

5. Respondent's professional nursing employment history includes:

1979 - 10/80	Staff Nurse	Bristol General Hospital Dallas, Texas
10/80 - 4/07	Staff Nurse	Methodist Dallas Medical Center Dallas, Texas
4/07 - 6/08	Home Health Nurse	Girling Home Health Dallas, Texas
7/08 - present	Not employed in nursing	

6. At the time of the incidents in Findings of Fact Numbers Seven (7) through Nine (9), Respondent was employed as a Staff Nurse with Methodist Dallas Medical Center, Dallas, Texas, and had been in this position for approximately twenty-seven (27) years.
7. On or about March 15, 2007, while employed as a Staff Nurse at Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to collect a bedside blood specimen for laboratory analysis of Hemoglobin and Hematocrit levels from Patient Number DU00257168, who was hemodynamically unstable, actively bleeding, and in need of immediate surgical intervention. Respondent failed to collect the blood specimen because blood could not be drawn via the peripheral or central line that was in place. Although Respondent had used an i-STAT machine (a portable clinical analyzer system to perform blood analysis at the point of care) to draw capillary blood to check blood sugar results, she failed to utilize the machine to obtain a capillary blood specimen to check the levels for Hemoglobin and Hematocrit, as ordered. Upon arrival to the operating room, staff obtained a blood specimen which resulted in critical levels of Hemoglobin at "5.4" and Hematocrit at "16." Respondent's conduct may have delayed emergent medical intervention which placed the patient at risk of complications from the surgical intervention needed to stabilize the patient's condition.
8. On or about March 15, 2007, while employed as a Staff Nurse at Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to initiate Sepsis Protocol to stabilize Patient Number DU00257168, who had a diagnosis of severe sepsis, was hemodynamically unstable, actively bleeding, and in need of immediate surgical intervention. Specifically, Respondent failed to administer Levophed, to Patient Number DU00257168 when the patient's mean arterial pressure (MAP) fell below "65", failed to collect a blood specimen for stat laboratory analysis, and failed to promptly obtain blood from the Blood Bank to administer to the patient. Respondent's conduct resulted in a delay in treatment and contributed to the further deterioration of the patient's condition.

9. On or about March 15, 2007, while employed as a Staff Nurse at Methodist Dallas Medical Center, Dallas, Texas, Respondent inaccurately documented in the flow sheet blood glucose levels collected from Patient Number DU00257168 as follows:

<u>Accucheck Readings</u>	<u>Flow Sheet</u>
0832 - "113"	0800 - "110"
0915 - "120"	0900 - "113"
1026 - "101"	1000 - "120"
1232 - ""29"	1200 - "100"
No recorded BS	1300 - "89"

Respondent's conduct deprived the patient of timely medical intervention needed to stabilize the patient's critically low blood sugar level of "29" and created an inaccurate record on which subsequent caregivers would base their ongoing medical care.

10. In response to Finding of Fact Number Seven (7), Respondent states she was informed in report by the previous nurse that she had been unable to obtain a blood specimen via the central line and had notified the physician, who ordered that the lab be held until a new central line could be inserted into Patient DU00257168 later that day. Respondent states that she also attempted to draw a blood specimen from the existing central line, but was unable to do so. She was not aware that she could draw blood from an i-STAT machine, however the equipment to do so was not available on her unit.
11. In response to Finding of Fact Number Eight (8), Respondent states that she did not initiate the Sepsis Protocol, because she did not receive the information in report. However, Respondent was told in report of an order for Levophed, should the blood pressure drop below 90. When the physician arrived on the unit at 1300, the blood pressure had been 75-85 for approximately 30 minutes. Respondent informed the physician of the drop in the patient's blood pressure to which the physician stated it was okay since the patient was going to the Operating Room (OR) in about an hour. Another physician saw the patient shortly after that and Respondent states she received no additional instructions. Regarding her failure to promptly obtain blood from the blood bank, Respondent states that the physician had previously ordered two (2) units of packed red blood cells to be placed on hold. When the CRNA from OR was at the bedside, he asked Respondent to contact the blood bank to see if the blood was ready and have it sent to the OR. Respondent was informed by the blood bank that the blood was ready, but she would need to complete a form before the blood could be released. When Respondent relayed this information to the CRNA, and was instructed to complete this form, Respondent refused because she had never had to do this in the past. When Respondent relayed this information to the CRNA, and was instructed to complete this form, Respondent refused because she had never had to do this in the past and the requested form was not available on the unit. After a discussion between the CRNA and another nurse who was on the unit, Respondent retrieved the blood from the blood bank, as ordered. Respondent states that if the CRNA had stated that he wanted to get the blood prior to going to the OR, she would have gladly gone and gotten it.

12. In response to Finding of Fact Number Nine (9), Respondent denies falsifying the medical record regarding the patient's blood sugar. Respondent states that when she performs FSBS and gets a result that she feels is inaccurate, she will automatically recheck and treat appropriately by giving an amp of D50 if ordered, turn off the insulin drip if applicable, and notify the MD. Respondent states that the fact that she did not recheck blood sugar proves that she did not see a questionable reading and feels that she may have misread the glucometer or that it had malfunctioned. Respondent states that it appears the 0832 Accucheck Reading was recorded on the flow sheet at 0900. The 0915 Accucheck Reading was recorded on the flow sheet at 1200 and the 1232 Accucheck Reading of 29 was recorded on the flow sheet as 89 at 1300.
13. Charges were filed on January 27, 2009.
14. Charges were mailed to Respondent on January 28, 2009.
15. Respondent completed Board approved courses entitled "Overview of Texas Nursing-Legal & Ethical Foundation" and "Sharpening Critical Thinking Skills," which would have been a requirement of this Order.

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 violation of Section 301.452(b)(10) & (13), Texas Occupations Code, 22 TEX. ADMIN. CODE §217.11(1)(B),(C),(D),(M),(N) & (P) and 22 TEX. ADMIN. CODE §217.12(1)(A) & (B), (4) and (6)(A).
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 244064, heretofore issued to JANET CLAIRE WALLACE, including revocation of Respondent's license to practice professional 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 multistate licensure privilege, if any, to practice professional nursing in compact states.

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 multistate licensure 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 deliver the wallet-sized license issued to JANET CLAIRE WALLACE, to the office of the Texas Board of Nursing within ten (10) days from the date of ratification of this Order.

(2) RESPONDENT SHALL be issued a multi state compact privilege to practice professional nursing in the State of Texas with the appropriate notation.

(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. 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>.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A REGISTERED 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 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 THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(5) 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.

(6) 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.

(7) For the duration 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.

(8) 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 or Licensed Vocational 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 one (1) years of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license and multistate licensure privileges, if any, to practice professional nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

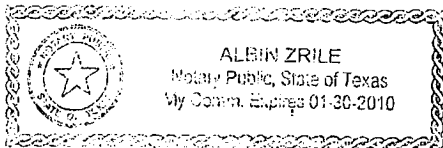
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid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

Signed this 6 day of July, 2009.

Janet Claire Wallace
JANET CLAIRE WALLACE, Respondent

Sworn to and subscribed before me this 6th day of July, 2009.

SEAL



[Signature]
Notary Public in and for the State of TEXAS

Approved as to form and substance.
[Signature]

Nancy Roper Willson
Nancy Roper Willson, Attorney for Respondent

Signed this 16th day of August, 2009

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 6th day of July, 2009, by JANET CLAIRE WALLACE, Registered Nurse License Number 244064, and said Order is final.

Effective this 8th day of September, 2009.



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

