

BEFORE THE TEXAS BOARD OF NURSING



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

In the Matter of § AGREED
Registered Nurse License Number 629581 and §
Vocational Nurse License Number 149698 §
issued to STEPHANIE MARIE LEWIS § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of STEPHANIE MARIE LEWIS, Registered Nurse License Number 629581 and Vocational Nurse License Number 149698, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal conference, notice and hearing, and agreed to the entry of this Order offered on December 30, 2007, 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 license.
2. Respondent waived representation by counsel, informal conference, 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 currently in "delinquent" status.
4. Respondent received a Certificate in Vocational Nursing from El Paso Community College, El Paso, Texas, on August 12, 1994, and received an Associate Degree in Nursing from El Paso Community College, El Paso, Texas, on March 1, 1996. Respondent was licensed to practice vocational nursing in the State of Texas on October 18, 1994, and was licensed to practice professional nursing in the State of Texas on June 19, 1996.

5. Respondent's nursing employment history includes:

10/1994 - 2/1996	Unknown	
3/1996 - 8/1996	Staff Nurse, GN & RN	MonteVista Health Care Center El Paso, Texas
9/1996 - 2/2006	RN Staff Nurse	Providence Memorial Hospital El Paso, Texas
3/2006 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a RN Staff Nurse with Providence Memorial Hospital, El Paso, Texas, and had been in this position for nine (9) years and five (5) months.
7. On or about February 10, 2006, while employed as a RN Staff Nurse with Providence Memorial Hospital, El Paso, Texas, Respondent failed to institute appropriate nursing interventions that may have been required to stabilize the condition of Patient Medical Record Number 832535 and prevent complications after the patient suffered numerous episodes of watery diarrhea and developed a fever and low blood pressure. Subsequently, the patient became septic, hypotensive and was transferred to the Intensive Care Unit, where he developed multi-organ system failure and expired the next day. Respondent's conduct exposed the patient unnecessarily to the complications of septicemia and hypovolemic shock, and may have contributed to his demise.
8. On or about February 10, 2006, while employed as a RN Staff Nurse with Providence Memorial Hospital, El Paso, Texas, Respondent failed to report changes in the condition of the aforementioned Patient Medical Record Number 832535 to the on-call physician after becoming aware that the patient was not being followed by an Infectious Disease physician. Subsequently, the patient was transferred to the Intensive Care Unit, where he developed multi-organ system failure and expired the next day. Respondent's conduct deprived the physician of vital information which would have been required to institute timely medical interventions to stabilize the patient, and may have contributed to his demise.
9. On or about February 10, 2006, while employed as a RN Staff Nurse with Providence Memorial Hospital, El Paso, Texas, Respondent failed to accurately and completely document changes in the condition of the aforementioned Patient Medical Record Number 832535 in the medical record, as required. Respondent's conduct was likely to injure the patient in that it deprived subsequent caregivers of vital information on which to base further nursing care and interventions, which may have contributed to the patient's subsequent demise.
10. In response to the incidents in Findings of Fact Numbers Seven (7) through Nine (9), Respondent states that when she received report on the patient, the nurse informed her that she was afraid that she would have to code the patient several times on her shift due to "low blood pressures, frequent loose stools" and because "he looked bad." According

to Respondent, she asked the nurse why the patient had not been moved to a higher level of care, and she was told that the physician was aware of the patient's condition and didn't want to transfer him. Respondent states that at 2000, she medicated the patient for loose stools and that at 2130, he requested additional medication, so she contacted the physician and received an order. Respondent says she was in and out of the patient's room between 2130 and 0100, for various reasons, including a complaint of a mild bloody nose, pain and nausea, all of which she treated per physician's orders. Respondent states that the patient's blood pressure was 80/32 and his temperature was 102 at midnight, so she rechecked him in one hour, at which time the patient denied chills and was not diaphoretic. Respondent states she removed his blankets, and when she returned 30 minutes later, his temperature was 101.2. Respondent states she called Dr. Portillo to inform him of the patient's condition and received orders for an intravenous fluid bolus and Tylenol. Respondent states that the physician asked her if the patient had an infectious disease consult working on his case, and she mistakenly informed him that there was one. Respondent indicates that she believes the patient became stabilized after she administered the fluid bolus and Tylenol because his pressure had improved and his temperature had come down. Respondent states that later while reviewing the patient's medical record she discovered that she had made a mistake by telling the physician that there was a consult for an Infectious Disease physician, but indicates she decided not to call the physician because Dr. Portillo had not given orders to contact a Infectious Disease physician earlier in the evening and because the patient's condition had stabilized. Respondent believes that she made her decision based on what she considered good nursing practice and good judgment, and states that she later informed Dr. Lopez of her mistake and that he ordered antibiotics at that time. Respondent asserts that "it might have been prudent to call the doctor back, instead of waiting until the morning; however, any nurse is required to make hundreds of decisions every single shift and some of those decisions might be considered wrong. I do not believe that the decision to wait led to this man's death. If the issue was sepsis, then the sepsis actually started (a week earlier) when his blood pressure was 80/40, and it was apparently missed by everyone. As the (blood) culture was negative, I'm confused as to how he died of bacterial sepsis. If he did not have bacterial sepsis, (then) the time the antibiotics were started is irrelevant."

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),(1)(B), (1)(D),(1)(M)&(1)(P) and 217.12(1)(A),(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 629581 and Vocational Nurse License Number 149698, heretofore issued to STEPHANIE MARIE LEWIS, 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, Revised Civil Statutes of Texas as amended, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.01 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate licensure privileges, if any, to practice nursing in compact states.

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 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 licenses issued to STEPHANIE MARIE LEWIS, to the office of the Texas Board of Nursing within ten (10) days from the date of ratification of this Order for appropriate notation.

(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 Chemical Dependency, 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/about/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. 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/about/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/about/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://www.learningext.com/products/generalce/critical/ctabout.asp>.

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 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) months for two (2) years of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued unencumbered licenses and 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 waive representation by counsel. 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 29 day of January, 20 08.

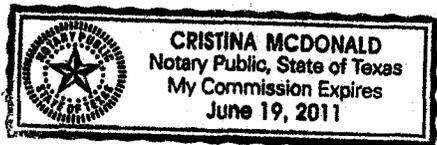
Stephanie Marie Lewis
STEPHANIE MARIE LEWIS, Respondent

Sworn to and subscribed before me this 29 day of January, 2008.

SEAL

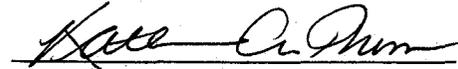
Cristina McDonald

Notary Public in and for the State of Texas



WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 29th day of January, 2008, by STEPHANIE MARIE LEWIS, Registered Nurse License Number 629581 and Vocational Nurse License Number 149698, and said Order is final.

Effective this 18th day of March, 2008.



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