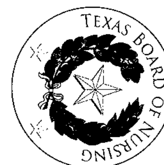

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§	AGREED
License Number 429086	§	
issued to CHARLOTTE M. G. DRONE	§	ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Bo produced evidence indicating that CHARLOTTE M. G. DRONE, hereinafter referred tc Respondent, Registered Nurse License Number 429086, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on November 27, 2007, 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 Taralynn R. Mackay, Attorney at Law. In attendance were Katherine A. Thomas, MN, RN, Executive Director; James W. Johnston, General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Susan Anderson, RN, Investigator; J. L. Skylar Caddell, RN,C, Lead Investigator; and Douglas Boone, 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 received a Diploma in Nursing from Lutheran Hospital School for Nurses, Moline, Illinois, on August 12, 1962; received a Baccalaureate Degree in Nursing from Angelo State University, San Angelo, Texas, in May 1994; received a Certificate of Completion from the Clinical Nurse Specialist Program in Medical-Surgical Nursing from The University of Texas at San Antonio, San Antonio, Texas, on December 21, 1996, and received a Master's Degree in Science from The University of Texas at San Antonio, San Antonio, Texas, on December 21, 1996. Respondent was licensed to practice professional nursing in the State of Texas on November 19, 1973, and became Board recognized as a Clinical Nurse Specialist in Medical-Surgical Nursing on August 13, 1998.

4. Respondent is currently licensed to practice professional nursing in the State of Texas. Respondent's authorization as a Clinical Nurse Specialist in Medical-Surgical Nursing has been in "inactive" status since January 8, 2001.

5. Respondent's professional nursing employment history includes:

1962 - 1964	Charge Nurse	Lutheran Hospital Moline, Illinois
1964	Staff Nurse	St. Luke's Presbyterian Hospital Marquette, Michigan
1964 - 1965	Staff Nurse Charge Nurse	U.S.Veteran's Hospital Shreveport, Louisiana
1966 - 5/1971	Staff Nurse Charge Nurse	Doctor's Hospital Shreveport, Louisiana
6/1971 - 1973	Staff Nurse	U.S. Naval Hospital Guam
1974 -7/1975	House Supervisor Head Nurse	St. John's Hospital San Angelo, Texas
8/1975 - 1991	Staff Nurse - ICU Head Nurse - ICU Director Critical Care	Shannon Medical Center San Angelo, Texas
1991 - 2004	Staff Nurse, As Needed	Shannon Medical Center San Angelo, Texas
1997 - 2004	Instructor, Lecturer, Professional Specialist	Angelo State University San Angelo, Texas
7/2004 - 9/2006	Patient Care Manager Intensive Care Unit	Shannon Medical Center San Angelo, Texas
10/2006 - 12/2006	Unknown	
2007 - Present	Nursing Faculty	Angelo State University San Angelo, Texas

6. At the time of the incidents in Findings of Fact Numbers Seven (7) and Eight (8), Respondent was employed as a Patient Care Manager of the Intensive Care Unit with Shannon Medical Center, San Angelo, Texas, and had been in this position for six (6) months.

7. On or about January 11, 2005 while employed as the Patient Care Manager of the Intensive Care Unit with Shannon Medical Center, San Angelo, Texas, Respondent failed to document in the medical record that she contacted the physician when the blood pressure of Patient Number 7581572 increased to 202/109 and that the physician authorized administration of Labetalol, which had been previously administered on an "as needed" basis to the patient. Respondent's conduct resulted in an incomplete medical record and was likely to injure the patient in that subsequent care givers would not have accurate information on which to base their care decisions.

8. On or about January 11, 2005, while employed as the Unit Manager of the Intensive Care Unit with Shannon Medical Center, San Angelo, Texas, Respondent failed to verify the correctness of the medication she obtained from the Accudose Dispensary System prior to administering it to the aforementioned Patient Number 7581572. As a result, Respondent erroneously administered Epinephrine instead of Labetalol, as ordered. Patient Number 7581572 was a status post brain surgery patient whose blood pressure had become elevated. The patient's blood pressure then rose from 202/109 to 320/178 and returned to baseline in four (4) minutes. Respondent utilized telemetry strips to document the patient's blood pressures and heart rates, including one strip with a printed time of 13:38 reflecting a blood pressure of 320/178 and a heart rate of 164, and with a handwritten note that the time was ten (10) minutes slow and it was after the Epinephrine had been administered. Respondent documented on the medication administration record and in the nurses' notes that she administered the Epinephrine at 13:55. The patient was pronounced deceased two (2) days later after having undergone additional surgical procedures. On or about August 17, 2007, Luis E. Duarte, MD, who was the treating physician for the aforementioned Patient Number 7581572, submitted a letter to the Board indicating that he does not feel that Respondent's medication error adversely impacted the patient's prognosis or contributed to his demise, and that while he feels the medication error was unfortunate, it did not cause the patient's death.

9. In response to the incidents in Findings of Fact Numbers Seven (7) and Eight (8), Respondent admits responsibility for giving the wrong medication to the patient, and states that she immediately obtained and administered medication to reduce the patient's blood pressure as soon as she realized her mistake. According to Respondent, she notified the patient's wife, the physician, her Nursing Director, the physician Unit Director, the Quality Assurance Nurse and the Director of Nurses about the incident, and she both requested Peer Review and participated in the facility's root-cause analysis. Respondent states that she believes there was a system problem related to the Accudose, that the Labetalol and Epinephrine were placed in the bottom drawer next to each other, and that she uses her error "as a way to stress to other nurses the importance of safety checks." Respondent submitted numerous letters of reference and recommendation, including letters from the following:
   - Leslie M. Mayrand, Ph.D., RN, CNS, Professor and Head, Department of Nursing, Angelo State University, San Angelo, Texas;
   - Denver Marsh, Jr., MD, Shannon Regional Heart Center, San Angelo, Texas;
   - Martha Tafoya, MSN, RN, Professional Specialist, Angelo State University, San Angelo, Texas;
   - Sherry Halfman, PhD, RN, Assistant Professor, Angelo State University, San Angelo, Texas;

- Paul Osmanski, MSN, RN, Professional Specialist, Angelo State University, San Angelo, Texas;
- Linda Stephens, RN, Chief Nursing Officer, West Houston Medical Center, Houston, Texas;
- Verna J. Morse, RN, San Angelo, Texas;
- Evelyn Aguilar, RN, CCRN, San Angelo, Texas;
- Beverly Edmundson, RN, CCRN, San Angelo, Texas;
- Mavis Bell, RN, CPAN, San Angelo, Texas;
- Millicent (Kells) Shaw, State Registered Nurse, Ireland;
- Sheila Herndon, RN, San Angelo, Texas;
- Linda Barajas, RN, San Angelo, Texas;
- Amy Lyn Fisher, RN, San Angelo, Texas;
- Stephanie S. Gesch, RN, LVN, San Angelo, Texas; and
- Leslie Cody Snodgrass, RN, EMT-LP, Flight Nurse, Paramedic, Lohn, Texas.

10. On or about January 17, 2005, through February 2005, Shannon Medical Center, San Angelo, Texas, determined through root-cause analysis that a recent change in the type of Medication Dispensing System at the time of the incident, from a Pyxis System to an Accudose System, may have contributed to the medication error, as follows:
    - The Accudose System had only been implemented for sixty (60) days, and Respondent states that the ICU was the last unit to change to the system;
    - The Accudose System changed the drug profile list from generic to brand, which was not known by Respondent at the time; and
    - The pockets in the drawers of the Accudose System were labeled differently, which was confusing.

11. On or about March 29, 2007, an investigation by the Texas Department of State Health Services (TDSHS) substantiated that Epinephrine had been administered in error to the patient and that there was a patient death; however, the TDSHS investigation concluded that evidence did not support a definitive link between the two events.

12. On or about June 7, 2007, Respondent successfully completed a Board approved course in Texas Nursing Jurisprudence and Ethics, which would have been a requirement of this Order.

13. On or about August 5, 2007, Respondent successfully completed a Board approved course in Medication Administration, which would have been a requirement of this Order.

14. On or about March 8, 2008, Respondent successfully completed a Board approved course in Nursing Documentation, which would have been a requirement of this Order.

15. Respondent states that the incident in Findings of Fact Numbers Seven (7) and Eight (8) represents an isolated, singular occurrence in her practice of nursing, and that she has, since 1987, continuously maintained her CCRN® as a critical care nurse through the AACN Certification Corporation, Aliso Viejo, California.

16. Formal Charges were filed on April 28, 2008.

17. Formal Charges were mailed to Respondent at her address of record on April 29, 2008.

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) 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 429086, heretofore issued to CHARLOTTE M. G. DRONE, 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 LIMITED LICENSE 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 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-size license issued to CHARLOTTE M. G. DRONE, to the office of the Texas Board of Nursing within ten (10) days from date of ratification of this Order for appropriate notation.

(2) While under the terms of this Order, RESPONDENT SHALL NOT provide direct patient care. For the purposes of this Order, direct patient care involves a personal relationship between the Nurse and the client, and includes, but is not limited to: teaching, counseling, assessing the client's needs and strengths, and providing skilled nursing care. **While under the terms of this Order, RESPONDENT MAY teach nursing as long such teaching does not include supervision of students in a clinical practicum setting.**

(3) SHOULD RESPONDENT desire to return to a clinical practice setting, which would require her to provide direct patient care, RESPONDENT SHALL petition the Board for such approval.

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RESPONDENT'S CERTIFICATION

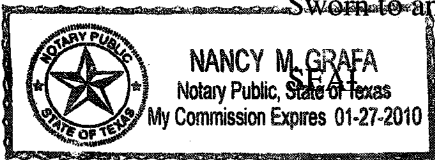
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid 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 12th day of June, 2008.

Charlotte M.G. Drone

CHARLOTTE M.G. DRONE, Respondent

Sworn to and subscribed before me this 12th day of June, 2008.



SEAL

Nancy M. Grafa

Notary Public in and for the State of Texas

Approved as to form and substance.

Taralynn R. Mackay

Taralynn Mackay, Attorney for Respondent

Signed this 10th day of June, 2008.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the12th day of June, 2008, by CHARLOTTE M. G. DRONE, Registered Nurse License Number 429086, and said Order is final.

Effective this 17th day of July, 2008.

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