



Respondent's nursing employment history continued:

1998 - 2002	Staff Nurse	Trinity Medical Center Carrollton, Texas
2000 - 2002	Staff Nurse as Needed	Presbyterian Hospital Plano, Texas
2001 - 2007	Owner/Program Director	Gideon Services, Nurse Aide Training Dallas, Texas
2005 - 2009	Staff Nurse/House Supervisor/PICC Team	Trinity Medical Center Carrollton, Texas
06/2009 - 08/2009	Staff Nurse Cath Lab	Methodist Richardson Medical Center Richardson, Texas
09/2009 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Methodist Richardson Medical Center, Richardson, Texas and had been in this position for two (2) months.
7. On or about July 15, 2009, while employed with Methodist Richardson Medical Center, Richardson, Texas, Respondent administered ten thousand, four hundred (10,400) units of Heparin to Patient Medical Record Number 322466 in excess of the physician's order, which was "Heparin bolus per protocol", which was a maximum bolus of five thousand (5000) units. Respondent's conduct resulted in the patient receiving more than double the dose of Heparin ordered by the physician and could have injured the patient from excessive bleeding.
8. On or about July 29, 2009, while employed with Methodist Richardson Medical Center, Richardson, Texas, Respondent administered Plavix 600mg to Patient Medical Record Number 548843 at 0544, which had already been administered in the Emergency Room at 0416. Respondent's conduct unnecessarily exposed the patient to the effects of excess Plavix, such as excessive bleeding.

9. On or about August 3, 2009, while employed with Methodist Richardson Medical Center, Richardson, Texas, Respondent administered a syringe of 1 mg epinephrine to Patient Medical Record Number 548899 without a physician's order. The physician had ordered a 1 mg syringe of epinephrine diluted in normal saline to be "on hand" in case of a reaction; however, Respondent administered the syringe of 1 mg epinephrine. Consequently, the patient went into ventricular tachycardia and experienced hypertension, which was eventually stabilized. Respondent's conduct put the patient at risk for the side effects of administration of epinephrine, including possible demise.
10. In response to the Findings of Fact Numbers Seven (7) through Nine (9), Respondent states that she had found the protocol of the heparin five thousand (5000) units and asked the physician if this was what he wanted, and he stated "No," and gave Respondent a formula based on weight. Respondent states that she calculated ten thousand five hundred (10,500) units and asked the physician if that was what he wanted, and he stated "Yes." Respondent states that on July 29, 2009, she was working with her preceptor who received report on the patient; however, her preceptor received no report of Plavix having been administered in the Emergency Room and there was no medication reconciliation sheet. Respondent states that she administered the Plavix having no idea it had already been done. Respondent concludes that on August 3, 2009, the physician told her to have the epinephrine ready because the patient had had a reaction to contrast in the past. Respondent states that when the physician prepared to push the contrast, he looked at her and said, "Ready, go." Respondent states that she mistakenly took this as an order to administer the epinephrine.
11. Charges were filed on November 28, 2011.
12. Charges were mailed to Respondent on November 29, 2011.

#### 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) and (13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C),(1)(M)&(1)(N) and §217.13(1)(A)&(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 636077, heretofore issued to CHRISTINE LYNN LUTTRELL, 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 LIMITED LICENSE 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 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) While under the terms of this Order, RESPONDENT SHALL NOT provide direct patient care. For the purposes of this Order, direct patient care involves a personal relationship between the Nurse and the client, and includes, but is not limited to: teaching, counseling, assessing the client's needs and strengths, and providing skilled nursing care.

(2) SHOULD RESPONDENT desire to return to a clinical practice setting, which would require her to provide direct patient care, RESPONDENT SHALL petition the Board for such approval.

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RESPONDENT'S CERTIFICATION

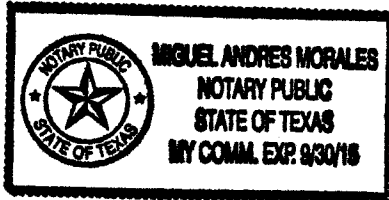
I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and 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 \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

*Christine Lynn Luttrell*  
CHRISTINE LYNN LUTTRELL, Respondent

Sworn to and subscribed before me this 30 day of July, 2012.

SEAL



*Miguel Morales*

Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 30<sup>th</sup> day of July, 2012, by CHRISTINE LYNN LUTTRELL, License Number 636077, and said Order is final.

Effective this 11<sup>th</sup> day of September, 2012.



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