

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.  
*Patricia P. Thomas*  
Executive Director of the Board

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In the Matter of Registered Nurse § AGREED  
License Number 742921 §  
issued to MONICA JOAN GARCIA § ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Board, produced evidence indicating that MONICA JOAN GARCIA, hereinafter referred to as Respondent, Registered Nurse License Number 742921, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on February 1, 2011, 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 notified of her right to be represented by legal counsel and elected to waive representation by counsel. In attendance were Bonnie Cone, MSN, RN, Executive Director's Designee; Lance Brenton, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and Amy Grissom, RN, 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(s).
2. Respondent waived representation by counsel, notice and hearing, and consented 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 The University of Texas Health Sciences Center, San Antonio, Texas, on May 19, 2007. Respondent was licensed to practice professional nursing in the State of Texas on June 21, 2007.

5. Respondent's nursing employment history includes:

7/2007-10/2007	RN	Santa Rosa Children's Hospital San Antonio, Texas
11/2007-6/2008	RN	Methodist Children's Hospital San Antonio, Texas
7/2008-8/2008	Unknown	
9/2008-9/2008	RN	Angel Staffing Agency San Antonio, Texas
10/2008-10/2008	Unknown	
11/2008-5/2010	RN Telemetry	Texasan Heart Hospital San Antonio, Texas
5/2010-11/2010	RN	Cristus Santa Rosa San Antonio, Texas
12/2010-Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Methodist Children's Hospital of South Texas, San Antonio, Texas, and had been in this position for six (6) months.
7. On or about May 17, 2008, while employed with Methodist Children's Hospital of South Texas, San Antonio, Texas, Respondent failed to follow the policy and procedure for the wastage of medication in that she left a morphine syringe which had been withdrawn to administer to Patient Number W122593090 unattended in the patient's room. After the patient was discharged, housekeeping discovered the unopened morphine syringe under the patient's bed. Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).
8. On or about May 21, 2008, while employed with Methodist Children's Hospital of South Texas, San Antonio, Texas, Respondent failed to correctly administer medication to Patient Number W122657527 when she set the Total Parenteral Nutrition (TPN) to infuse at a rate of 6cc/hour rather than 65cc/hour, as ordered by the physician. Consequently, the patient did not receive the required caloric intake to promote healing and sustain life for more than eight (8) hours. Respondent's conduct exposed the patient unnecessarily to a risk of harm from non-efficacious treatment/care.

9. On or about May 20, 2008, while employed with Methodist Children's Hospital of South Texas, San Antonio, Texas, Respondent failed to enter into the Meditech system a physician order for Home Health Services for Patient Number W122658137, who was scheduled to be discharged home on May 21, 2008, with Home Health follow up. Respondent's error was not discovered until 3:00 p.m. the day of the scheduled discharge, at which time it was too late for Home Health Services to be scheduled. Respondent's conduct resulted in the patient remaining in the hospital for an additional day.
10. On or about May 2008, through June 3, 2008, while employed with Methodist Children's Hospital of South Texas, San Antonio, Texas, Respondent:
- Failed to follow physician orders to schedule Home Health services for a patient, which resulted in the patient being discharged home without needed wound care; and
  - Discharged a patient from the hospital without home medications.
- Respondent's conduct was likely to injure the patients from non-efficacious care.
11. In response to the incidents in Findings of Fact Numbers Seven (7) through Ten (10), Respondent states that the patient involved in the morphine incident was a teenage girl who had a PCA pump. Respondent states she had gone into the patient's room to change the syringe in the PCA, and while she was on her knees next to the pump preparing to exchange the syringes, she placed the new syringe on the floor next to her, at which time the patient indicated she felt really sleepy and her head drooped to one side. Respondent states she was fearful the patient was overdosing and immediately intervened with a dose of Narcan to reverse any possible overdose. Respondent states she called the physician and reported what had happened and was given an order to discontinue the PCA pump. Respondent states she removed the pump from the patient's room and wasted the remaining narcotic from the old syringe. Respondent states she did not remember the new syringe until her manager called her two days later when the syringe was found under the patient's bed after the patient was discharged. In regard to the Total Parenteral Nutrition (TPN) infusion, Respondent states that the patient had TPN infusing along with intravenous fluids (IVF). Respondent states she adjusted the IVF rate according to the amount of Nasal Gastric Tube (NGT) output during her first assessment of the patient. Respondent states she returned to the patient's room about an hour later, because she still didn't feel comfortable with the amount of drainage she had noted in the NGT canister earlier. Respondent looked at the canister closely and noted faint pen marks on the canister that indicated the amount of output. Based on this information, Respondent made the adjustment to 6cc/hour for the IVF, which she states was the correct replacement rate for the amount of output. Respondent states when she reassessed the patient 3 hours later she found that the IV rate was back at the higher rate from the morning. Respondent states she doesn't know why she thought it, but she thought that maybe somebody who had taken care of the patient earlier decided to change the rate for her. Respondent states she changed the IV rate again to the replacement rate and again when she did her final assessment that shift. Respondent states that when the night shift nurse called her to ask about the TPN infusion rate she realized that when she had changed the rate of the IVF she had actually changed the rate of the TPN. Regarding the delay discharging Patient Number W122658137 home, Respondent states that the patient had orders for home health and when the physician and the patient's case manager realized the orders had not been initiated they patiently explained to her and helped her through the process of initiating home

health orders. Respondent states that unfortunately this did mean the patient had to wait another day before being discharged home. Concerning the incident of discharging a patient without Home Health services Respondent states she has no good reasoning for this error. Respondent states it was a slow day and she procrastinated on the orders and at the end of her shift the orders were not completed. Respondent states the patient was not scheduled to discharge until the next day and so she was not in a rush to do the orders. Respondent states the procrastination was irresponsible of her. Respondent states, in regard to discharging a patient home without medications, that the patient had multiple medications, multiple prescriptions, and long discharge orders so she overlooked one medication. Respondent states she did not know she had missed the medications until a few days later when she was told that the patient's mother had come back 2-3 days later to ask for the medication because the mother didn't have it. Respondent states she takes responsibility for the omission.

12. On or about January 17, 2011, 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),(1)(N)&(3) and 217.12(1)(A),(4)&(10)(C).
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 742921, heretofore issued to MONICA JOAN GARCIA, 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 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 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 (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. 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.

(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.

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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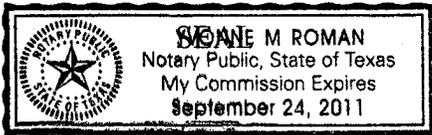
RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I 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 license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 18 day of February, 2011.

Monica Joan Garcia  
MONICA JOAN GARCIA, Respondent

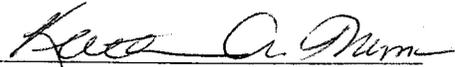
Sworn to and subscribed before me this 18<sup>th</sup> day of February, 2011.



[Signature]  
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 18<sup>th</sup> day of February, 2011, by MONICA JOAN GARCIA, Registered Nurse License Number 742921, and said Order is final.

Effective this 28<sup>th</sup> day of April, 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