BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 758587	§	
issued to NETRA SABU OOMMEN	§	ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Boa produced evidence indicating that NETRA SABU OOMMEN, hereinafter referred to as Respondent, Registered Nurse License Number 758587, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on September 6, 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 represented by Nancy Roper-Willson, Attorney at Law. In attendance were Denise Benbow, MSN, RN, CMSRN, Executive Director's Designee; Kyle Hensley, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and Toni Frizell, RN, CNOR, Investigator; Katie Hall, Investigator, and Valerie Walsh, 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 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 El Centro College-AD, Dallas, Texas, on May 8, 2008. Respondent was licensed to practice professional nursing in the State of Texas on July 17, 2008.

5. Respondent's nursing employment history includes:

7/08 - 2/2010	RN	Baylor Medical Center at Irving Irving, Texas
3/2010 - Present	RN	Plano Specialty Hospital Plano, Texas
3/2010 - Present	RN	Parkland Health Hospital Dallas, Texas

6. At the time of the initial incident, Respondent was employed as a RN with Baylor Medical Center at Irving, Irving, Texas, and had been in this position for three (3) months.

7. On or about October 11, 2008, while working as a RN at Baylor Medical Center at Irving, Irving, Texas, Respondent failed to administer a Heparin infusion to Patient Medical Record Number 64944, as ordered by the physician and noted by Respondent. Patient Medical Record Number 64944 was admitted with a diagnosis of CVA and Respondent's conduct delayed the onset of the patient's emergency medical care that was needed to prevent further complications, including the patient's possible demise.

8. On or about February 1, 2009, while working as a RN at Baylor Medical Center at Irving, Irving, Texas, Respondent failed to identify a patient and consequently incorrectly administered multiple wrong medications to Patient Medical Record Number 718583. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in nonefficacious treatment or the patient suffering adverse reactions.

9. On or about January 26, 2010, while working as a RN at Baylor Medical Center at Irving, Irving, Texas, Respondent failed to initiate the facility/physician's potassium protocol, including administration of replacement potassium to stabilize Patient Medical Record Number 218027, in response to a "3.3" potassium lab result. Respondent's conduct delayed the onset of the patient's emergency medical care that was needed to prevent further complications, including the patient's possible demise.

10. On or about January 30, 2010, while working as a RN at Baylor Medical Center at Irving, Irving, Texas, Respondent incorrectly administered 500 mg Renexa instead of 500 mg Renvela to Patient Medical Record Number 649447, as ordered. Consequently, the patient required transfer to the ICU for further monitoring. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in nonefficacious treatment or the patient suffering adverse reactions.

11. In response to Findings of Facts Numbers Seven (7) through Ten (10), Respondent admits to delaying the administration of the Heparin infusion because the orders were confusing. In

response to Finding of Fact Number Eight (8), Respondent admits she failed to correctly identify the patient while administering her medications. Respondent states that she administered the correct medications to the correct patient and identified the patient by name against the MAR. Respondent admits she did not check the arm band and failed to discover that the Patient had the wrong arm band on. Respondent asserts that no medication errors or incorrect medications were administered to the patient. In response to Finding of Fact Number Nine(9), Respondent admits she did not have time to check the morning labs until 0700. Respondent asserts that she is responsible for administering potassium replacement in response to the potassium lab result which was 3.3 and states she passed the information on to the morning staff nurse while giving report. Respondent adds that most of the night staff nurses did not administer any potassium replacement unless there was a critical potassium level of less than 3.0 and asserts there were no specific directions regarding this procedure at Baylor. In response to Finding of Fact Number Ten (10), Respondent admits to administering Renexa instead of Renvela. Respondent states the Pharmacy transcribed the medication incorrectly and while reconciling the MAR, Respondent noticed that the pharmacy transcribed the Ranexa instead of Renvela. Since both the medication names sounded similar, Respondent asserts that she thought that Ranexa was an auto substitution of Renvela and gave the medication as transcribed in the MAR. Respondent states she was later told that the patient was transferred to the ICU for further monitoring.

12. Respondent completed courses in Nursing Ethics and Jurisprudence, Medication Administration and 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 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)(M) and 22 TEX. ADMIN. CODE §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 Vocational Nurse License Number 758587, heretofore issued to NETRA SABU OOMMEN, 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, 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 THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(1) 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.

(2) 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.

(3) 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.

(4) 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 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 4th day of October, 2011.

NETRA SABU OOMMEN, Respondent

Sworn to and subscribed before me this 4th day of October, 2011.

SEAL

KYLE BENJAMIN RUSSELL
Notary Public, State of Texas
My Commission Exp. 03-15-2013

Notary Public in and for the State of Texas

Approved as to form ~~and substance~~.

Nancy Roper-Willson, Attorney for Respondent

Signed this 4th day of October, 2011.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 4th day of October, 2011, by NETRA SABU OOMMEN, Registered Nurse License Number 758587, and said Order is final.

Effective this 27st day of October, 2011.

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