BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED
Registered Nurse License Number 661942	§	
issued to EDITH MICHELLE CROWELL	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of EDITH MICHELLE CROWELL, Registered Nurse License Number 661942, 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 September 14, 2016.

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 Baccalaureate Degree in Nursing from Stephen F. Austin State University, Nacogdoches, Texas on May 1, 1999. Respondent was licensed to practice professional nursing in the State of Texas on July 8, 1999.

5. Respondent's nursing employment history includes:

07/1999 - 05/2015	Registered Nurse	The Methodist Hospital Houston, Texas

Respondent's nursing employment history continued:

05/2015 - 09/2015	Registered Nurse	Texas Children's Hospital The Pavilion for Women Houston, Texas
10/2015 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Texas Children's Hospital, The Pavilion for Women, Houston, Texas, and had been in that position for three (3) months.

7. On or about August 12, 2015, while employed as a Registered Nurse with Texas Children's Hospital-The Pavilion for Women, Houston, Texas, Respondent removed Morphine from the Medication Dispensing System for Patient Medical Record Number 3001210492, but failed to follow the facility's policy and procedure for the wastage of the unused portions of the medication. Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

8. On or about August 12, 2015, while employed as a Registered Nurse with Texas Children's Hospital-The Pavilion for Women, Houston, Texas, Respondent violated the boundaries of the nurse/client relationship in that she discussed her personal life, including family issues, and unhappiness with her job with a patient. Respondent was observed to be crying in the patient's room and requested the patient's phone number to discuss a job opportunity. Subsequently, the patient became uncomfortable and requested another nurse. Respondent's conduct was likely to injure the patient in that it could have resulted in confusion between the needs of the nurse and those of the patient. In addition, Respondent's conduct may have caused delayed distress for the patient, which may not be recognized or felt by the patient until harmful consequences occur.

9. On or about August 25, 2015, while employed as a Registered Nurse with Texas Children's Hospital-The Pavilion for Women, Houston, Texas, Respondent failed to obtain a blood glucose level for Patient Medical Record Number 3001766298 prior to the patient eating lunch and failed to administer Insulin to the patient as ordered by the physician. Respondent's conduct was likely to injure the patient in that failure to administer insulin as ordered by the physician could have resulted in non-efficacious treatment.

10. On or about September 5, 2015, while employed as a Registered Nurse with Texas Children's Hospital-The Pavilion for Women, Houston, Texas, Respondent withdrew Phenergan from the Medication Dispensing System for Patient Medical Record Number 3001538289 but failed to follow the facility's policy and procedure for the wastage of the unused portions of the medications. Respondent's conduct was likely to deceive the hospital pharmacy and

placed them in violation of Chapter 483 of the Texas Health and Safety Code (Dangerous Drug Act).

11. On or about September 5, 2015, while employed as a Registered Nurse with Texas Children's Hospital-The Pavilion for Women, Houston, Texas, Respondent mislabeled a blood specimen with the incorrect patient label. As a result the specimen had to be recollected. Respondent's conduct exposed the patient unnecessarily to a risk of harm from medical complications and delayed processing of the specimen.

12. In response to Finding of Fact Number Seven (7), Respondent states: "I received an alert from the unit secretary stating my patient was requesting pain medication. I withdrew a 2mg vial from the Omnicell, assessed that patient's pain, and drew up the entire 2mg in front of the patient and her husband. Right before scanning her armband and vial/administration, the patient voiced concerns and confusion about her pain regimen in regards to what was best for her and her baby. I suggested that we give just 1mg of the Morphine and reassess in an hour. Instead of holding the 1mg I disposed of it in the sink, not wanting the family to have any doubts as to what happened to the Morphine. This was after looking out of my patients room twice, not seeing anyone available to witness for me."

In response to Finding of Fact Number Nine (9), Respondent states: "The patient was hypoglycemic when admitted to the unit from the Emergency Room (ER). The basic metabolic panel was drawn in the ER around 1630 and showed a reading in the 60's. This was not communicated to me by the ER nurse. I was concerned and asked the nursing assistant to recheck the sugar. It was 88. I was told that the blood sugar did not interface from the glucometer to the chart. The night nurse was told of the readings. I wanted to be very cautious the next day and monitor appropriately. The patient was monitored and assessed very closely, and blood sugars were obtained throughout my shift."

In response to Finding of Fact Number Ten (10), Respondent states: "I was seconds from administering the mediation when the patient began vomiting. All pumps were alarming and assistance was immediately rendered to the patient. After getting her cleaned up, comfortable, and settled, I was looking for the phenergan and realized when I was picking up things that had fallen on the floor. I had accidently threw it in the sharps container along with the flushes I had used when the pumps were alarming."

In response to Finding of Fact Number Eleven (11), Respondent states: "In this situation, the requisition order and patient were checked and were correct, however the sticker placed on the tube was incorrect."

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)(J)&(3) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(4),(6)(C),(10)(C)&(11)(D).

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 661942, heretofore issued to EDITH MICHELLE CROWELL, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

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 **LIMITED LICENSE WITH STIPULATIONS** in accordance with the terms of this Order.

A. 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.

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

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

D. 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 entry of this Order**:

> **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.
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> 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 PATIENT CARE PRIVILEGE AND/OR UNENCUMBERED LICENSE(S)

SHOULD RESPONDENT desire to provide direct patient care, RESPONDENT SHALL petition the Board for such approval, at which time, the RESPONDENT MUST satisfy all

then existing requirements for re-issuance of the privilege to provide direct patient care. Further, the Board may impose reasonable conditions that must be satisfied by the RESPONDENT before re-issuance of an unencumbered license, which, at a minimum, shall include the remedial education courses, work restrictions, supervised practice, and/or employer reporting which would have been requirements of this Order had the license(s) not been placed in limited status.

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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 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 24 day of January, 2017.

EDITH MICHELLE CROWELL, Respondent

Sworn to and subscribed before me this 24th day of January, 2017.

SEAL

MICHELE A. EVANSON NOTARY PUBLIC STATE OF TEXAS EXPIRES JULY 3, 2020 NOTARY ID: 124953014

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 24th day of January, 2017, by EDITH MICHELLE CROWELL, Registered Nurse License Number 661942, and said Order is final.

Effective this 14th day of February, 2017.

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