BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 759429	§	
issued to MYRNA WALESKA DIAZ	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Boar considered the matter of MYRNA WALESKA DIAZ, Registered Nurse License Number 759429, 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 6, 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 Suffolk County Community College, Selden, New York, on August 1, 2004. Respondent was licensed to practice professional nursing in the State of Texas on August 4, 2008.

5. Respondent's nursing employment history includes:

09/2005 - 01/2008	Staff Nurse	Southside Hospital Bayshore, New York
02/2008 - 05/2008	Travel Nurse	Medical Express Travel Nursing Texas City, Texas

5. Respondent's nursing employment history continued:

06/2008 - 08/2008	Travel Nurse	Cross Country TravCorps Boca Raton, Florida
07/2008 - 08/2008	Supervisor	Maxim Healthcare Hauppauge, New York
09/2008 - 03/2010	PRN Nurse	Lyndon B. Johnson Houston, Texas
03/2010 - Present	Staff Nurse	Clear Lake RehabCare Group, Inc. Webster, Texas
08/2011 - Present	Home Health Nurse	Immaculate Home Health Houston, Texas

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with All About Staffing, Houston, Texas, assigned to Mainland Medical Center, Texas City, Texas and had been in this position for four (4) months.

7. On or about June 24, 2009, while employed as a Registered Nurse with all About Staffing, Houston, Texas, and assigned to Mainland Medical Center, Texas City, Texas, Respondent failed to correctly identify Patient Medical Record Number E000430285 and placed on the IV pole in the patient's room an IV bag containing Zosyn, an intravenous antibiotic, that was ordered for a different patient. Respondent planned to return later to the patient's room to start the infusion. After Respondent placed the IV medication on the IV pole a co-worker later entered the patient's room, observed the medication bag hanging on the pole, hooked it up to the intravenous line and started the medication. The co-worker notified Respondent that he had started the infusion of the antibiotic. Patient Medical Record Number E000430285 noticed the patient's name on the antibiotic label was not his name. He stopped the infusion and called Respondent into his room to make her aware of the error. Respondent told the patient it was a one time order from his physician, took the label off of the intravenous infusion bag and then placed it on her cart where it could not be observed. Respondent's conduct exposed the patient unnecessarily to a risk of harm from the administration of an intravenous antibiotic without a physician's order and the physician's expertise to monitor the effects of antibiotic therapy. Further, Respondent's conduct was deceptive and unprofessional resulting in the patient experiencing a lack of confidence in the nursing care he received, fear and concern regarding potential adverse reactions to the medication administered in error.

8. On or about June 24, 2009, while employed as a Registered Nurse with all About Staffing, Houston, Texas, and assigned to Mainland Medical Center, Texas City, Texas, Respondent administered Zosyn, an intravenous antibiotic, ordered for a different patient, to Patient Medical Record Number E000430285 and then failed to notify the patient's physician of the error. Respondent's conduct was likely to deceive the physician and subsequent care givers who needed complete information on which to base their care.

9. On or about June 24, 2009, while employed as a Registered Nurse with all About Staffing, Houston, Texas, and assigned to Mainland Medical Center, Texas City, Texas, Respondent falsely stated to the Administrator on Site that there was an order from the physician to administer Zosyn to Patient Medical Record Number E000430285. Respondent's conduct was deceptive and likely to injure the patient in that Nursing Management and subsequent care givers were not notified of the medication error and could not assess or monitor the patient for potential adverse reactions to the medication including the development of itching, hives, respiratory distress and anaphylaxis, which could result in the patient's demise.

10. In response to Findings of Fact Seven (7) through Nine (9), Respondent states that on June 24, 2009, her computer cart had been malfunctioning off and on all day and she was having trouble scanning arm bands and medications. Patient Medical Record Number E000430285 had two (2) intravenous antibiotics due, the first being Clindamycin, which would not scan so she checked it with the Medication Administration Record, right patient, medication, dose, route, and time. She spiked the second bag of antibiotic with new tubing, and placed it coiled but not primed on the IV pole with the intention of returning to complete the process when the first antibiotic had infused. A co-worker, B., heard the patient's pump beeping, went into Patient Medical Record Number E000430285's room, came out and informed her that he had started the other antibiotic that was on the pole. Ten (10) minutes later the Charge Nurse informed her that Patient Medical Record Number E000430285 said that he was getting the wrong medication. She and the Charge Nurse went into the room and found the medication was infusing but the bag had another patient's name on it. She thought it was the right medication but was mislabeled. When she realized it was the wrong medication, Zosyn, she stopped the infusion after one-half of the bag had infused. She told the Charge Nurse that the co-worker, B., was trying to do her a favor and had started the antibiotic without asking her. She asked the Charge Nurse, "What are we going to do?" "I was so scared I didn't know what to do." She obtained the correct antibiotic, went to the patient's room to hang it, and the patient kept asking her about the other medication. "I did not know what to say, I was so nervous and my anxiety level was through the roof." I answered the patient with 'Sometimes M.D.'s write one (1) time orders'." She asked the Charge Nurse if they could contact the physician and get a one time order for the medication. The Charge Nurse said "It would look like they were trying to cover it up and I would have to write this up. Don't worry about it." Respondent went home and later received a call from the Administrator on Site asking her if Patient Medical Record Number E000430285 had received the wrong medication. "I said no because again I was so scared I didn't know what

to do. I asked her if she spoke with the Charge Nurse (Debbie), and she said that Debbie only knows what I told her." Respondent called the Director of the Unit and left a message for her to call. She then called her Agency Supervisor, Angela, and "told her everything." She called and spoke with the Director of the Unit the next day. She called the co-worker, B., who had started the infusion of Zosyn and told him that she needed to tell the truth about what happened and that he also needed to tell the truth. He told the Charge nurse that he had heard the alarm on the pump and just restarted the pump. She told B. that's not what happened, "you started that IV." The tubing was not primed, "so in order for him to hang it he had to uncoil the tubing, prime it, then take out the Clindamycin tubing and then put new antibiotic through the pump, then start it." B. and the Charge Nurse are friends. B. was trying to get transferred to the Intensive Care Unit and if he was written up for a medication error that transfer would be delayed for six (6) months.

"I am beside myself, and so incredibly sorry that this has happened."

Her actions involving hanging the second IV bag (with the wrong medication) ready to be primed were initiated to expedite caring for her patients in the face of a Pyxis computer that was malfunctioning, that a colleague tried to assist her, most probably in good faith, but because he did not scan the patient or the medication, that is where the error occurred.

Her statements made to the patient and the Administrator On Site were due to extreme stress and her inability to quickly process that others were not trying to respond to the situation in a professional manner, but were in fact trying to figure a way out of a compromising situation. She understands that it is her professional responsibility as a registered nurse to always act in a professional and forthright manner, and she accepts responsibility for her actions which despite the Charge Nurse's advice, were wrong."

"This incident is not one showing a pattern of repeated attempts to circumvent procedures or professionalism or the NPA, but is a one time unfortunate circumstance that ensnared a perhaps naive, but well meaning nurse."

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)&(3)(A) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C),(4),(6)(H).

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 759429, heretofore issued to MYRNA WALESKA DIAZ, 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 STIPULATION AND FINE, 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, 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 Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(5) RESPONDENT SHALL pay a monetary fine in the amount of two hundred fifty dollars ($250.00). RESPONDENT SHALL pay this fine within forty five (45)days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

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:

(6) 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.

(7) 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.

(8) 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.

(9) 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 7 day of November 2011.

MYRNA VALESKA DIAZ, Respondent

Sworn to and subscribed before me this 7th day of November 2011.

SEAL

Notary Public in and for the State of Texas

BRANDI NICOLE WINDSOR
Notary Public, State of Texas
My Commission Expires
December 09, 2012

Approved as to form and substance.

Joyce Stamp Lilly, Attorney for Respondent

Signed this 7th day of November 2011.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 7th day of November, 2011, by MYRNA WALSESKA DIAZ, Registered Nurse License Number 759429, and said Order is final.

Effective this 13th day of December, 2011.

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

BOARD OF NURSING
STATE OF TEXAS