BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED
Registered Nurse License Number 845695	§	
& Vocational Nurse License Number 302006	§	
issued to CHRISTELLE E. TCHONANG	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of CHRISTELLE E. TCHONANG, Registered Nurse License Number 845695 and Vocational Nurse License Number 302006, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived notice and hearing and agreed to the entry of this Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on May 17, 2015.

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

4. Respondent received a Certificate in Vocational Nursing from Capital Health Institute, Washington, D.C., on July 17, 2009, and received a Baccalaureate Degree in Nursing from Chamberlain College in Nursing, Houston, Texas, on June 30, 2013. Respondent was licensed to practice vocational nursing in the State of Texas on August 23, 2011, and was licensed to practice professional nursing in the State of Texas on October 8, 2013.

5. Respondent's nursing employment history includes:

6/2011 - 8/2012	Staff Nurse	Brenham State Supported Living Center Brenham, Texas
8/2011 - 10/2013	Staff Nurse	Encompass Home Health Houston, Texas
10/2013 - 5/2014	RN	The Crescent Transitional Health Center Matol Health Services Houston, Texas
6/2014 - 9/2014	Staff RN	Houston Methodist Willowbrook Hospital Houston, Texas
10/2014 - Present	Unknown	

6. At the time of the incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff RN with Houston Methodist Willowbrook Hospital, Houston, Texas, and had been in that position for one (1) month.

7. On or about July 29, 2014, while employed as a Staff RN with Houston Methodist Willowbrook Hospital, Houston, Texas, Respondent drew up insulin in a 3 cc syringe to administer to Patient Medical Record Number 012496709 instead of an insulin syringe before the error was caught prior to administration. The order was for 2 units of insulin. Respondent's conduct could have exposed the patient to a risk of harm from adverse effects of taking an inexact dosage of insulin.

8. On or about September 7, 2014, while employed as a Staff RN with Houston Methodist Willowbrook Hospital, Houston, Texas, Respondent went to administer aspirin to Patient Medical Record Number 021899281 without reviewing medications given to the patient in the emergency room. The patient had received aspirin already in the emergency room, and the error was caught prior to administration. Respondent's conduct could have exposed the patient to a risk of harm from receiving unintended medications.

9. On or about September 7, 2014, while employed as a Staff RN with Houston Methodist Willowbrook Hospital, Houston, Texas, Respondent withdrew Coreg 6.25 mg from the Pyxis to administer to Patient Medical Record Number 026311431 before the error was caught prior to administration. The order was for Coreg 3.125 mg. Respondent's conduct could have exposed the patient to a risk of harm from adverse effects of taking a medication in excess of what was ordered by the provider.

10. On or about September 10, 2014, while employed as a Staff RN with Houston Methodist Willowbrook Hospital, Houston, Texas, Respondent removed Reglan 10 mg from the Pyxis to administer to Patient Medical Record Number 017842493 before the error was caught prior to administration. The order was for Reglan 5 mg. Respondent's conduct could have exposed the patient to a risk of harm from adverse effects of taking a medication in excess of what was ordered by the provider.

11. On or about September 11, 2014, while employed as a Staff RN with Houston Methodist Willowbrook Hospital, Houston, Texas, Respondent drew up Haldol and prepared to administer it by intravenous (IV) route to Patient Medical Record Number 017842493 before the error was caught prior to administration. The order was for Haldol by intramuscular (IM) route. Respondent's conduct could have exposed the patient to a risk of harm from intravenous administration of medication that was not properly formulated for safe intravenous use.

12. In response to the incidents in Findings of Fact Numbers Seven (7) through Eleven (11), Respondent states that during her orientation she was assigned four (4) patients with a preceptor. Respondent relates that while in the medication room she became distracted listening to her preceptor's concerns regarding her health, and grabbed a 3cc syringe instead of an insulin syringe. Respondent states that on September 7, 2014, she was with her seventh preceptor, and all had different working styles, and did not provide focused, consistent or experienced training. Respondent recounts that she doesn't recall being told in report that the patient had received Aspirin. Respondent explains that she had never been trained regarding care of Emergency Room (ER) patients so didn't know it was necessary to go back to the ER patient profile to cross-check if the patient medication had already been administered. Respondent states on that day that she withdrew Coreg from the Pyxis along with other medication needed for the patient. Respondent indicates that as they were walking to the patient's room, her preceptor told her she had the wrong dose of Coreg. Respondent states that when she went to the Pyxis to remove a Haldol vial, she realized there were no 2 ml syringes stocked in the medication room. Respondent explains she went to the supply room to get the 2 ml syringe. Respondent adds that she then realized that she did not pick out the IM needle from the supply room, and her preceptor questioned why she did not pick up both supplies at the same time. Respondent states that she said she forgot to get the needle, but would go back and get it.

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)(M)&(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 845695 and Vocational Nurse License Number 302006, heretofore issued to CHRISTELLE E. TCHONANG.

5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of **REMEDIAL EDUCATION** in accordance with the terms of this Order.

A. This Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

B. This Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

C. Respondent may not work outside the State of Texas in another nurse licensure compact party state without first obtaining the written permission of the Texas Board of Nursing and the Board of Nursing in the nurse licensure compact party state where Respondent wishes to work.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to 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.

III. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that 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. Home study courses and video programs will not be approved.

B. **A Board-approved course in medication administration** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components be provided by the same Registered Nurse. The course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the six (6) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The clinical component SHALL focus on tasks of medication administration only. 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. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

C. **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/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of*

Course Completion forms are available from the Board at www.bon.texas.gov/compliance.

IV. RESTORATION OF UNENCUMBERED LICENSE(S)

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 may 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 violation(s) alleged herein. By my signature on this Order, I agree to the entry of this 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 when this Order becomes final and the terms of this Order become effective, 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 possible revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 6 day of July, 2015.

C. Christelle

CHRISTELLE E. TCHONANG, Respondent

Sworn to and subscribed before me this 6TH day of July, 2015.

SEAL

CHARLES T YUEN
My Commission Expires
June 7, 2017

Notary Public in and for the State of TEXAS

Approved as to form and substance.

Taralynn R. MacKay

Taralynn R. Mackay, Attorney for Respondent

Signed this 6th day of July, 2015

WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 6th day of July, 2015, by CHRISTELLE E. TCHONANG, Registered Nurse License Number 845695 and Vocational Nurse License Number 302006, and said Order is final.

Effective this 7th day of July, 2015.

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

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