

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

In the Matter of Registered Nurse § AGREED
License Number 741695 §
issued to CYNTHIA GWEN ROBERTS § ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Board, produced evidence indicating that CYNTHIA GWEN ROBERTS, hereinafter referred to as Respondent, Registered Nurse License Number 741695, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on October 12, 2010, 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 Elizabeth Higginbotham, R.N., J.D., Attorney at Law. In attendance were Bonnie Cone, MSN, RN, Executive Director's Designee; Kyle Hensley, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and Jennifer Ellis, 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.
2. Respondent waived 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 an Associate Degree in Nursing from Blinn College, Bryan, Texas, on May 10, 2007. Respondent was licensed to practice professional nursing in the State of Texas on June 7, 2007.

5. Respondent's nursing employment history includes:

07/2007 - 12/2007	Staff RN	St. Joseph Regional Healthcare System Bryan, Texas
12/2008 - 04/2008	RN Charge Nurse	Sheridan Health and Rehab on Rock Prairie College Station, Texas
05/2008 - Present	Staff RN	College Station Medical Center College Station, Texas

6. At the time of the initial incident, Respondent was employed as a Staff RN with St. Joseph Regional Healthcare System, Bryan, Texas, and had been in this position for four (4) months.
7. On or about November 12, 2007, while employed with St. Joseph Regional Healthcare System, Bryan, Texas, Respondent inappropriately administered "NOW" blood pressure medications Procardia XL 60mg and Clonidine 0.2mg to Patient Medical Record Number M000731661 by mouth without verifying the order and after having received report that those same medications had been administered by the Night Shift RN at 0530. When the patient complained of shortness of breath at approximately 1130 and had a decline in blood pressure of 76/53, Respondent administered two (2) doses of Nitroglycerin when there was no order to administer the Nitroglycerin for complaints of shortness of breath (the order was only for chest pain). Further, Respondent did not consider the cumulative effects of multiple medications that could lower the patient's blood pressure. Respondent's conduct resulted in the patient experiencing a hypotensive crisis requiring transfer of care to the Intensive Care Unit to stabilize her condition.
8. On or about November 12, 2007, while employed with St. Joseph Regional Healthcare System, Bryan, Texas, Respondent failed to timely notify her supervisor of changes in the condition of the aforementioned Patient Medical Record Number M000731661 in that the patient complained of shortness of breath at 1134 with a blood pressure of 76/53 and Respondent did not notify the Charge Nurse until 1200. Respondent's conduct resulted in the delay of assessment and intervention by the more experienced Charge Nurse, resulting in worsening of the patient's hypotensive crisis, which required transfer of care to the Intensive Care Unit to stabilize the patient's condition.
9. On or about November 12, 2007, while employed with St. Joseph Regional Health Center, Bryan, Texas, Respondent failed to accurately and completely document assessments and nursing care provided to the aforementioned Patient Medical Record Number M000731661 in the patient's medical record. Respondent's conduct resulted in an incomplete medical record with potential for injury in that subsequent care givers would not have accurate information upon which to base their care decisions.
10. In response to the incidents in Findings of Fact Numbers Seven (7), Eight (8), and Nine (9), Respondent states that her orientation to the unit to which she was assigned was abbreviated

compared to her peers. Respondent states that she was informed during report that the patient had not had any chest pain, but that the physician had been called because of high blood pressures and that Procardia and Clonidine had been ordered, which were subsequently administered around 0530. Respondent states that she administered the 0900 medications at 0830, based on the electronic Medication Administration Record, which included Procardia 80 mg. Shortly thereafter, Respondent indicates she went to the computer to document her morning assessments, and the Unit Secretary notified her of "NOW" orders for the patient. Respondent was at a satellite nursing station; the medical record was located at a different station. Believing that the orders were newly written by the physician in response to the patient's elevated Troponin levels and because the prior shift had not noted the orders, Respondent states she checked the Diabold Medication System at 10:10 for new orders and called the pharmacy for clarification. According to Respondent, the pharmacy clarified that two (2) doses of Procardia had already been dispensed, one (1) at 0500 by the night shift and one (1) at 0730 by her. Respondent states that she realized the patient should not get another dose of Procardia because she had already received 120 milligrams, but since the Clonidine appeared on the electronic Medication Administration Record, which, as part of her orientation process, indicated to her that the order had been verified by the pharmacist as part of the error prevention process, Respondent obtained and administered the Clonidine. At 1130, Respondent states that beeper alarmed and she went to the patient's room to find her complaining of shortness of breath. Respondent obtained vital signs and the patient had a "lower than baseline" blood pressure, which Respondent attributed to having administered the Clonidine in the last hour. According to Respondent, the patient had complained of shortness of breath and chest pain the day before, and those symptoms had been relieved after she administered Nitroglycerin, so Respondent administered one (1) Nitroglycerin sublingual and set the blood pressure machine to every 5 minutes. The patient's blood pressure remained "lower than baseline," which she documented on the Kardex / log, and when at 1145 the patient's shortness of breath had improved but not resolved, Respondent administered another nitroglycerin sublingual and then went to notify the Charge Nurse at 1200. When it was discovered that the "NOW" doses were written at 0500, the Charge Nurse notified the physician of the error and the physician ordered an intravenous bolus of normal saline and a dopamine infusion to support the patient's blood pressure. According to Respondent, she recorded vital signs informally on paper, which was ultimately placed in the shredder bin prior to her transcribing into the computer but which Respondent states she showed the Charge Nurse at approximately 1200.

11. Since the November 12, 2007, event Respondent has obtained and been recertified in Advanced Cardiac Life Support and is enrolled in the bridge to MSN program.

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)(A),(1)(B), (1)(C),(1)(D),(1)(M),(1)(P)&(3)(A) and 217.12(1)(A),(1)(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 741695, heretofore issued to CYNTHIA GWEN ROBERTS, 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 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 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 successfully completed a nursing jurisprudence course entitled "Nursing in Texas: A Regulatory Foundation for Safe Practice" presented by the Texas Board of Nursing on June 20, 2008, which would have been a requirement in this Order.

(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 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>.*

(4) 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://ncsbn.hivelive.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 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) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD.

(5) 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.

(6) 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.

(7) 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.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

BALANCE OF PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE.

RESPONDENT'S CERTIFICATION

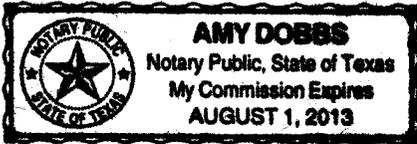
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to settle this matter in accordance with Tex. Occ. Code 301.463 to avoid the uncertainty of trial. 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 16 day of December, 2010.

Cynthia Gwen Roberts
CYNTHIA GWEN ROBERTS, Respondent

Sworn to and subscribed before me this 16 day of December, 2010.

SEAL



Amy Dobbs

Notary Public in and for the State of TEXAS

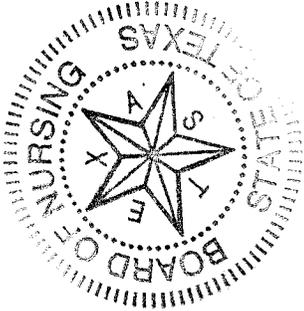
Approved as to form.

[Signature]

Elizabeth L. Higginbotham, Attorney for Respondent

Signed this 16 day of December, 2010.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 16th day of December, 2010, by CYNTHIA GWEN ROBERTS, Registered License Number 741695, and said Order is final.



Effective this 27th day of January, 2011.


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