BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§	AGREED
License Number 517341	§	
issued to BARBARA JEAN COX	§	ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Boa produced evidence indicating that BARBARA JEAN COX, hereinafter referred to as Respondent, Registered Nurse License Number 517341, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on February 2, 2010, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person. Respondent was notified of her right to be represented by legal counsel. Respondent was represented by Nancy Roper-Willson, Attorney at Law. In attendance were Mary Beth Thomas, Ph.D., RN, Executive Director's Designee; John F. Legris, Assistant General Counsel; Lance Brenton, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Toni Frizell, RN, Investigator; Kathy Duncan, RN, Investigator; and Nancy Krause, RN, Investigator.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.

2. Respondent waived notice and hearing, and consented to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from Angelo State University, San Angelo, Texas on May 1, 1984. Respondent was licensed to practice professional nursing in the State of Texas on August 24, 1984.

5. Respondent's nursing employment history includes:

8/1984 - 1990	Staff Nurse	Angelo Community Hospital San Angelo, Texas
1990 - 1993	Staff Nurse	Irving Healthcare System Irving, Texas
8/1993 - 3/1995	Emergency Room Staff Nurse	Columbia North Hills North Richland Hills, Texas
3/1995 - 1/1997	Staff Nurse Pediatrics	Columbia Medical City Dallas Dallas, Texas
1/1997 - 8/2000	Staff Nurse Out-patient Pre-op	Columbia Medical City Dallas Dallas, Texas
8/2000 - 9/2002	Staff Nurse	Pediatric Pulmonary Assoc. of North Texas Dallas, Texas
11/2002 - 5/2007	Staff Nurse	Children's Medical Center Dallas, Texas
6/2007 - Present	Agency Nurse, PACU	Perioperative Nurses, Inc. Arlington, Texas

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Children's Medical Center, Dallas, Texas, and had been in this position for three (3) years and four (4) months.

7. On or about March 9, 2006, while employed as a Staff Nurse with Children's Medical Center, Dallas, Texas, Respondent administered Versed 15mg to Patient MR#1402957, instead of Versed 20mg as ordered by the physician, and administered Albuterol 0.5mg breathing treatment to Patient MR#1318895 instead of Albuterol 0.25 mg as ordered by the physician. Respondent's failure to accurately administer medication as ordered was likely to injure the patients in that the patients did not receive the intended doses and may not have experienced appropriate benefits from the medications.

8. In response to the incident in Finding of Fact Number Seven (7) Respondent states, after assessing the patient and discussing it with the anesthesiologist, it was deemed prudent to only give 15mg of Versed. At the time she discussed it with the doctor she did not have the chart in hand, she was running two (2) Operating Rooms with two (2) anesthesiologists at a very fast turn over rate. When the Nurse Practitioner ordered the Albuterol nebulizer breathing treatment, Respondent did not have an order sheet so she went to the anesthesiologist assigned to the patient and got the order for Albuterol 0.5mg, the usual amount used. Respondent states she gave the amount ordered by the anesthesiologist not the Nurse Practitioner.

9. On or about May 24, 2006, while employed as a Staff Nurse with Children's Medical Center, Dallas, Texas, Respondent failed to document a physician's verbal order for Morphine that was administered to Patient MR#1129892. Respondent's conduct deprived subsequent care givers of essential information they would rely on to evaluate the patient's condition and provide further patient care.

10. In response to the incident in Finding of Fact Number Nine (9), Respondent states, the patient was in emergent delirium and she was attempting to care for the child, the parent, and give report to the anesthesiologist. Due to staffing constraints she focused on getting the medication for the child, and states she should have followed hospital policy with regard to documentation.

11. On or about December 8, 2006, through December 11, 2006, while employed as a Staff Nurse with Children's Medical Center, Dallas, Texas, Respondent administered Tylenol without a physician's order to a step-down unit patient. Respondent's conduct exposed the patient to risk of harm in that the administration of Tylenol without a physician's written order resulted in an inaccurate medical record that subsequent care givers would rely on to provide further patient care.

12. In response to the incidents in Finding of Fact Number Eleven (11), Respondent states, she was the only Registered Nurse in the step-down unit at the time and taking care of another patient when the anesthesiologist came through. Respondent needed a Tylenol order for a separate patient and the anesthesiologist said, "yes." Respondent states she does not know why the anesthesiologist did not write the order, but Respondent states she should have checked the medical record for the order but she didn't.

13. On or about February 14, 2007, while employed as a Staff Nurse with Children's Medical Center, Dallas, Texas, Respondent failed to clarify orders to administer Tetracaine, Neosynephrine, Mydriacyl, and Cyclogel to a Patient MR#001469988 as ordered by the physician. The physician ordered that the drops be administered in both eyes, when the patient was undergoing a Left Eye Cataract Removal with Intraocular Lens Implant. Respondent's conduct was likely to injure the patient in that both eyes would be dilated and the operating room staff could misinterpret which eye to perform the procedure on.

14. In response to the incident in Finding of Fact Number Thirteen (13), Respondent states that many times the patients would arrive without orders and when the pro-op nurse attempted to get them, a resident would call back and there was no consistency in the process. Eventually, the confusion got to be so huge that the charge nurse said no one was going to get written up until this was clarified. They tried using pre-printed order sheets but the physicians did not use them consistently and Respondent states she should have taken the hand-written sheet she had that day to get it clarified.

15. On or about April 2, 2007, through April 3, 2007, while employed as a Staff Nurse with Children's Medical Center, Dallas, Texas, Respondent administered Versed 6mg to Patient MR#1467769, instead of Versed 5mg as ordered by the physician. Respondent's conduct was likely to injure the patient in that the patient could have experienced the effects of over-sedation.

16. In response to the incidents in Finding of Fact Number Fifteen (15), Respondent states she was the only nurse in pre-op trying to check in patients, man the phones, coordinate care, and medicate four (4) patients pursuant to physicians' orders by four (4) different doctors. All the patients were properly medicated but her documentation fell short. Respondent states she should have checked her work, and she is disappointed in herself for staying in such an environment for so long, but she believed she had no other choice at the time.

17. On or about April 2, 2007, while employed with Children's Medical Center, Dallas, Texas, Respondent failed to document that she administered Versed 8mg by mouth to Patient MR#1482504. Respondent's conduct deprived subsequent care givers of essential information they would rely on to evaluate the patient's condition and provide further patient care.

18. In response to the incidents in Finding of Fact Number Seventeen (17), Respondent states all the patients were properly medicated but her documentation fell short and she should have checked her work.

19. Respondent successfully completed Nursing Ethics/Jurisprudence course on November 14, 2009, and Sharpening Critical Thinking Skills course on January 31, 2010, which would have been requirements of this order.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(B),(1)(C),(1)(D)&(1)(N) and 217.12(1)(B).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 517341, heretofore issued to BARBARA JEAN COX, including revocation of Respondent's license to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE § 211.1 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be

approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to

accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD.

(3) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all

Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(4) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(5) RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT's license to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

BALANCE OF PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE.

RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 12 day of March, 2011.

Barbara Jean Cox

BARBARA JEAN COX, Respondent

Sworn to and subscribed before me this 12 day of March, 2011.

SEAL

Beau Redden

Notary Public in and for the State of Texas

BEAU ASHTON REDDEN
Notary Public, State of Texas
My Commission Expires
September 27, 2014

Approved as to form and substance.

Nancy Roper-Willson

Nancy Roper-Willson, Attorney for Respondent

Signed this 12th day of March, 2011.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 12th day of March, 2011, by BARBARA JEAN COX, Registered Nurse License Number 517341, and said Order is final.

Effective this 28th day of April, 2011.

Katherine A. Thomas, MN, RN
Executive Director on behalf
of said Board