BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 624668	§	
issued to ROBIN R. EBELING	§	ORDER

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.
Executive Director of the Board

On this day the Texas Board of Nursing, hereinafter referred to as the B considered the matter of ROBIN R. EBELING, Registered Nurse License Number 62 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 informal proceedings, notice and hearing, and agreed to the entry of this Order offered on December 22, 2010, 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 informal proceedings, 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.

4. Respondent received a Baccalaureate Degree in Nursing from Houston Baptist University, Houston, Texas on November 1, 1995. Respondent was licensed to practice professional nursing in the State of Texas on January 15, 1996.

5. Respondent's nursing employment history includes:

3/1996 - 1/1997	Registered Nurse Lyndon B. Johnson Hospital Houston, Texas

Respondent's nursing employment history continued:

1/1997 - 2/2002	Staff Nurse The Methodist Hospital Houston, Texas
11/2001 - 8/2008	Staff Nurse Texas Children's Hospital Houston, Texas
9/2008 - Present	Unknown

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Texas Children's Hospital, and had been in this position for two (2) years and six (6) months.

7. On or about May 31, 2004, while employed with Texas Children's Hospital, Houston, Texas, Respondent improperly infused Dopamine into a arterial line site of Patient Medical Record Number 863382, instead of the central line as ordered. Respondent's conduct placed the patient at risk of harm in that the administration of Dopamine through an arterial line instead of a central line exposed the patient to risk of the site of the arterial line to become necrotic with extravastion.

8. In response to Finding of Fact Number Seven (7), Respondent states that she gave report to the oncoming nurse, which included verifying drips and nothing was discovered at that time. Respondent states she believes that when another nurse went to change IV lines, she discovered that Dopamine had apparently been connected to the arterial line and the arterial line flush has been connected to central line where Dopamine should have been. Respondent adds that all the IV tubing used for flushes for lines as well as for drips are the same lines. Respondent denies that she hung the Dopamine or the arterial line flush but states she did not recall having traced the lines when she started her shift.

9. On or about July 1, 2004, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed to clarify a physician's order to "increase IV fluids" and incorrectly increased "1ccHeparin/1ml NS" to "10cc Heparin/1ml NS" to one-year-old Patient Medical Record #8855883 instead of restarting D5 1/4NS, as ordered. Respondent's conduct placed the patient at risk of the symptoms of heparin overdose including excessive bruising and hemorrhage.

10. In response to Finding of Fact Number Nine (9), Respondent states that she received the order to increase IV fluids to 10cc/hr and went to the IV pump and increased it from 1cc/hr to 10cc/hr without contacting the physician to clarify the order. Respondent states that she should have contacted the physician to clarify the order before she increased the rate of the Heparin infusion.

11. On or about August 2, 2004, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed to ensure that the correct dialysate fluid was administered to Patient Medical Record Number 8860556, who was receiving peritoneal dialysis. Another staff member administered an incorrect solution of calcium instead of dialysate fluid while Respondent was on break, which Respondent did not discover until several hours later. Respondent's conduct placed the patient at risk of symptoms of hypercalcemia, including arrhythmias, kidney failure and, if left untreated, death.

12. In response to Finding of Fact Number Eleven (11), Respondent states that when she went on dinner break, she gave report to the nurse covering her assignment and informed her that the patient's dialysate bag may need to be changed before she returned. Respondent adds that she showed this nurse where there were bags of dialysate and other dialysis solutions in boxes on the floor. Respondent states that she left for lunch and when she returned, this nurse informed her she had changed the dialysate solution for her. Respondent admits that she did not check the solution until it was noted that the patient had elevated calcium levels. Respondent states that she checked the bag and noted that the wrong solution had been hung.

13. On or about August 23, 2007, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed to follow a physician's order to administer "Nicardiopine 8mg/hr then decrease by 1mg/hr every hour until off" for Patient Medical Record Number 90145154. Respondent administered the drip as follows:

Rate of Nicardepine	Blood Pressure
2200 - 8mg	140/100
2300 - 7mg	135/105
2400 - 6mg	160/120
0100 - 6mg	170/125
0200 - 5 mg	115/145
0300 - 4mg	115/170
0400 - 4 mg	135/165
0500 - 4 mg	130/145
0700 - 8 mg	

Respondent's conduct resulted in the patient experiencing elevated blood pressures, which resulted in the patient requiring an extended stay in the Intensive Care Unit to stabilize the patient's condition.

14. On or about August 23, 2007, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed to document she had notified the physician that Patient Medical Record Number 90145154 had experienced elevated blood pressure results when Respondent decreased the administration of a Nicardipine drip. Additionally, Respondent failed to document her nursing care or interventions in the patient's nurses narrative notes. Respondent's conduct created an incomplete medical record and deprived subsequent caregivers of essential information on which to provided ongoing medical care.

15. In response to Findings of Fact Numbers Thirteen (13) and Fourteen (14), Respondent states that she received an order from the physician to decrease Nicardipine drip 1mg each hour until off. Respondent reports that when tried to wean the patient from the Nicardipine drip, the patient's blood pressure would increase, so she contacted the physician and he had ordered that she wean the Nicardipine drip when blood pressure permits. Respondent denies that she wrote a new order because she felt the previous order was still in effect when the patient's blood pressure was more stable and tolerated weaning again. Respondent states that she gave verbal report to the oncoming shift regarding the patient's status.

16. On or about September 20, 2007, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed follow a physician's order to type and crossmatch blood product for Patient 9087465, who was scheduled for a circuit replacement secondary to clot formation. Respondent's conduct resulted in the delay of the surgery, which placed the patient at risk of non-effacicious treatment and delayed recovery.

17. In response to Finding of Fact Number Sixteen (16), Respondent states she does not recall getting any order for a type and crossmatch for this patient. Additionally, Respondent states that the blood bank usually calls and notifies the nurse on the unit for the special patient circumstances such as a VAD. Respondent reports that she assumed the type and cross was already current because the patient was a VAD patient.

18. On or about December 5, 2007, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed to completely and accurately document assessments of Patient Medical Record Number 9125341. Respondent's conduct created an incomplete medical record and deprived subsequent caregivers of essential information on which to provided ongoing medical care.

19. In response to Finding of Fact Number Eighteen (18), Respondent states she missed her narrative, shift summary and second assessment on her assigned patient. Respondent states that an outside personal stress was present and she was visibly upset upon arrival to work. Respondent adds that she felt that she was not fully prepared mentally to work, but it was too late to call in.

20. On or about February 13, 2008, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed to timely document the nursing care provided to Patient Medical Record Number 9145314, who became bradycardic and subsequently arrested requiring cardiopulmonary resuscitation (CPR) shortly after Respondent left the facility. Additionally, when Respondent returned to the facility to finish documenting her nursing care, she failed to indicate her entries were "late entries" resulting in patient safety being jeopardized due to late documentation and lack of accurate facts. Respondent's conduct created an incomplete and inaccurate medical record on which subsequent caregivers would rely on to provide ongoing medical care.

21. In response to Finding of Fact Number Twenty (20), Respondent states she had completed all vital signs and I's and O's, but needed to complete her narrative and shift summary, which she planned on doing after giving report, but forgot to do before she left. Respondent states that she remembered when she was almost home. Respondent adds that she went back to work when she received a phone call from the charge nurse who told her she needed to come back and complete her charting. Respondent admits that when she wrote her narrative, she neglected to write "late entry" but asserts that everything she charted was correct.

22. On or about August 23, 2008, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed to institute the appropriate nursing intervention required to stabilize Patient Medical Record Number 9145314 in that she:
    - administered half a dose of pain medication to a patient instead of the entire ordered dose and failed to communicate this to the physician when the patient's pain issues were inadequately addressed by on-call fellows;
    - failed to respond to critical alarms; and
    - failed to recognize and communicate the patient's deteriorating condition (un-managed pain, increased B/P, increase CT output) to the physician.

    Subsequently, Patient Medical Record Number 9145314 was taken to the operating room to evacuate a large clot around the patient's lung. Respondent's conduct deprived the patient of timely medical intervention required to stabilize the patient's condition. Additionally, Respondent's conduct deprived the physician of essential information on which to base ongoing medical care.

23. On or about August 23, 2008, while employed with Texas Children's Hospital, Houston, Texas, Respondent failed document that Patient Medical Record Number 9145314 was experiencing significant changes in condition, including signs, symptoms and responses, as identified in Finding of Fact Number Twenty-two (22). Respondent's conduct created an incomplete and inaccurate medical record on which subsequent caregivers would rely on to provide ongoing medical care.

24. In response to Findings of Facts Numbers Twenty-two (22) and Twenty-three (23), Respondent states the patient's father insisted that the patient have water, even though the patient was fluid restricted. Respondent states that she explained what fluid restriction was and why the patient couldn't have the water. Respondent reports that the patient's father was very demanding and insistent about everything his daughter wanted, which continued throughout her shift. Respondent states that the patient stated she was having pain so Respondent went to the Omni cell and pulled out pain medication that was ordered and gave it to her. Respondent noted that as soon as the father stepped out to the waiting room, the patient calmed down stating her pain was better, and would appear to be restful and asleep, however when the father returned, the patient's pain level and blood pressure would elevate. Respondent adds that when she would medicate the patient, the patient's father would insist that she give the patient more. Respondent states that she informed a fellow on-call physician who wrote an order for additional pain medication. Because she wasn't sure what the patient's pain level truly was, Respondent reports that she tried a half dose of pain medication to see if it would help the patient's pain because she didn't want to over medicate the patient. Regarding the alarms, Respondent states that she had the patient's alarms pulled up in her other assigned patient's room so she could observe them. Respondent reports that twice she was called back to the patient's room due to an alarm going off, one was the respiratory rate alarm, which was not an accurate reading and another was an alarm for the blood pressure. Respondent states she was en route to the patient's room to check the blood pressure alarm when the patient's father called. Respondent concludes that the patient's father was aggressive and verbally abusive toward her and she believes in this situation, the patient's family, namely the father, became disruptive to the care of his daughter.

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 violation of Section 301.452(b)(10) & (13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(A)(B)(C)(D)(M)(N)&(P) and 22 TEX. ADMIN. CODE §217.12(1)(A)&(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 624668, heretofore issued to ROBIN R. EBELING, 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 REPRIMAND 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 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 is 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 <u>not</u> 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 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.*

(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/disciplinaryaction/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/disciplinaryaction/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://learningext.com/hives/a0f6f3e8a0/summary.*

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) 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 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.

(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) month period for two (2) years 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 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 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 nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 14 day of February, 2011.

Robin R. Ebeling

ROBIN R. EBELING, Respondent

Sworn to and subscribed before me this 14th day of February, 2011.

SEAL

Christine M. Rodriguez

Notary Public in and for the State of Texas

CHRISTINE M. RODRIGUEZ
MY COMMISSION EXPIRES
February 14, 2015

Approved as to form and substance.

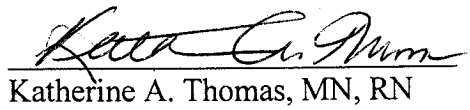
Monica M. Lawrence

Monica M. Lawrence, Attorney for Respondent

Signed this 14th day of February, 2011.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 14th day of February, 2011, by ROBIN R. EBELING, Registered Nurse License Number 624668, and said Order is final.

Effective this 28th day of April, 2011.



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