



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 § AGREED
License Number 642779 §
issued to SUSAN THOMAS § ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Bo produced evidence indicating that SUSAN THOMAS, hereinafter referred to as Responde... Registered Nurse License Number 642779, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on February 17, 2009, 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 represented by Edward P. "Joe" Waller, Jr., Attorney at Law. In attendance were Katherine A. Thomas, MN, RN, Executive Director; Jena Abel, Assistant General Counsel; Kyle Hensley, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Amy Grissom, RN, Investigator; and Skylar Caddell, RN,C, Lead 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 San Antonio College, San Antonio, Texas, in May 1997. Respondent was licensed to practice professional nursing in the State of Texas on July 8, 1997.

5. Respondent's nursing employment history includes:

7/1997 - 8/2000	Staff & Charge Nurse	Fresenius Medical Care Central Kidney Disease Clinic San Antonio, Texas
8/2000 - 7/2005	Staff & Charge Nurse	Christus Santa Rosa Medical Center Renal Dialysis Unit San Antonio, Texas
7/2005 - 12/2005	Staff Nurse	Christus Santa Rosa Medical Center Medical/Surgical Floor San Antonio, Texas
12/2005 - 2/2007	Staff & Charge Nurse	Kidney Treatment Center Northwest San Antonio, Texas
2/2007 - 7/2007	Staff & Charge Nurse	US Renal Care, East Houston Clinic San Antonio, Texas
7/2007 - 6/2008	Staff & Charge Nurse	US Renal Care, Medina County Dialysis Clinic Hondo, Texas
7/2008 - Present	Staff & Charge Nurse	US Renal Care Bandera Road Dialysis Clinic San Antonio, Texas

6. At the time of the incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff and Charge Nurse with US Renal Care, Medina County Dialysis Clinic, Hondo, Texas, and had been in this position for eleven (11) months.

7. On or about June 30, 2008, while employed as a Staff and Charge Nurse with US Renal Care, Medina County Dialysis Clinic, Hondo, Texas, Respondent administered in error Vancomycin intravenously to Patient 634077815, as ordered by the physician, even though the patient had an allergy to that medication, which, although documented on the patient's admitting orders and in the facility's Kardex, was not documented on the patient's allergy sticker at the front of the medical record. Within a minute of beginning the administration, the patient started complaining of tingling in her mouth and tongue and experienced warm flushing to her face and chest. Respondent immediately stopped the medication and notified the physician, but when Respondent returned to the patient, the patient had become unresponsive and stopped breathing. Respondent initiated cardiopulmonary resuscitation and called for EMS (Emergency Medical Services) to transport the patient to a local emergency department, where the patient was pronounced deceased within the hour. Respondent's conduct may have contributed to the patient's demise.

8. In response to the incident in Finding of Fact Number Seven (7), Respondent states that when she began employment at the location, the clinic was overseen by a Facility Manager, who was designated by the facility's policy as the medical records supervisor and who was responsible for ensuring all records are properly documented, completed, and preserved. According to Respondent, the Facility Manager is exclusively responsible for ensuring that all drug allergies are perfectly documented in the patient's medication record, and consistent with the facility's policy, Respondent contends that nursing staff could appropriately rely upon the completeness and accuracy of the medical records. Respondent states that she has never operated in the capacity of Facility Manager at any US Renal Care facility at any time. Regarding the specific incident, Respondent indicates that the patient's allergy to Vancomycin was not written on the outside of the medical record or on the patient's medication record, even though the patient's allergy to Penicillin was written there, and that she relied upon that notation to ascertain whether or not the patient was allergic to Vancomycin before beginning the intravenous administration. Respondent acknowledges that it was only after the event that it was determined that the patient's allergy to both Penicillin and Vancomycin, written on the patient's Standing Order Sheet dated January 3, 2007, and on the patient's Kardex, had not been transcribed in its entirety to the outside of the patient's medical record. According to Respondent, though, the Kardex was set up for the exclusive purpose of anemia monitoring and the entry on the Kardex was made prior to her employment at the facility. On the date of the incident, Respondent indicates she physically made rounds with a nephrologist at the facility, and states that although the nephrologist was giving verbal orders for antibiotics for the patient, both she and the nephrologist visually reviewed the patient's chart and found only that an allergy to Penicillin was clearly visible on the outside of the patient's medical record and within the patient's home medication record, and noted that there was no mention of any allergy to Vancomycin on either record. Based upon this review, the nephrologist ordered Vancomycin to be administered, and Respondent accordingly made such administration, as ordered.
9. The Board finds that the facility was cited by the Texas Department of State Health Services for insufficient staffing because Respondent was the only nurse present for at least 12 patients at the time of the incident, and that subsequently, the facility implemented a new policy requiring all nurses to check the Kardex, the front of the medical record, the standing orders, and the History & Physical, as well as asking the patient about any allergies, prior to administering medications.
10. On or about February 10, 2009, Respondent successfully completed a Board approved course in "Sharpening Critical Thinking Skills," which would have been a requirement of this Order.

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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) and 217.12(1)(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 642779, heretofore issued to SUSAN THOMAS, 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 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 SUSAN THOMAS, to the office of the Texas Board of Nursing within ten (10) days of the date of this Order.

(2) 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) contact 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>.*

(3) 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>

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:

(4) 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.

(5) 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.

(6) Should RESPONDENT choose to work in the area of dialysis nursing, RESPONDENT'S practice of professional nursing will be monitored for one (1) year by a licensed Registered Nurse Consultant proficient in the area of dialysis nursing approved by the Board. RESPONDENT MUST, within ten (10) days of employment in the area of dialysis nursing, provide a list of three (3) RN's for the Board to select; the list should include the name, RN license number, educational experience and work experience of each proposed Registered Nurse Consultant. Monitoring shall commence no later than thirty (30) days following the date of Respondent's receipt of the name of the monitor selected by the Board. The monitor must identify and document individualized goals and objectives, resources to be utilized, and the methods to be used to determine successful completion of the monitoring period relative to the violations identified in this Order. RESPONDENT SHALL meet with the monitor at least twice a month, for a minimum of one (1)

hour each session. RESPONDENT SHALL ensure that the monitor submits reports addressing Respondent's progress toward achievement of the identified monitoring goals and objectives to the office of the Board at the end of each three (3) month period for the one (1) year stipulation period. Meetings may be longer and more frequent if the monitor determines necessary. If either improvement of documentation and/or physical assessment skills is a goal or objective of the monitoring, RESPONDENT SHALL perform assessments on and document assessment findings for live patients. Performing assessments on and documenting findings for mock patients or mannequins WILL NOT be accepted. Multiple employers are prohibited.

(7) 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.

(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 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) year 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 license and RESPONDENT shall be eligible for multistate licensure privileges, if any, to practice 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 3 day of March, 2009.

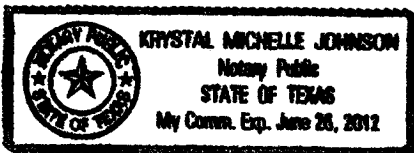
Susan K. Thomas RN
SUSAN THOMAS, Respondent

Sworn to and subscribed before me this 3rd day of March, 2009.

SEAL

Krystal Michelle Johnson

Notary Public in and for the State of Texas



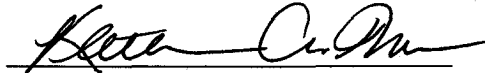
Approved as to form and substance.

Edward P. "Joe" Waller, Jr.
Edward P. "Joe" Waller, Jr., Attorney for Respondent

Signed this 3rd day of March, 2009

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 3rd day of March, 2009, by SUSAN THOMAS, Registered Nurse License Number 642779, and said Order is final.

Effective this 23rd day of April, 2009.

A handwritten signature in black ink, appearing to read "Katherine A. Thomas", written over a horizontal line.

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