseling has been successfully completed by the
4 Respondent. During the duration of the course of
5 counseling Respondent shall have the ethics counselor
6 provide written reports to the Board every month. The
7 Board reserves the right to amend this Order based on the
8 recommendations of the ethics counselor.⁵

9 8. At the Board's regularly scheduled meeting in November 2013, it considered
10 Respondent's failure comply with the Consent Agreement by failing to provide the name of a
11 psychotherapist for the Board's approval, by failing to begin psychotherapy, by failing to undertake
12 ethics counseling with a Fellow from the Lincoln Center for Applied Ethics, and by continuing to post
13 information about the patient at the Hospital on her Facebook page and blog, NURSEINTERRUPTED
14 [sic].

15 9. The Board voted to refer the matter to the Office of Administrative Hearings, an
16 independent agency, for an evidentiary hearing on Respondent's failure to comply with the Consent
17 Agreement.

18 10. On December 5, 2013, the Board issued a Complaint and Notice of Hearing, charging
19 Respondent with having committed unprofessional conduct as defined by A.R.S. § 32-1601(22)(d) and
20 (j) (effective August 2, 2012),⁶ specifically A.A.C. R4-19-403(9) (effective January 31, 2009),⁷ and
21 A.R.S. § 32-1601(22)(g) and (i) (effective August 2, 2012).⁸

23 ⁵ Id. at 8-9.

24 ⁶ These statutory subsections are identical to A.R.S. § 32-1601(18)(d) and (j) (effective September 9, 2009).

25 ⁷ A.A.C. R4-19-403(9) provides as follows:

26 For purposes of A.R.S. § 32-1601(22)(d), any conduct or practice that is or might be harmful or dangerous to the
27 health of a patient or the public includes one or more of the following:

28
(9) Failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the
29 nurse's employer designed to safeguard the patient

⁸ A.R.S. § 32-1601(22)(g) and (i) define "unprofessional conduct" as follows:

(g) Wilfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter.

. . . .
(i) Failing to comply with a stipulated agreement, consent agreement or
board order.

1 investigation and the Consent Agreement. Respondent testified that she could not afford to pay for
2 psychotherapy.

3
4 16. Ms. Smith testified that the Board's mission is to protect the public and patients. Ms.
5 Smith testified that if the nurse is doing everything she can to comply with a consent agreement, it is
6 not uncommon for the Board to allow the nurse additional time, for example, 30 to 90 days, to comply
7 if patient safety and the public welfare are not affected. Ms. Smith testified that due to the holidays, on
8 or about January 15, 2013, the Board agreed to a 30-day extension for Respondent to submit the name
9 of a psychotherapist and to begin ethics counseling with a fellow from the Lincoln Center of Applied
10 Ethics.
11

12 17. Ms. Smith testified that the Board has many psychotherapists on its approved list and that if
13 a nurse wishes to be treated by a psychotherapist who is not on the Board's approved list, she need only
14 submit the name of the psychotherapist and that the Board would review the psychotherapist's
15 qualifications to ensure that he or she has the appropriate experience and qualifications to treat the
16 nurse.
17

18 18. Ms. Smith testified that on February 17, 2013, Respondent notified Board staff that she
19 had selected psychologist Mark Treegoob, Ph.D. and had scheduled her initial therapy session with Dr.
20 Treegoob to begin the second week in March. Dr. Treegoob is on the Board's approved list. However,
21 the Board never received confirmation from Dr. Treegoob that Respondent had started psychotherapy
22 or that Dr. Treegoob had received a copy of the Consent Agreement.
23

24 19. Ms. Smith testified that Respondent never indicated that she had undertaken
25 psychotherapy with a Board-approved psychotherapist or submitted the name of a different
26 psychotherapist for the Board's approval.
27
28
29

1 20. Respondent indicated that she was receiving healthcare benefits provided by the Arizona
2 Health Care Cost Containment System (“AHCCCS”) and that through her AHCCCS benefits, she could
3 obtain psychotherapy from a psychotherapist at Terros behavioral health services in Phoenix. At the
4 January 15, 2014 hearing date, Respondent stated that she would submit the name of a psychotherapist
5 at Terros for the Board’s approval. However, as of the February 3, 2014 hearing date, Respondent had
6 not submitted the name of any psychotherapist for the Board’s approval and had not started
7 psychotherapy.
8

9
10 21. Ms. Smith testified that the Lincoln Center for Applied Ethics offers a fellowship
11 program through Arizona State University (“ASU”) that includes some professionals in the ASU
12 School of Nursing. Ms. Smith testified that the Lincoln Center recently started offering a new program
13 free of charge.
14

15 22. On February 17, 2013, Respondent informed Board staff that she had contacted the
16 Lincoln Center for Applied Ethics and had been informed that it was not prepared to accept students at
17 that time, but anticipated that enrollment would begin in July 2013.
18

19 23. On or about June 24, 2013, the Board sent an email to all nurses who were required to
20 take ethics courses that ASU was offering a free, four-day Board-approved course entitled, “Ethical
21 Foundations and Decision Making for Nursing Practice” that might fulfill the requirements of their
22 consent agreements. Respondent replied to the message, “If you offer other free ethics courses let me
23 know.”¹⁰
24

25 24. Ms. Smith testified that the goal of one-on-one counseling for an individual who has
26 been in trouble for not taking responsibility for poor decisions in her nursing practice was that through
27 such mentoring, the individual could obtain greater insight and accountability.
28

29

¹⁰ The Board’s Exhibit 3 at 3.

1 25. On or about October 3, 2013, the Board sent a letter to Respondent, informing her that
2 she had not timely submitted evidence of her compliance with the requirements of the Consent
3 Agreement that she obtain ethics counseling from a Board-approved fellow at the Lincoln Center for
4 Applied Ethics and that she obtain psychotherapy from a Board-approved psychotherapist.
5

6 26. On October 13, 2013, Respondent sent an e-mail in response to the Board’s October 3,
7 2013 letter that stated that she was working at a minimum wage job at a gas station for 32 hours a week
8 because although she continued to apply for nursing jobs, “unfortunately once they read what the board
9 has to say about me I usually get raked up and down at every interview and rejected.”¹¹ As a result,
10 Respondent stated that she could not afford to pay a psychotherapist or take time off work to undertake
11 ethics counseling.
12

13 27. On or about November 21, 2013, Respondent’s former attorney sent a facsimile to Ms.
14 Smith about a course in Bioethics offered by Dr. Aimée Koeplin. Ms. Smith testified that she was able
15 to determine that Dr. Koeplin was employed by a California university, though she did not know which
16 one, and that Dr. Koeplin was Respondent’s friend on Facebook. Ms. Smith testified that the Board
17 requires counselors and therapists who provide treatment pursuant to a consent agreement to be
18 independent and to have no prior relationship with the nurse.
19

20 28. Ms. Smith stated that although Respondent could submit the name of a psychotherapist
21 for the Board’s approval, because the Consent Agreement specified that she undertake ethics
22 counseling from a fellow at the Lincoln Center for Applied Ethics, staff could not modify the terms of
23 the Consent Agreement. Therefore, ethics counseling from a different provider would not fulfill the
24 requirements of the Consent Agreement. Ms. Smith testified that although she updated her Monitoring
25 Non-Compliance Investigative Report (“Investigative Report”) to include Respondent’s prior attorney’s
26 facsimile, the Board did not approve the substitution.
27
28

29 ¹¹ The Board’s Exhibit 3 at 10.

1 **Respondent’s Postings on her Blog, NURSEINTERRUPTED**

2 29. On November 14, 2013, Ms. Smith interviewed Respondent in the presence of her
3 former attorney to discuss her failure to comply with the Consent Agreement. Respondent stated that
4 she could not afford to pay a psychotherapist to undertake psychotherapy or to take time off from her
5 job at Circle K to undertake ethics counseling with a fellow at the Lincoln Center for Applied Ethics.
6 According to Ms. Smith’s Investigative Report, before the interview, Respondent posted the comment,
7 “I’d rather be getting a pelvic exam ----- feeling special at the Board of Nursing.”¹²
8

9
10 30. At the November 14, 2013 interview, Ms. Smith informed Complainant that the Board
11 had become aware of a posting made by her on her Facebook page that appeared to threaten Nikki
12 Austin, a member of the Board’s staff. Ms. Smith’s Investigative Report summarized the remainder of
13 the interview as follows:

14
15 I showed Respondent a copy of the posting “Share this if
16 you know someone who deserves a smack in the face with a
17 shovel!!!! . . . Nikki Austin at the state board of nursing.”
18 Respondent stated that she has a first amendment right and
19 denied that [her posting about Ms. Austin] is a form of
20 harassment or bullying. I shared with Respondent that I had
21 reviewed other postings on her Facebook and although she
22 verbally states she has not entered psychotherapy or ethics
23 counseling due to financial and health related constraints,
24 her postings appear to indicate that she believes she has
25 not engaged in wrongdoing and lacks insight and
26 accountability for her actions and decisions that led to the
27 complaint being filed and her subsequent licensure
28 probation. Respondent stated that it is her perception of
29 reality and she has a right to share that with others. She
30 further stated that the Board does not seem to notice or care
31 that she began a national organization with 13 chapters
32 focused on advocacy and peer support for nurses; that she
33 began a local weekly peer support group for nurses; her
34 Blogs are being used by nursing schools across the country
35 to teach students; and, she is writing a nursing textbook that
36 will be used in nursing curriculums across the country. . . .¹³

12 The Board’s Exhibit 1 at 5.

13 The Board’s Exhibit 1, Monitoring Non-Compliance Investigative Report, at 6-7.

1
2 31. After Ms. Smith's interview, on November 14, 2013, Respondent posted comments on
3 her blog, NURSEINTERRUPTED, about her care of the patient at the Hospital, beginning with "I have
4 said this before and I will say it again until the day I die and I will not waver [sic] from it: I did not do
5 anything wrong with that patient"14 Respondent then proceeded to identify the name of the
6 facility, the exact date and time of her assessment of the patient, the patient's diagnosis, and the care
7 that she rendered to the patient.
8

9 32. Respondent testified consistently with her remarks to Ms. Smith in the November 14,
10 2013 interview. Respondent testified that she signed the Consent Agreement because she could not
11 afford to pay her attorney to defend the Board's complaint at a hearing.
12

13 33. Respondent testified that she researched and was very careful not to violate the federal
14 Health Insurance Portability and Accountability Act ("HIPAA") in her postings on Facebook and her
15 blog about her care of the patient at the Hospital in April 2011. Respondent testified that she
16 conscientiously took care not to use patient identifiers. Respondent testified at length about her
17 responsibility to advocate for patients and for other nurses and the injustices in losing her job at the
18 Hospital and being forced to defend against the Board's complaint about the care that she rendered to
19 the patient and her postings on social media:
20

21 Earlier I talked about what happens when law and ethics
22 overlap, which commonly occurs in the current health care
23 environment. And this occurs because of several
24 misunderstandings between the priorities that a nurse has,
that a hospital has, that a regulatory agency has.

25 And in my ethical beliefs as a nurse, at least what I have
26 applied to my nursing practice, is directly derived from
27 philosopher Immanuel Kant, which is to treat people as a
28 means to an end in themselves, meaning my sole priority is
that of keeping my oath to serving and protecting the public,
meaning my first priority is to them.

29

¹⁴ The Board's Exhibit 2 at 3.

1 When I went forward with what happened to me and my
2 patient, it was after a lot of ethical thought process occurred,
3 and also because it was my ethical obligation to protect the
4 greater public from practices that were unsafe to people at
5 large in a particular facility. This does fall within my duties
6 as a registered nurse, and that is definitely highlighted in the
7 nurse's code of ethics as well as in our oath.

8 One of the things I believe in strongly when I work with
9 patients is to promote the best interests of the patient and
10 what the patient wants to do. And in this particular instance,
11 the patient was not allowed to achieve the outcome that they
12 had wanted, nor was I allowed to perform my function as a
13 nurse to the best of my education and preparation and
14 licensure.

15 In provision 6 of the code of ethics, it says that selfdetermination
16 is paramount, and that the nurse's primary
17 commitment is to the patient, whether individual, family
18 group, or community, and the right to know, and that
19 includes not just one patient but the community at large.

20 And when something threatens one patient, it threatens a
21 community of people. And in this instance, a patient's rights
22 were violated. The patient's right to determine their course
23 of treatment.

24

25 Because I went up the chain of command to all of my
26 superiors and asked for assistance and asked for their
27 intervention, and nobody came forward or was willing to
28 listen or to help me, on professional obligation, I had to
29 come forward to the media to report what happened to both
30 me and my patient as a means of illuminating where patient
31 errors occur and how they can be corrected for the future.

32 These are controversial subjects that are discussed every
33 day, not just in social media, but on television, in
34 newspapers, in health-care blogs, in health-care
35 organizations, how to best promote the best interests of the
36 patient and the patient's right of self-determination.

37 We cannot learn from mistakes that occur in the course of
38 caregiving if what we do is shut down everything that
39 happened and keep it from the public. When we do that,
40 what we do is we put at risk a greater population of people
41 who could be harmed by the same practices.

1

2 Social media is a means of communicating, at least in this
3 day and age and within this health-care system. It is a
4 means of communicating with one's colleagues, with other
5 health-care providers, other health-care disciplines, healthcare
6 consumers themselves. And in so doing, these various
7 people come together and discuss ways to keep patientcare
8 errors from happening again.

9 Social media has accomplished that. I have interacted with
10 several people within the nursing community, several
11 nursing organizations. I have interacted with patients,
12 patient advocacy groups. I have been involved in
13 troubleshooting and developing new policies and new
14 regulations within different patient care advocacy
15 organizations that would help promote the greater good of
16 the greatest amount of people, and that is what I seek to do
17 when I take care of patients.

18 I don't seek to just focus on one. I always seek to focus on
19 doing what is right for the greatest amount of people. And in
20 this case, if I hadn't come forward, and if I hadn't have
21 continued to speak out about what happened to me and my
22 patient via social media, via television interviews, radio
23 interviews, then this problem is going to continue to happen,
24 because nobody listened within the organizational level,
25 from the immediate nurse manager to the CNL to the
26 medical director of the hospital, right up to the CEO of the
27 health-care system.

28 Nobody listened when I brought forth patient safety
29 concerns and possible conflict of interests pertaining to
30 surgery when the patient wanted something else. So for this
31 reason, I came forward, and I started discussing my case on
32 the blog for other nurses and other organizations to learn
33 from so that this type of mistake would not occur to another
34 nurse or to another patient. . . .¹⁵

35 34. After the November 14, 2013 interview, Respondent posted on her
36 NURSEINTERRUPTED blog that she had “been desperately trying to figure out some way to make the
37 week feel longer, so that I could put off this latest little field trip to the principal’s office at the Arizona
38 Board of Nursing” and recounted the details of Ms. Smith’s interview.¹⁶

39 ¹⁵ Reporter’s Transcript January 15, 2014, at 171, l. 20 to 175, l. 20.

1 35. On December 7, 2013, Respondent posted the following statements on her
2 NURSEINTERRUPTED blog concerning the Board’s complaint against her:

3 Merry Christmas and good tidings to Amanda Trujillo from
4 the Arizona Board of Nursing. In this latest installment of
5 nursing’s reality TV and social media saga I get a packet
6 (right before Christmas of course) informing me I will be
7 privy to a hearing before an administrative judge on January
8 15, 2014 where he will decide whether my nursing license is
9 to be suspended or stripped. On the agenda: My failure to
10 protect the interests and well-being of patients, my conduct
11 unbecoming of a professional nurse, and the ongoing
12 favorite—their concern that I am a danger to the public at
13 large. In addition to this the fact I haven’t been able to
14 complete the ethics counseling or the psychiatric care that
15 even the staff at this latest facility have deemed to be
16 completely unnecessary in their professional opinion. Yes,
17 for the second time mental health professionals have found
18 me to be normal after evaluating me. On this occasion the
19 staff went further to say that they are stunned I am still up,
20 walking, and breathing after almost three years of this
21 ordeal and its sequelae. Their quote was that I was “the
22 most normal client they have seen in a very long time.” . . .¹⁷

23 Respondent did not submit any mental health records and the record in this matter contains no
24 psychological evaluations other than Dr. Lett’s evaluation, which, as noted above, recommended that
25 Respondent undertake psychotherapy and ethics counseling. On December 7, 2013, Respondent also
26 posted another lengthy narrative describing and defending her care of the patient at the Hospital in
27 April 2011.¹⁸

28 36. Ms. Smith testified that Arizona statutes protect the confidentiality of investigative
29 reports and patient records. Ms. Smith testified that based on her education and experience,
30 Respondent’s continued postings about her feelings that the Board’s attempt to enforce the Consent
31 Agreement was unfair and unjustified indicated that Respondent did not take the Consent Agreement

32 ¹⁶ The Board’s Exhibit 2 at 1-2.

33 ¹⁷ The Board’s Exhibit 2 at 6.

34 ¹⁸ See the Board’s Exhibit 2 at 7-10.

1 seriously. Ms. Smith testified that Respondent's continued posting of information defending her care of
2 the patient at the Hospital and her insistence that she had done nothing wrong either in her patient care
3 or the continued postings about the patient demonstrated a lack of insight and accountability.

4
5 37. Ms. Smith testified that A.A.C. R4-19-403(3) is broader than the patient privacy and
6 security requirements of HIPAA because the regulation prohibits nurses from publicizing any
7 information from which the patient could be identified without the patient's express permission. Ms.
8 Smith testified that Respondent violated the Consent Agreement by continuing to post information
9 about the care that she rendered to the patient at the Hospital in April 2011.

10
11 38. Respondent submitted the "White Paper: A Nurse's Guide to Social Media" published by
12 National Council of State Boards of Nursing ("NCSBN"). Ms. Smith pointed out the following
13 information in the NCSBN's White Paper:

14
15 **Confidentiality and Privacy**

16 To understand the limits of appropriate use of social media,
17 it is important to have an understanding of confidentiality
18 and privacy in the health care context. Confidentiality and
19 privacy are related, but distinct concepts. Any patient
20 information learned by the nurse during the course of
21 treatment must be safeguarded by that nurse. Such
22 information may only be disclosed to other members of the
23 health care team for health care purposes. Confidential
24 information should be shared only with the patient's
25 informed consent, when legally required or where failure to
26 disclose the information could result in significant harm.
27 Beyond these very limited exceptions the nurse's obligation
28 to safeguard such confidential information is universal.

29
30 Privacy relates to the patient's expectation and right to be
31 treated with dignity and respect. Effective nurse patient
32 relationships are built on trust. The patient needs to be
33 confident that their most personal information and their
34 basic dignity will be protected by the nurse. Patients will be
35 hesitant to disclose personal information if they fear it will be
36 disseminated beyond those who have a legitimate "need to
37 know." Any breach of this trust, even inadvertent, damages

1 the particular nurse-patient relationship and the general
2 trustworthiness of the profession of nursing.

3

3 **Common Myths and Misunderstandings of Social Media**

4 While instances of intentional or malicious misuse of social
5 media have occurred, in most cases, the inappropriate
6 disclosure or posting is unintentional. A number of factors
7 may contribute to a nurse inadvertently violating patient
8 privacy and confidentiality while using social media. These
9 may include:

8

- 9 ■ A mistaken belief that it is acceptable to discuss or refer
10 to patients if they are not identified by name, but referred
11 to by a nickname, room number, diagnosis or condition.
12 This too is a breach of confidentiality and demonstrates
13 disrespect for patient privacy.

12

- 13 ■ The ease of posting and commonplace nature of sharing
14 information via social media may appear to blur the line
15 between one's personal and professional lives. The
16 quick, easy and efficient technology enabling use of
17 social media reduces the amount of time it takes to post
18 content and simultaneously, the time to consider whether
19 the post is appropriate and the ramifications of
20 inappropriate content.¹⁹

18 Ms. Smith testified that Respondent never claimed to have had the consent of the patient at the Hospital
19 to share the details of the patient's health care on Respondent's blog. Ms. Smith pointed out that
20 Respondent identified the patient's health condition, the Hospital in which she received treatment, and
21 the unit, in violation of Respondent's ethical and legal duty to maintain the patient's confidentiality.

22 39. Ms. Smith testified that if Respondent was concerned about mistreatment of the patient
23 by the Hospital and the persons in her chain of command at the Hospital were not responsive to her
24 complaints, she could have notified other organizations that oversee the Hospital or the health care
25 professionals involved in the care of the patient, such as the Board, the Arizona Department of Health
26 Services, the Arizona Medical Board, or the federal Centers for Medicare & Medicaid Services.

29

¹⁹ Respondent's Exhibit E at 1-3.

1 to obtain free psychotherapy at Terros, and did not dispute that the required ethics counseling at the
2 Lincoln Center for Applied Ethics was free, Complainant did not establish that she failed to undertake
3 psychotherapy or ethics counseling due to her financial constraints.
4

5 6. The Board also established that Respondent continued to violate the rights to
6 confidentiality and privacy of her former patient at the Hospital by continuing to disclose details about
7 the patient's treatment on her blog without the patient's permission, in violation of the Consent
8 Agreement and A.A.C. R4-19-403(9).
9

10 7. Therefore, the Board established that Respondent committed unprofessional conduct as
11 defined by A.R.S. § 32-1601(22)(d) and (j), specifically A.A.C. R4-19-403(9), and A.R.S. § 32-
12 1601(22)(g) and (i) by failing to undertake psychotherapy, by failing to undertake ethics counseling,
13 and by failing to refrain from posting confidential and private information about her care of the patient
14 at the Hospital in April 2011, on her blog.
15

16 8. Therefore, the Board established cause to revoke, suspend, or otherwise discipline
17 Respondent's license under A.R.S. §§ 32-1663(D)²⁵ and 32-1664(N).²⁶
18

19 9. Respondent's postings on her blog and testimony at the hearing demonstrate a continued
20 lack of insight and failure to take responsibility for the unprofessional conduct that the Board
21 established at hearing. Therefore, the Board established that Respondent cannot be regulated at this
22 time.
23

24 **ORDER**

25 In view of the Findings of Fact and Conclusions of Law, the Board issues the following Order:
26
27

28 ²⁵ This statute provides that if the Board determines a licensee has committed an act of unprofessional conduct,
the Board may revoke or suspend the license, impose a civil penalty, censure the license, place the licensee on
probation, or accept the voluntary surrender of the license.

29 ²⁶ This statute provides that if the Board finds that the licensee has committed an act of unprofessional conduct,
the Board may revoke or suspend the license.

1 Pursuant to A.R.S. § 32-1664(N), the Board **REVOKES** registered nurse license number
2 RN137552 issued to Amanda Lucia Trujillo.

3 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

4 Pursuant to A.R.S. § 41-1092.09, Respondent may file, in writing, a motion for rehearing
5 or review within 30 days after service of this decision with the Arizona State Board of Nursing.
6 The motion for rehearing or review shall be made to the attention of Trina Smith, Arizona State
7 Board of Nursing, 4747 North 7th Street Ste 200, Phoenix AZ 85014-3655, and must set forth
8 legally sufficient reasons for granting a rehearing. A.A.C. R4-19-608.
9

10 For answers to questions regarding a rehearing, contact Trina Smith at (602) 771-7844.
11 Pursuant to A.R.S. § 41-1092.09(B), if Respondent fails to file a motion for rehearing or review
12 within 30 days after service of this decision, Respondent shall be prohibited from seeking judicial
13 review of this decision.
14

15 This decision is effective upon expiration of the time for filing a request for rehearing or
16 review, or upon denial of such request, whichever is later, as mandated in A.A.C. R4-19-609.
17

18 Respondent may apply for reinstatement of the said license pursuant to A.A.C. R4-19-404 after
19 a period of five years. Respondent may apply for reinstatement of said certificate pursuant to A.A.C.
20 R4-19-815 after a period of five years
21

22 DATED this 28th day of March, 2014.

23
24 SEAL

ARIZONA STATE BOARD OF NURSING

25 *Joey Ridenour R.N. M.N. F.A.A.N.*

26 Joey Ridenour, R.N., M.N., F.A.A.N.
27 Executive Director
28
29

1 COPIES mailed this 28th day of March, 2014, by Certified Mail No. 7011 3500 0001 5219 1039 and
2 First Class Mail to:

3 Amanda Lucia Trujillo
4 7977 West Wacker Road #260
5 Peoria, AZ 85381

6 COPIES of the foregoing mailed this 28th day of March, 2014, to:

7 Case Management
8 Office of Administrative Hearings
9 1400 W Washington Ste 101
10 Phoenix AZ 85007

11 Carrie H. Smith, Esq.
12 Assistant Attorney General
13 1275 W Washington LES Section
14 Phoenix AZ 85007

15 By: Trina Smith
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