



5. Respondent's nursing employment history includes:

1982 - 1986	Intensive Care Charge Nurse	Baptist Medical Center Oklahoma City, Oklahoma
1987 - 04/2005	Not employed in Nursing	
05/2005 - 07/2005	Unknown	
08/2005 - 07/2006	Intensive Care Nurse	Presbyterian Hospital of Dallas Dallas, Texas
08/2006 - 2006	Unknown	
2007 - Present	Registered Nurse	Baylor Health Care System Dallas, Texas

6. At the time of the initial incident, Respondent was employed as an Intensive Care Nurse with Presbyterian Hospital of Dallas, Dallas, Texas, and had been in this position for five (5) months.
7. On or about January 28, 2006, while employed with Presbyterian Hospital of Dallas, Dallas, Texas, Respondent failed to administer doses of Protonix and Unasyn which were scheduled at 6:00 p.m. to Patient Medical Record Number 390590, as required. The omission was not found until the next shift. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment.
8. On or about February 18, 2006, while employed with Presbyterian Hospital of Dallas, Dallas, Texas, Respondent failed to complete neurological (neuro) checks every one (1) hour on a post craniotomy patient, Patient Medical Record Number 1195206, and monitor the patient's Increased Intracranial Pressure, as ordered by the physician. Respondent's conduct was likely to injure the patient due to incomplete assessment information needed in order to formulate clinical care decisions and prevent clinical complications.
9. On or about March 29, 2006, while employed with Presbyterian Hospital of Dallas, Dallas, Texas, Respondent failed to timely ensure that the Sequential Compression Device (SCD) was applied to Patient Medical Record Number 1267475, as ordered. Although the physician wrote the order at 1235, the SCD was not applied until more than six (6) hours later, at 1900, when Respondent's shift was nearing an end. Respondent's conduct was likely to injure the patient in that the delay of application of the compression device could have resulted in complications from blood clot formation in the lower extremities.
10. On or about May 24, 2006, while employed with Presbyterian Hospital of Dallas, Dallas, Texas, Respondent failed to document vital signs, vascular checks or surgical site status in

the medical record during an incident of pulsatile bleeding at the right 3<sup>rd</sup> toe amputation wound site of Patient Medical Record Number 1181152. Although the incident of bleeding occurred at 1735, no vital signs were documented until the next shift, at 1930. Respondent's conduct resulted in an incomplete medical record, and was likely to injure the patient in that subsequent care givers did not have accurate and complete information on which to base their decisions for further care.

11. On or about July 11, 2006, while employed with Presbyterian Hospital of Dallas, Dallas, Texas, Respondent failed to document in the medical record the status of the aforementioned Patient Medical Record Number 630917 from 0900 through the remainder of the shift, which ended at 1900. Respondent's conduct resulted in an incomplete medical record and was likely to injure the patient from clinical care decisions formulated based upon incomplete information.
12. In response to the incidents in Findings of Fact Numbers Seven (7) through Fourteen (14), Respondent states that she missed giving the Protonix and the Unasyn, that this was a missed medication error. According to Respondent, was a documentation oversight on her part not to document the neuro checks and ICP monitoring of Patient Medical Record Number 1195206. Respondent states she had delegated the task of assuring that Patient Medical Record Number 1267475 received the SCD to a Patient Care Tech (PCT). Respondent states further that she failed to follow up with the PCT, but that Central Supply did not bring the SCD sleeves up in a timely manner and that she was with a critically ill patient at the time who took priority. Respondent indicates that during the incident in which the patient experienced pulsatile bleeding, the patient was wearing a monitor which measured blood pressure, oxygen saturation, and heart activity with alarms, that no alarms sounded during this time, and that vital signs were available to physicians and next-shift nurses through the central monitor. Respondent continues, stating that she was not contacted regarding the missing information so she could correct her documentation.
13. On or about December 1, 2006, Respondent successfully completed a Board approved course in nursing documentation, which would have been a requirement of this Order.
14. On or about December 5, 2006, Respondent successfully completed a Board approved course in Texas nursing jurisprudence, which would have been a requirement of this Order.
15. On or about December 19, 2008, Respondent successfully completed a Board approved course in "Sharpening Critical Thinking Skills", which would have been a requirement of this Order.

#### CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, 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, and 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (1)(B), (1)(C), (1)(D), (1)(M), (3)(A) & (3)(B) and 217.12(1)(A)(1)(B), (1)(C), (1)(F) & (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 719912, heretofore issued to ELIZABETH GARRETT, including revocation of Respondent's license 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 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, 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 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) NURSE LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD.**

(2) 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.

(3) 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.

(4) 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.

(5) 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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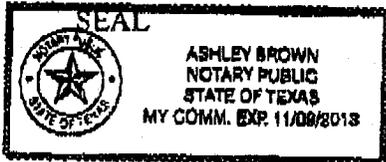
RESPONDENT'S CERTIFICATION

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 19 day of April, 2010.

Elizabeth Garrett  
ELIZABETH GARRETT, Respondent

Sworn to and subscribed before me this 19 day of April, 2010.



Ashley Brown  
Notary Public in and for the State of Texas

Approved as to form and substance.

Nancy Roper Willson  
Nancy Roper Willson, Attorney for Respondent

Signed this 20 day of April, 2010

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 19<sup>th</sup> day of April, 2010, by ELIZABETH GARRETT, Registered Nurse License Number 719912, and said Order is final.

Effective this 22<sup>nd</sup> day of July, 2010.



A handwritten signature in cursive script, reading 'Katherine A. Thomas'.

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