

5. Respondent's nursing employment history includes:

1991 - 1992	Staff Nurse	Rush Presbyterian St. Luke's Medical Center, Chicago, Illinois
1992 - 1993	Nurse Clinician	Children's Memorial Hospital Hematology/Oncology, Chicago, Illinois
1993 - 1995	Staff Nurse	Children's Hospital of Austin Hematology/Oncology, Austin, Texas
1995 - 1997	Case Manager	Children's Hospital of Austin Hematology/Oncology, Austin, Texas
1997 - 1998	Staff Nurse	Children's Hospital of Austin Hematology/Oncology, Austin, Texas
1998 - 2001	Coordinator	Children's Hospice Services Hospice at the Texas Medical Center Houston, Texas
2001 - 2003	Instructor of Pediatrics	Baylor College of Medicine Houston, Texas
	Pediatric Nurse Practitioner	Texas Children's Cancer Center, Texas Children's Hospital, Houston, Texas
2003 - Present	Instructor	The University of Texas Health Science Center, Department of Pediatrics San Antonio, Texas
	Pediatric Nurse Practitioner, Director of Community Programs	Center for Comprehensive Care of Children with Complex Chronic Conditions, CHRISTUS Santa Rosa Children's Hospital San Antonio, Texas

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Pediatric Nurse Practitioner and Director of Community Programs with the Center for Comprehensive Care of Children with Complex Chronic Conditions, CHRISTUS Santa Rosa Children's Hospital, San Antonio, Texas, and had been in this position for five (5) years.

7. On or about October 14, 2008, through October 26, 2008, while employed as a Pediatric Nurse Practitioner and Director of Community Programs with the Center for Comprehensive Care of Children with Complex Chronic Conditions, CHRISTUS Santa Rosa Children's Hospital, CHRISTUS HomeCare, San Antonio, Texas, Respondent failed to document the complete vital signs of Patient M21249. The 16 year-old patient had been admitted to the

facility's palliative care program on September 10, 2008, with diagnoses of malignant neoplasm of the brain, convulsions and dysphagia, and developed respiratory distress with dyspnea and increased productive cough on October 14, 2010. On October 15, 2010, Respondent diagnosed the patient as having pneumonia. Respondent's conduct resulted in an incomplete medical record.

8. On or about October 15, 2008, through October 26, 2008, while employed as a Pediatric Nurse Practitioner and Director of Community Programs with the Center for Comprehensive Care of Children with Complex Chronic Conditions, CHRISTUS Santa Rosa Children's Hospital, CHRISTUS HomeCare, San Antonio, Texas, Respondent failed to fully inform the parents of the aforementioned Patient M21249 that the patient had pneumonia, which Respondent had newly diagnosed and which continued throughout treatment. After diagnosing pneumonia on October 15, 2008, and prescribing treatment, to include antibiotics and a bronchodilator, Respondent next saw the patient on October 22, 2008, and documented that the patient's lungs had improved. Respondent evaluated the patient in her home again on October 24, 2008, and documented slight wheezing in the lungs with inspiration, but no rales or rhonchi and prescribed an inhaled steroid. The Respondent's next home visit to the patient was October 26, 2008, to follow-up on a call from the palliative care RN the prior evening related to the patient reporting chest pain, shortness of breath, and crackles for which the patient received steroids, bronchodilators and oxygen. At the time of the visit, Respondent documented that the lungs had improved, there were no rales or rhonchi, but breath sounds were slightly diminished at the bases. On October 27, 2008, the patient's parents called for Emergency Medical Services (EMS) due to the patient's increasing respiratory difficulty, and upon arrival, EMS stated the patient was gray and in her last hours. Upon transfer and admission to an acute care center, it was determined that the patient was suffering from septic shock and chronic aspiration pneumonia. The patient was discharged home, dependent upon a ventilator due to respiratory failure, five (5) weeks later and died on December 28, 2008. Respondent's conduct may have affected the parent's ability to make fully informed decisions regarding the patient's care.
9. In response to the incidents in Findings of Fact Numbers Seven (7) and Eight (8), Respondent states that she did assess the patient's heart and respiratory rates as part of her routine assessments but that she did not document them in the medical record because she usually completed her documentation back at her office and after she left the patient's home. Regarding informing the parents about the pneumonia, Respondent indicates that she did inform them that she heard crackles in the patient's lungs that could suggest fluid in the lungs; that she was concerned about infection in the lungs; and that she was prescribing antibiotics and a bronchodilator. Respondent further indicates that she might not have used the actual term "pneumonia" in explaining the patient's status to the parents.

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)(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(D),(1)(F),(1)(P)&(4)(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 598404, heretofore issued to MELODY BROWN HELLSTEN, including revocation of Respondent's license(s) 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, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact 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 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) 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>.

(2) 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 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.

(3) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). 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(s). 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.

(4) 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.

(5) 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.

(6) 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 collaborating physician or advanced practice Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising physician or advanced practice 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(s) to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

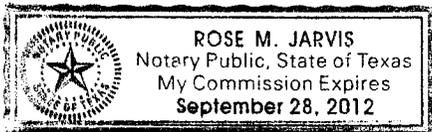
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violation alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid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

Signed this 19 day of April, 2011.

Melody Brown Hellsten
MELODY BROWN HELLSTEN, Respondent

Sworn to and subscribed before me this 19 day of April, 2011.

SEAL



Rose M. Jarvis
Notary Public in and for the State of Texas

Approved as to form and substance.

Lisa A. Rocheleau
Lisa A. Rocheleau, Attorney for Respondent

Signed this 5th day of May, 2011.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 19th day of April, 2011, by MELODY BROWN HELLSTEN, Registered Nurse License Number 598404, and said Order is final.

Effective this 14th day of June, 2011.

A handwritten signature in cursive script, appearing to read "Katherine A. Thomas".

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