BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 717559,	§	
issued to ETTIE KRISTEN VILLARREAL	§	ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Bo produced evidence indicating that ETTIE KRISTEN VILLARREAL, hereinafter referred to as Respondent, Registered Nurse License Number 717559, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on March 29, 2011, at the office of the Texas Board of Nursing, in accordance with Section 301.464, Texas Occupations Code.

Respondent appeared in person. Respondent was represented by Oscar San Miguel, Attorney at Law. In attendance were Mary Beth Thomas, PhD, RN, Director of Nursing, Executive Director's Designee; Kyle Hensley, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and Nancy Krause, 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(s).

2. Respondent waived notice and hearing, and agreed to the entry of this Order.

3. Respondent is currently licensed to practice nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from San Antonio College, San Antonio, Texas, on May 6, 2005. Respondent was licensed to practice professional nursing in the State of Texas on June 23, 2005.

5. Respondent's nursing employment history includes:

June 2005 - August 2009	Staff Nurse	University Medical Center at Brackenridge Austin, Texas
September 2009 - Present	Staff Nurse	Heart Hospital of Austin Austin, Texas

6. At the time of the incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff Nurse with University Medical Center at Brackenridge, Austin, Texas, and had been in this position for four (4) years and two (2) months.

7. On or about August 14, 2009, while employed as a Staff Nurse with University Medical Center at Brackenridge, Austin, Texas, Respondent failed to completely and accurately document a pain assessment in the medical record of Patient Medical Record Number 859542, and inaccurately documented in the medical record by placing a late entry into the body of an earlier assessment without notation of it being a late entry. Furthermore, Respondent failed to document the administration of Phenergan on the Medication Administration Record as well as any urinary output on the Intake/Output Record. Respondent's conduct resulted in an inaccurate, incomplete medical record, and was likely to injure the patient in that subsequent care givers would rely on her documentation in order to provide further patient care.

8. In response to the incident in Finding of Fact Seven (7), Respondent states she made multiple evaluations of the patient in the general notes and that recording a full documentation of all systems versus making exception notes is not common practice when dealing with implementation and evaluation of interventions. Respondent states that the difficult patient situation and being very new to procedures, policies, and electronic charting contributed to the lack of documentation but she did keep notes regarding her assessment so that she could record the information later in the evening when she had time to open the computer charting and make notes. Respondent states the patient was confused, agitated and combative, making it difficult to leave the patient's room to document in the computer and she did not document on the Medication Administration Record, but she did document on the Omni Cell medication log and in the nurse's narrative, which should have been sufficient evidence to support that the medication had been given. Respondent also states she did empty the urine collection device when she came on duty and there was approximately 200cc's present at the time, and the patient care assistant emptied the device again during the shift but they failed to document the amount.

9. On or about August 14, 2009, while employed as a Staff Nurse with University Medical Center at Brackenridge, Austin, Texas, Respondent failed to administer Sliding Scale Novolog Insulin to Patient Medical Record Number 859542, as ordered by the physician. According to the physician's order, the patient was to receive four (4) unit of Novolog Insulin for blood glucose readings of 200 - 249. Respondent documents a blood glucose reading of 207 at 19:42, however, the Novolog was not administered. Respondent's conduct

exposed the patient unnecessarily to a risk of harm from medical complications related to untreated hyperglycemia.

10. In response to the incident in Finding of Fact number Nine (9), Respondent states she did overlook administering the HS Insulin due to the patient's difficult behavior. Respondent states she was concentrating on keeping the patient safe and keeping in contact with the physicians.

11. On or about August 14, 2009, while employed as a Staff Nurse with University Medical Center at Brackenridge, Austin, Texas, Respondent failed to notify the physician of significant changes in the vital signs of Patient Medical Record Number 859542 including, but not limited to, a drop in the patient's blood pressure to 87/61 and continued complaints of abdominal pain. Respondent's conduct deprived the patient of timely assessment and intervention by the physician, which may have been necessary to stabilize the patient's condition. Subsequently, the patient experienced respiratory distress and expired.

12. In response to the incident in Finding of Fact Eleven (11), Respondent states that she did notify the physician of the patient's increased agitation and abdominal pain, and she did receive orders for Ativan and Morphine.

13. The Respondent's conduct described in the preceding Findings of Fact were reportable under the provisions of Texas Occupations Code, Sections 301.401-301.419.

14. The Board finds that there exists serious risk to public health and safety as a result of impaired nursing care.

15. Charges were filed on January 19, 2011.

16. Charges were mailed to Respondent on January 20, 2011.

17. Respondent's continued compliance with the terms of a Board approved peer assistance program previously implemented and to be extended an additional six (6) months should be sufficient to protect patients and the public.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-.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)(B),(1)(C),(1)(D)&(1)(M) and 217.12(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 717559, heretofore issued to ETTIE KRISTEN VIILARREAL, including revocation of Respondent's license to practice nursing in the State of Texas.

5. The Board may, in its discretion, order a nurse to participate in a peer assistance program approved by the Board if the nurse would otherwise have been eligible for referral to peer assistance pursuant to Section 301.410, Texas Occupations Code.

ORDER

IT IS THEREFORE AGREED and ORDERED that RESPONDENT, in lieu of the sanction of Revocation under Section 301.453, Texas Occupations Code, SHALL comply with the following conditions for such a time as is required for RESPONDENT to successfully complete the Texas Peer Assistance Program for Nurses (TPAPN):

(1) RESPONDENT SHALL, within forty-five (45) days following the date of entry of this final Order, apply to TPAPN and SHALL, within ninety (90) days following the date of entry of this final Order, sign and execute the TPAPN participation agreement. It is understood that, since Respondent is currently enrolled in the TPAPN program, the participation fee in the amount of five hundred dollars ($500.00) will not be required.

(2) Upon acceptance into the TPAPN, RESPONDENT SHALL waive confidentiality and provide a copy of the executed TPAPN participation agreement to the Texas Board of Nursing.

(3) RESPONDENT SHALL comply with all requirements of the TPAPN participation agreement during its term and SHALL keep her license to practice nursing in the State of Texas current.

(4) RESPONDENT SHALL CAUSE the TPAPN to notify the Texas Board of Nursing of any violation of the TPAPN participation agreement.

IT IS FURTHER AGREED AND ORDERED, 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, that the terms of this Agreed 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, SHOULD RESPONDENT fail to comply with this Order or the terms of the participation agreement with the TPAPN, such noncompliance will result in further disciplinary action including EMERGENCY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of Respondent's license(s) and nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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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. I do acknowledge possessing a diagnosis that deems me eligible to participate in the Texas Peer Assistance Program for Nurses. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, and Conditions One (1) through Four (4) of this Order to obtain disposition of the allegations through peer assistance and to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes effective upon acceptance by the Executive Director on behalf of the Texas Board of Nursing, 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 5 day of August 2011.

Ettie Kristen Villarreal

ETTIE KRISTEN VILLARREAL, Respondent

Sworn to and subscribed before me this 5 day of August, 2011.

SEAL

Joy Rivera

Notary Public in and for the State of Texas

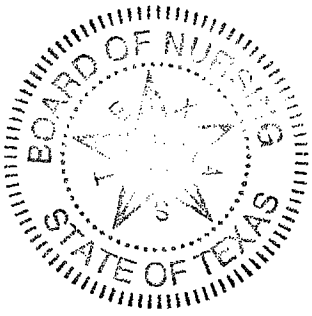
JOY RIVERA
Notary Public, State of Texas
My Commission Expires
March 05, 2014

Approved as to form and substance.

Oscar San Miguel, Attorney for Respondent

Signed this 5th day of August, 2011.

WHEREFORE PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby accept and enter the Agreed Order that was signed on the 5th day of August, 2011, by ETTIE KRISTEN VILLARREAL, License Number 717559, and said Order is final.



Entered and effective this 9th day of August, 2011.

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