



I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Katherine A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse	§	AGREED
License Number 718932	§	
issued to LAURA DANIELLE JONES	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the B considered the matter of LAURA DANIELLE JONES, Registered Nurse License Number 718932, 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 representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on February 11, 2011, by Katherine A. Thomas, MN, RN, Executive Director.

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 representation by counsel, 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 Galveston College, Galveston Texas, on May 18, 2005, and Respondent received a Baccalaureate Degree in Nursing from The University of Texas Medical Branch, School of Nursing, Galveston, Texas, December 15, 2006. Respondent was licensed to practice professional nursing in the State of Texas on July 19, 2005.

5. Respondent's nursing employment history includes:

5/2005 - 5/2008	Staff Nurse	The University of Texas Medical Branch Galveston, Texas
6/2008 - 3/2009	Staff Nurse	St. John's Nassau Bay Nassau Bay, Texas
4/2009 - 6/2009	Unknown	
7/2009 - 12/2009	Staff Nurse	Triumph Hospital-Clear Lake Webster, Texas
1/2010	Staff Nurse	Bayshore Hospital Pasadena, Texas
2/2010 - 9/2010	Staff Nurse	Qstaff Houston, Texas
10/2010 - Present	Unknown	

6. At the time of the incident in Finding of Fact Number Seven (7), Respondent was employed as a staff nurse with Triumph Hospital-Clear Lake, Texas, and had been in this position for six(6) months.

7. On or about December 8, 2009, while employed as a staff nurse with Triumph Hospital-Clear Lake, Webster, Texas, Respondent engaged in the intemperate use of Marijuana and Cocaine in that Respondent produced a specimen for a drug screen which resulted positive for Marijuana and Cocaine. Possession of Marijuana and Cocaine is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Marijuana and Cocaine by a Registered Nurse, while subject to call or duty, could impair the nurse's ability to recognize subtle signs, symptoms or changes in the patient's condition, and could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.

8. In response to the incident in Finding of Fact Number Seven (7), Respondent states she was under a lot of stress after Hurricane Ike and realized she could not smoke Marijuana anymore. Respondent denies knowledge of voluntarily consuming Cocaine and states she went to a Christmas party and left feeling ill and suspects that may be where she unknowingly ingested Cocaine. Respondent states she agreed to the drug test because she did not know the illegal drugs were in her system.

9. At the time of the incident in Finding of Fact Numbers Ten (10), Twelve(12), Fourteen (14), Sixteen (16), Respondent was employed as a staff nurse with The University of Texas Medical Branch, Galveston, Texas, and had been in this position for four (4) years and three (3) months.
10. On or about May 22, 2008, while employed at The University of Texas Medical Branch, Galveston, Texas, Respondent failed to provide adequate care when she did not irrigate the Nasogastric (NG) tubing for patient #UH063312Q, as ordered by the physician. The tubing was discovered to be completely obstructed by the following shift. Respondent's conduct failed to promote a safe environment in that it deprived the patient of medical intervention as ordered by the physician.
11. In response to the incident in Finding of Fact Number Ten (10), Respondent states she flushed the nasogastric tubing several times during the shift, and clear return drainage was seen in the tubing, but there was not enough to measure.
12. On or about May 22, 2008, while employed at The University of Texas Medical Branch, Galveston, Texas, Respondent failed to document and report the condition of the Nasogastric in Patient#UH063312Q's medical record, as required. Respondent's conduct resulted in an inaccurate medical record that subsequent care givers would rely on to base further medical decisions and deprived subsequent care givers of timely detection and medical intervention to prevent complications from the obstructed nasogastric tube.
13. In response to the incident in Finding of Fact Number Twelve (12), Respondent states she unintentionally failed to document the condition of the nasogastric tubing or the nursing actions she did perform. Respondent adds that she understands that failure to document assumes that the procedures were not completed.
14. On or about May 22, 2008, while employed at The University of Texas Medical Branch, Galveston, Texas, Respondent failed to provide adequate care when she did not ambulate post-operative patient UH#002362K, as ordered by the physician. Respondent's conduct unnecessarily exposed the patient to the risk of post surgical complications due to immobility, including blood clot formation and/or delayed return of gastric function.
15. In response to the incident in Finding of Fact Number Fourteen (14), Respondent states she did ambulate the patient once, however, the patient refused to be ambulated a second time due to severe pain. Respondent states she contacted the on-call physician who ordered Toradol and discontinued ambulation until the next day. Respondent states this is documented in the nurses notes and that she reported it to the next shift.
16. On or about May 22, 2008, while employed at The University of Texas Medical Branch, Galveston, Texas, Respondent failed to change the soiled central line dressing for patient UH#05727S, and failed to change the Jackson-Pratt ostomy drainage bags as necessary, when

discovered they were leaking. The Jackson-Pratt ostomy bags were found to be inappropriately secured to the patient using wide foam tape that prevented proper drainage and were not connected to suction as ordered by the physician. Respondent's conduct was likely to cause injury to the patient in that the central line insertion site was likely to become infected. Additionally, the leaking ostomy bag drainage could cause irritation and integumentary system breakdown, and ineffectual drainage, which could compromise the surgical site.

17. In response to the incident in Finding of Fact Number Sixteen (16), Respondent states the ostomy bags were placed over the Jackson-Pratt drains, a hole was slit on top to pull the drain out, and wide microfoam tape was placed over the hole to prevent leakage. Respondent denies the microfoam tape was used to cover up leakage, and states that she had another nurse check the dressings to be sure they had been done correctly by the previous shift. Respondent states they both came to the conclusion the dressings were done correctly to catch seepage and she had been informed in report that the suction had been discontinued. Respondent states the documentation on the drainage bags was confusing and she informed the oncoming shift that the central line dressing needed to be changed and the nurse stated she would do it. Respondent states she had requested her assignment be changed because she had several acute patients and didn't feel she was able to perform her usual level of care, however her request was denied.
18. At the time of the incident in Finding of Fact Number Nineteen (19), Respondent was employed as a staff nurses with The University of Texas Medical Branch, Galveston, Texas, and had been in this position for three (3) years and six (6) months.
19. On or about August 17, 2007, while employed as a staff nurse with The University of Texas Medical Branch, Galveston, Texas, Respondent lacked fitness to safely practice nursing in that she was observed falling asleep during the shift and was sent home due to extreme sleepiness. Respondent's condition could have affected her ability to recognize subtle signs, symptoms or changes in patients' conditions, and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patients in potential danger.
20. In response to the incident in Finding of Fact Number Nineteen (19), Respondent states that she was very sleepy when she was trying to chart, and got up and walked around but her migraine headache persisted. Respondent states that she reported this to the Charge Nurse. Respondent adds that she had been working overtime and sometimes five or six days in a row.
21. The Respondent's conduct described in the preceding Findings of Fact was reportable under the provisions of Sections 301.401-301.419, Texas Occupations Code.
22. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.

23. Respondent's conduct described in Findings of Fact Numbers Seven (7), Ten (10), Twelve (12), Fourteen (14), Sixteen (16), and Eighteen (18), were significantly influenced by Respondent's impairment by dependency on chemicals and mental illness.
24. Respondent's compliance with the terms of a Board approved peer assistance program should be sufficient to protect patients and the public.

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), (12) & (13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(B),(1)(C),(1)(D),(1)(M)& (1)(T) and 22 TEX. ADMIN. CODE §217.12(1)(B)&(E),(4),(5)&(10)(A)&(D).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Professional Nurse License Number 718932, heretofore issued to LAURA DANIELLE JONES, 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, which SHALL include payment of a non-refundable participation fee in the amount of five hundred dollars (\$500.00) payable to TPAPN.

(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, Section §§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 is encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a multistate licensure 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 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 waive representation by counsel. 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 to practice nursing in the State of Texas, as a consequence of my noncompliance.

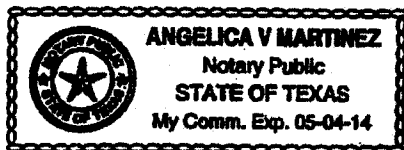
Signed this 28 day of March, 2011.

Laura Danielle Jones

LAURA DANIELLE JONES, Respondent

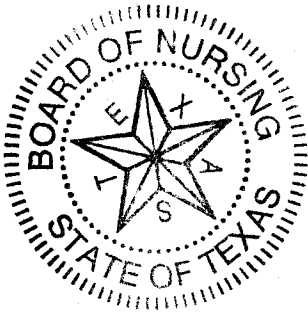
Sworn to and subscribed before me this 28th day of March, 2011.

SEAL




Angelica V. Martinez
Notary Public in and for the State of Texas

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 28th day of March, 2011, by LAURA DANIELLE JONES, Registered Nurse License Number 718932, and said Order is final.



Entered and effective this 29th day of March, 2011.


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