BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§	AGREED
License Number 742882	§	
issued to LYNETTE MARIE BROWNLEE	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of LYNETTE MARIE BROWNLEE, Registered Nurse License Number 742882, 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 19, 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 Austin Community College, Austin, Texas, on May 10, 2007. Respondent was licensed to practice professional nursing in the State of Texas on June 21, 2007.

5. Respondent's nursing employment history includes:

06/2007 - 02/2009	Emergency Room RN	St. David's North Austin Medical Center Austin, Texas
03/ 2009 - Present	Unknown	

6. At the time of the incidents, Respondent was employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, and had been in this position for one (1) year and nine (9) months.

7. On or about February 3, 2009, while employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, Respondent was aware that Patient Medical Record Number 116480 was placed in four (4) point restraints but failed to obtain a written order for the physical restraints, as required. Respondent's conduct exposed the patient unnecessarily to a risk of harm by not obtaining physician orders with defined parameters for the period of time the patient was in restraints, to include but not limited to the frequency of patient monitoring, physical / emotional assessments, range of motion activity, toileting, provision of food / fluids, and readiness for discontinuation of restraints / seclusion, as required per policy/procedure.

8. On or about February 3, 2009, while employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, after Patient Medical Record Number 116480 had been placed in four point restraints, Respondent, as the patient's assigned nurse, failed to provide documentation supporting the need for the restraints, placement of the restraints, removal of the restraints for range of motion needs, or that the patient's skin had been checked for injury during the period of time the patient was restrained. Respondent's conduct resulted in an incomplete medical record which was likely to deceive subsequent care givers who relied on the information while providing care to the patient and exposed the patient unnecessarily to a risk of harm from physical and emotional injury from unmonitored time in physical restraints.

9. On or about February 3, 2009, while employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, Respondent failed to ensure that wrist restraints were properly applied, to Patient Medical Record Number 116480. The wrist restraints were less securely attached to the bed rails instead of to the bed frame. Respondent's conduct exposed the patient unnecessarily to risk of harm from wrist / arm injury.

10. On or about February 3, 2009, while employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, Respondent failed to ensure that Security staff was at the bedside of Patient Medical Record Number 116480, as required for a patient in restraints. Respondent's conduct exposed the patient unnecessarily to risk of harm from injury due to the lack of monitoring to ensure the patient remained safely positioned on the bed while in restraints.

11. On or about February 3, 2009, while employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, Respondent failed to offer nutrition or toileting opportunities to Patient Medical Record Number 116480 during the nine (9) hour period he was in four point restraints. The Patient was later found soiled in urine. Respondent's conduct exposed the patient unnecessarily to risk harm from the physical and emotional discomfort from being physically restrained, isolated and having unmet nutrition and elimination needs.

12. On or about February 3, 2009, while employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, Respondent falsified and "back charted" documentation regarding Patient Medical Record Number 116480 being placed in restraints. Respondent's conduct resulted in an inaccurate medical record, and was likely to deceive subsequent care givers who would rely on her documentation while providing further patient care.

13. On or about February 3, 2009, while employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, Respondent failed to report to the oncoming shift that Patient Medical Record Number 116480 was in four (4) point restraints. Respondent's conduct exposed the patient unnecessarily to risk of harm from medical complications in that it resulted in delayed monitoring and assessment of the patient to identify and prevent potential physical and emotional injury to the patient while he was in restraints.

14. On or about February 3, 2009, while employed as an Emergency Department RN with St. David's North Austin Medical Center, Austin, Texas, Respondent caused physical and emotional injury to Patient Medical Record Number 116480 by the above noted actions. Respondent's conduct was likely to injure the the patient in that she may have caused delayed distress for the patient, which may not be recognized or felt by the patient until harmful consequences occur.

15. In response to Findings of Fact Seven (7) through Fourteen (14) Respondent states:
    - Patient Medical Record Number 116480 was admitted for amphetamine exhaustion. She had at least four (4) other assigned patients on this night. "There were patients who had psychiatric diagnoses, who were admitted for over-doses and who had been in fights. There was not enough staff for the patient population."
    - She did not place the patient in restraints. The Emergency Department Technicians asked Dr. B. if he wanted the patient in restraints and he answered "yes." Two Emergency Department Technicians placed the patient in restraints with Dr. B. standing at the bedside. "The Technicians that applied the restraints have always done procedures the way they are supposed to." The patient was very violent, cussing, taking punches at the Technicians and the Emergency Department staff. "The order for restraints should have been written by the physician."
    - She provided documentation in the "triage notes" that the patient was verbally and physically abusive and trying to hit staff. She charted in the addendum that the Technicians applied the restraints.
    - She did not remove the restraints for range of motion needs. There was no injury from the restraints and she charted in the addendum that there was no skin breakdown noted, patient repositioned, patient irritable, and his breathing was un-labored.
    - Security staff was at the bedside as much as could realistically be expected. The unit was understaffed. There were several patients that required security that shift, the patients were not in close proximity to each other and there was only one (1) security officer on duty. At 1420 she "documented that the patient became violent, trooper notified and at bedside."

- "The patient had a foley catheter that was working fine." There is documentation at 1520 regarding the patient's foley catheter. When she left at 2300 the patient was clean and dry. "The patient was passed out the majority of the time, so food was not offered. When awakened, the patient would get mad and then go back to sleep."
- "I did not falsify records." The Nurse Manager notified her one (1) or two (2) days after her shift on February 3, 2009, that she had to chart an addendum because her charting for the shift was incomplete.
- Respondent states that the patient needed to be protected and "restraints have this purpose". The patient was sleeping except when awakened by staff. The reason the patient was angry was because his belongings could not be found initially, then later were found.

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),(1)(B),(1)(C),(1)(D),(1)(M) &(1)(P), and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C),(1)(F)&(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 742882, heretofore issued to LYNETTE MARIE BROWNLEE, 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 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.*

(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 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 AND RESPONDENT MUST WORK IN SUCH 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 THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, 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(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.

(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) For the remainder of the stipulation/probation period, 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.

(8) 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.

BALANCE OF THIS 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 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 26 day of June, 2012.

LYNETTE MARIE BROWNLEE, Respondent

Sworn to and subscribed before me this 26 day of June, 2012.

SEAL

VICKI C. HILTON
MY COMMISSION EXPIRES
June 5, 2014

Notary Public in and for the State of Texas

Approved as to form and substance.

Nancy Roper Willson, Attorney for Respondent

Signed this 27 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 26th day of June, 2012, by LYNETTE MARIE BROWNLEE, Registered Nurse License Number 742882, and said Order is final.

Effective this 14th day of August, 2012.

Katherine A. Thomas

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

BOARD OF NURSING
STATE OF TEXAS