



I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Katherine A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse
License Number 651563
and Vocational Nurse
License Number 163220
issued to ANGELA L. TROTTER
f.k.a. ANGELA L. LEWIS EMENIKE

§ AGREED
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§ ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of ANGELA L. TROTTER, f.k.a. ANGELA LEWIS EMENIKE, Registered Nurse License Number 651563 and Vocational Nurse License Number 163220, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13) Respondent waived informal proceedings, notice and hearing, and agreed to the entry of this Order offered on April 5, 2010, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

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 licenses.
2. Respondent waived informal proceedings, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas. Respondent's license to practice vocational nursing in the State of Texas is delinquent in status.
4. Respondent received a Certificate in Vocational Nursing from Lee College, Baytown, Texas, on May 1, 1997, and received an Associate Degree in Nursing from Lee College, Baytown, Texas, on May 1, 1998. Respondent was licensed to practice vocational nursing in the State of Texas on July 25, 1997, and was licensed to practice professional nursing in the State of Texas on June 23, 1998.

5. Respondent's nursing employment history includes:

1998 - 1999	Night Charge Nurse	Inova Cameron Glen Reston, Virginia
1999 - 2005	Staff Nurse	Inova Fairfax Hospital Falls Church, Virginia
8/05 - 6/06	Travel Nurse	Premier Healthcare Professionals Cummings, Georgia
5/06 - 12/06	Unknown	
1/07 - 11/07	Agency Staff Nurse	Independent Nursing Services Richland Hills, Texas
10/07 - 6/09	Staff Nurse	East Houston Regional Hospital/ Bayshore Medical Center Houston, Texas
6/09 - 11/09	Charge Nurse	Texas Specialty Hospital Houston, Texas
12/09 - Present	Agency Nurse	Pulse Staffing Houston, Texas

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff Nurse with Bayshore Medical Center, Pasadena, Texas, and had been in this position for one (1) year and two (2) months.
7. On or about December 5, 2008, while employed with Bayshore Medical Center, Pasadena, Texas, Respondent miscalculated an intravenous (IV) Heparin dose and infusion rate which resulted in the administration of an overdose of heparin to Patient MR#291034. Respondent's conduct resulted in the patient experiencing symptoms of Heparin overdose including frank bleeding and prolonged PTT levels.

8. In response to Finding of Fact Number Seven (7), Respondent states she was not familiar with the Bayshore Medical Center nomogram because she had been transferred from East Houston Medical Center to Bayshore Medical Center as a result of Hurricane Ike and requested that another staff nurse assist her with the calculations. When Respondent went to the medication room to check the Accudose Medication Dispensing System to see if the heparin bolus was on the patient's profile, Respondent noted that the pharmacist had programmed 5 X 1,000 unit syringes for her to pull from the Accudose Medication Dispensing System instead of a 5,000 unit vial. Respondent asked the nursing unit pharmacist who explained that there were new JACHO rules regarding providing a nurse with the least amount of concentrations, which was why pharmacy sent five 1,000 unit syringes instead of one with 5,000. This pharmacist gave Respondent a 5,000 unit vial of Heparin, which Respondent used to administer to the patient. Respondent asserts that she had a staff nurse verify the pump setting before she started the pump to administer the Heparin to the patient.
9. On or about June 6, 2009, while employed with Bayshore Medical Center, Pasadena, Texas, Respondent failed to institute the appropriate nursing intervention to stabilize Patient V000715709 after receiving report of a critical lab value result of K+ "7.3". Consequently, the patient became non-responsive with a heart rate into the 60's, and required the initiation of a Code Blue to resuscitate the patient. Respondent's conduct deprived the patient of timely detection and medical intervention by the physician, to stabilize the patient, which may have prevented the patient from experiencing cardiac arrest, which may have resulted in the patient's demise.
10. In response to Finding of Fact Numbers Nine (9), Respondent denies any knowledge that the patient's potassium level was "7.3". Respondent was in report when the lab noted that they called the value to HDU9689, which is Respondent states is her user number for the computer, however is a number known by others on the floor and by the lab.
11. On or about June 6, 2009, while employed with Bayshore Medical Center, Houston, Texas, Respondent failed to verify that the Alaris infusion pump was administering intravenous Vasopressin to Patient V000715709 at the rate of 1 Unit/hr, as she programmed, before leaving patient's bedside. The physician had ordered that Vasopressin be administered to keep the patient's systolic blood pressure above 90, and unbeknownst to Respondent at the time, the Alaris pump delivered 60 Units/hour and the error was not detected until the pump's alarm sounded. Respondent conduct placed the patient at risk of non-efficacious treatment, which may have prolonged the patient's recovery.

12. In response to Finding of Fact Number Eleven (11), Respondent states that Patient V000715709 (a dialysis patient) coded, and the physician had ordered a vasopressin drip for low blood pressure. The pharmacy sent 100 units in 100 ml concentration. Respondent programmed the Alaris IV pump by choosing the shock mode, and entered 1 unit per hour, which was verified by another staff nurse. Approximately 45 minutes later, both of them heard an IV pump alarming and rushed into the room. The vasopressin drip was nearly completed with the exception of 30 mls left in the bag. Respondent contacted the pharmacy for a larger bag containing 30 units in 250 ml bag and while talking to the pharmacist, the charge nurse overheard her conversation and explained that there were pumps on the unit that would default to the GI bleed mode at 1 unit per min. Respondent states that the order for the Vasopressin read "start Vasopressin keep SBP>90 and the patient's BP did go as high as 127 but the diastolic never went above 68. When the first bag ended before it should have, a second one was started, as the BP started decreasing again. Respondent states that the Alaris pumps had been recalled for this issue of defaulting to another program, and that nursing staff were never alerted to this issue, so although the problems with the pumps are well known now, however, the administration of this hospital never made mention to nursing staff that the pumps had problems or that they had been recalled.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, 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)(A),(B),(C),(M)&(P) and 217.12(1)(A) & (B)&(4).
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 651563 and Vocational Nurse License 163220, heretofore issued to ANGELA L. TROTTER f.k.a. ANGELA LEWIS EMENIKE, including revocation of Respondent's licenses 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 REPRIMAND 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 licenses are 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 Texas nursing jurisprudence and ethics. 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. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution 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 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. 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>.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in physical assessment. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. 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. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of twenty-four (24) hours. The clinical component SHALL focus on tasks of physical assessment only and shall be provided by the same Registered Nurse who provides the didactic portion of this course. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of forty-eight (48) hours. The clinical component SHALL focus on tasks of physical assessment only and shall be provided by the same Registered Nurse who provides the didactic portion of this course. To be approved, the course shall cover all systems of the body. Performing assessments on mock patients or mannequins WILL NOT be accepted. 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>.

(4) 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>.

(5) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of

Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: <http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary>.*

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 AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(6) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT's licenses. 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 licenses. 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.

(7) 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.

(8) For the first year of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(9) For the remainder of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(10) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice

nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) years of employment as a nurse.

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

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RESPONDENT'S CERTIFICATION

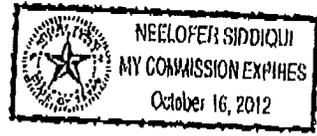
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid 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 licenses to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 22 day of July, 2010.

Angela L. Trotter
ANGELA L. TROTTER,
f.k.a. ANGELA LEWIS EMENIKE, Respondent

Sworn to and subscribed before me this 22nd day of July, 2010.

SEAL



Neelofar Siddiqui
Notary Public in and for the State of TEXAS

Approved as to form and substance.

Joyce Stamp Lilly
Joyce Stamp Lilly, Attorney for Respondent

Signed this 6 day of August, 2010.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 22nd day of July 2010, by ANGELA L. TROTTER f.k.a. ANGELA LEWIS EMENIKE, Registered Nurse License Number 651563 and Vocational Nurse License Number 163220. said Order is final.

Effective this 17th day of August, 2010.

A handwritten signature in black ink, appearing to read "Katherine A. Thomas". The signature is written in a cursive style and is positioned above a horizontal line.

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