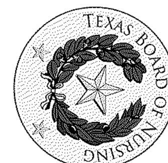


I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED
Registered Nurse License Number 454597	§	
issued to BARBARA JEANNE PARKHURST	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board considered the matter of BARBARA JEANNE PARKHURST, Registered Nurse License Number 454597, hereinafter referred to as Respondent.

Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.

The Board makes the following Findings of Fact and Conclusions of Law.

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's license to practice as a professional nurse in the State of Texas is in current status.

4. Respondent received a Diploma in Nursing from Lutheran Hospital School of Nursing, Milwaukee, Wisconsin, on May 1, 1970. Respondent was licensed to practice professional nursing in the State of Wisconsin on September 4, 1970 and was licensed to practice professional nursing in the State of Texas on August 28, 1980.

5. Respondent's nursing employment history includes:

6/1970 - 7/1972	Staff Nurse	Memorial Hospital at Oconomowoc Oconomowoc, Wisconsin
8/1972 - 1/1976	Staff Nurse	St. Joseph's Hospital Milwaukee, Wisconsin

Respondent's nursing employment history continued:

2/1976 - 7/1976	Staff Nurse	Duke University Medical Center Durham, North Carolina
9/1976 - 7/1980	Staff and Charge Nurse	Milwaukee County Medical Complex Milwaukee, Wisconsin
7/1980 - 10/1992	Registered Nurse	Rosewood Medical Center Houston, Texas
11/1992 - 12/1995	School Nurse	Houston Independent School District Ashford Elementary Houston, Texas
1/1996 - 3/1996		Unknown
4/1996 - 10/1996	Staff Nurse	StarCare Home Health Care Agency Austin, Texas
11/1996 - 1/1997		Unknown
2/1997 - Unknown	Staff Nurse	Seton Northwest Hospital Austin, Texas

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Seton Northwest Hospital, Austin, Texas, and had been in this position for sixteen (16) years and one (1) month.

7. On or about March 26, 2013, while employed as a Staff Nurse with Seton Northwest Hospital, Austin, Texas, Respondent failed to remove the post-surgical drains, as ordered, from Patient Number 327952 twenty-four (24) hours after surgery, and failed to report to oncoming nurse that the drains still needed to be removed. The drains were not removed until approximately fifteen (15) hours later than they should have been. Respondent's conduct was likely to injure the patient from possible complications of leaving surgical drains in longer than needed to include infection and/or possible demise.

8. In response to Finding of Fact Number Seven (7), in regards to the fifteen (15) hours Respondent states, "not true = 3 hours."

9. On or about July 3, 2013, while employed as a Staff Nurse with Seton Northwest Hospital, Austin, Texas, Respondent failed to timely administer two antibiotics to Patient Number 5471010 as ordered. Both medications were administered three (3) hours later than scheduled. Respondent's conduct was likely to injure the patient from a delay in antibiotic treatment to include infection and/or possible demise.

10. On or about September 6, 2013, while employed as a Staff Nurse with Seton Northwest Hospital, Austin, Texas, Respondent failed to document and implement orders to place Patient Number 547845 on Tier II (2) telemetry. As a result, the patient's vital signs were not

monitored for an extended period of time. Respondent's conduct was likely to injure the patient due to not knowing any possible significant changes in the vital signs which would have needed immediate intervention.

11. In response to Finding of Fact Number Ten (10), Respondent states, "Original report stated I worked 07-1500, when actually I worked from 07-1900. Pt. was admitted at 1530. Another had the chart & did the orders. I was with pt.; admitted pt, restarted IV, had a drug counselor in room (with) pt. during that whole time. I got the chart back at 1830, change of shift time & asked next nurse to review the orders, which she did, found the tele order & put him on. His the pt's, vital signs were monitored though tele wasn't put on immediately."

12. On or about September 11, 2013, while employed as a Staff Nurse with Seton Northwest Hospital, Austin, Texas, Respondent failed to verify a unit of blood against the physician's order before administering to Patient Number 800505. As result, the administered blood did not match the physician's order for the unit of blood to be irradiated after Respondent acknowledged that all specifications of the blood were matched against the physician's order. Respondent's conduct was likely to injure the patient from adverse transfusion reactions due to blood administered not ordered by the physician.

13. On or about September 16, 2013, while employed as a Staff Nurse with Seton Northwest Hospital, Austin, Texas, Respondent administered in error, three (3) 30 mg tablets of Oxycodone to Patient Number 802418 (90mg total), instead of one (1) 30 mg tablet, as ordered. Respondent's conduct was likely to injure the patient from adverse reactions to medication administered to include nervous system and respiratory depression and/or demise.

14. On or about February 20, 2014, while employed as a Staff Nurse with Seton Northwest Hospital, Austin, Texas, Respondent administered only 75 mg Lyrica (one (1) tablet) to Patient Number 5499827 instead of 150 mg (two (2) tablets), as ordered. Respondent's conduct was likely to injure patient from not receiving the proper dosage of medication which was ordered for arthritic purposes.

15. In response to the incidents in Findings of Fact Numbers Seven (7) through Fourteen (14), Respondent states she missed the order for irradiated blood at the bottom of the order sheet. Regarding the Oxycodone incident, Respondent states she removed 90 mg of Oxycodone because she failed to perform the five (5) rights before administering the medication. Regarding the Lyrica incident, Respondent states she administered to the patient the usual prescribed dose of Lyrica to post-op patients, which was 75 mg. Respondent states the patient's dose had been doubled to 150 mg and she administered only 75 mg.

16. Respondent, by her signature to this Order, expresses her desire to voluntarily surrender her license(s) to practice nursing in the State of Texas.

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(s) of 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)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 454597, heretofore issued to BARBARA JEANNE PARKHURST.

5. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

6. Under Section 301.453(d), Texas Occupations Code, as amended, the Board may impose conditions for reinstatement of licensure.

7. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TEX. ADMIN. CODE §213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the VOLUNTARY SURRENDER of Registered Nurse License Number 454597, heretofore issued to BARBARA JEANNE PARKHURST, to practice nursing in the State of Texas, is accepted by the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice professional nursing, use the title "registered nurse" or the abbreviation "RN" or wear any insignia identifying herself as a registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until one (1) year has elapsed from the date of this Order.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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.

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 violation(s) 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 becomes final when accepted by the Executive Director at which time the terms of this Order become effective and a copy will be mailed to me.

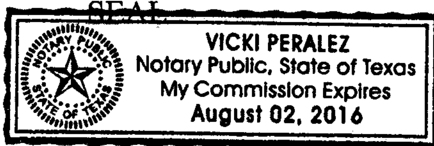
Signed this 23 day of September, 2014.

Barbara Jeanne Parkhurst

BARBARA JEANNE PARKHURST, Respondent

Sworn to and subscribed before me this 23 day of ~~October~~ September, 2014.

SEAL



Vicki Peralez

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 the voluntary surrender of Registered Nurse License Number 454597, previously issued to BARBARA JEANNE PARKHURST.

Effective this 24th day of October, 20 14.

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