BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 713716	§	
issued to TANGALON SHUGAIL WILKERSON	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board considered the matter of TANGALON SHUGAIL WILKERSON, Registered Nurse License Numbe. 713716, 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 August 28, 2011, 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(s).

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 an Associate Degree in Nursing from El Centro College, Dallas, Texas, on December 9, 2004. Respondent was licensed to practice professional nursing in the State of Texas on February 15, 2005.

5. Respondent's nursing employment history includes:

1/2005-7/2010	Registered Nurse III Parkland Health & Hospital System Dallas, Texas
8/2010	Unknown

Respondent's nursing employment history continued:

9/2010-Present	Staff Nurse, Intensive Care Unit (ICU) Baylor Plano Medical Center Plano, Texas

6. At the time of the incident, Respondent was employed as a Registered Nurse III with Parkland Health & Hospital System, Dallas, Texas, and had been in this position for five (5) years and seven (7) months.

7. On or about June 20, 2010, while employed as a Registered Nurse III and a member of the Rapid Assessment Team (RAT), with Parkland Health & Hospital System, Dallas, Texas, Respondent failed to assess Patient Number 1643427, and intervene appropriately when RAT was initiated following a change in the patient's telemetry monitored rhythm. Patient Medical Record Number 1643427, was a sixty-nine (69) year old male, with diagnosis of Congestive Heart Failure, Coronary Artery Disease, End Stage Renal Disease, and Diabetes, who had been admitted to Parkland Hospital for a foot infection. At approximately 9:45 p.m. the patient had an episode of Ventricular Tachycardia which triggered the RAT to respond. Respondent arrived at the patient's room and found him sitting up on the side of his bed with a nurse assisting him due to his complaints of nausea. Respondent noted in her narrative nursing note that the patient's vital signs were stable, but failed to document in the medical record what the vital signs were. Respondent noted that labs, chest x-ray, and an EKG had been ordered, but she failed to review and act upon the 12 lead EKG results. Respondent failed to document a comprehensive assessment or recommend appropriate interventions, utilizing critical thinking and the patient problem list and history as her role in RAT would require. Instead, Respondent documented that she would follow up with the patient within four (4) hours. At 11:16 p.m. the physician found the patient unresponsive and a Code Blue was initiated. The code was not successful and time of death was documented at 11:42 p.m. Respondent's conduct exposed the patient unnecessarily to risk of harm from ineffective treatment which may have contributed to the patient's demise.

8. In response to Finding of Fact Number Seven (7), Respondent states that she is one person in a two person team called the Rapid Assessment Team (RAT). She and a Respiratory Therapist make up the team. Respondent states she received a call from the patient's charge nurse who reported that the patient was in V-tach and that the patient's blood pressure and pulse were stable, pulse in the 80's. Respondent states that when she arrived at the patient's bedside he was sitting up, alert and oriented, and denying pain. The patient stated that the pain he had been having was gone and indicated that the pain had been in his epigastric area. Respondent states that as she was leaving the patient's room the on call physician was entering the patient's room and shortly arrived at the nurses station to observe the patient's telemetry and so she and the physician reviewed the patient's rhythm on the monitor together. Respondent states that to her memory the ventricular rate was wide and in the 70-80's. Respondent states that after reviewing the patient's rhythm the physician finished his note and ordered labs, chest x-ray, and a 12 lead EKG and the physician left. Respondent states she finished her note and left the unit, realizing it was not fatal V-tach. Respondent

states the patient presented as a hyperkalemic patient. Respondent states that a CODE was activated approximately an hour later and when she arrived the code was in progress. Respondent states that she told the physician the labs he had ordered earlier were pending from the laboratory. Respondent states that the patient's wife was called and told of the code and the wife asked that CPR be stopped, making the patient a Do Not Resuscitate. Respondent points out that:

- The patient had been an inpatient for five days prior to this incident.
- He had missed dialysis the day of the event and the day before.
- The patient's potassium was critically high on the 3 days leading up to this event.
- Respondent questions if the patient was dialyzed the days prior to the event.
- The lab ran a second test before notifying the charge nurse even though the results had been high the 3 days leading up to the event.
- The on call physician assessed the patient shortly after the Respondent did.

In closing, Respondent states that she takes this incident very seriously not only because the patient had a negative outcome, but because she feels the incident affected the RAT's reputation. Respondent states she takes accountability for her actions and feels that there were factors beyond her control that contributed to the incident. Respondent states that this was not a blatant disregard for a patient, that she would never have left the patient had his heart rate and/or blood pressure been outside acceptable limits, or if the patient had appeared to be in distress. Respondent states she feels that with this incident she focused on the issue of the V-Tach and going through the algorithm, and that now she carefully considers all the possible ramifications/conditions and does not rely on the physician's presence.

9. On or about September 29, 2011, Respondent successfully completed a Board approved class in Texas nursing jurisprudence and ethics, which would have been a requirement of this Order.

10. On or about November 28, 2011, Respondent successfully completed a Board approved class in sharpening critical thinking skills, which would have been a requirement of this Order.

11. On or about November 29, 2011, Respondent successfully completed a Board approved class in physical assessment, which would have been a requirement of this Order.

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 violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(D),(1)(M) &(3)(A) and 22 TEX. ADMIN. CODE §217.12(1)(A)&(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 713716, heretofore issued to TANGALON SHUGAIL WILKERSON, 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 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.texas.gov/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 AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEARS 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 THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, 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(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.

(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) **With the exception of Respondent's current position as a Staff Nurse in the ICU with Lake Pointe Medical Center, Rowlett, Texas,** RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. **Should Respondent's current position as a Staff Nurse in the ICU with Lake Pointe Medical Center, Rowlett, Texas, cease or change,** RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational 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.

(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 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(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 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 19 day of June, 2012.

, RN, CCRN
TANGALON SHUGAIL WILKERSON, Respondent

Sworn to and subscribed before me this 19 day of June, 2012.

Notary Public in and for the State of TEXAS
Notary For Ms. Wilkerson only

Yendy Elisa Barraza
NOTARY PUBLIC
STATE OF TEXAS
EXPIRES
07-15-2014

Approved as to form ~~and substance~~.

Nancy Roper Willson, Attorney for Respondent

Signed this 19th day of June, 2012

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 19th day of June, 2012, by TANGALON SHUGAIL WILKERSON, Registered Nurse License Number 713716, and said Order is final.

Effective this 19th day of July, 2012.

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