



Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of § AGREED ORDER
Registered Nurse License Number 913521 § FOR
issued to ANDREW SCOTT VOLAND § KSTAR PILOT PROGRAM

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of ANDREW SCOTT VOLAND, Registered Nurse License Number 913521, 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 18, 2018.

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 Covenant School of Nursing, Lubbock, Texas, on December 16, 2016. Respondent was licensed to practice professional nursing in the State of Texas on January 10, 2017.
5. Respondent's nursing employment history includes:

1/2017 - 1/2018	Day Surgery Staff Nurse	Covenant Children's Hospital Lubbock, Texas
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Respondent's nursing employment history continued:

1/2018 - 2/2018	Home Health Staff Nurse	Bright Star Lubbock, Texas
3/2018 - Present	Surgical Staff Nurse	TrustPoint Rehabilitation Hospital Lubbock, Texas

6. At the time of the incident in Finding of Fact Number Seven (7), Respondent was employed as a Surgical Staff Nurse with Covenant Children's Hospital, Lubbock, Texas, and had been in that position for seven (7) months.
7. On or about August 28, 2017, while employed as a Surgical Staff Nurse with Covenant Children's Hospital, Lubbock, Texas, Respondent failed to label a catheterized urine specimen obtained from Patient Medical Account Number PA0082808248, and the lab wouldn't accept it for processing. Respondent's conduct unnecessarily exposed the patient to a risk of harm from delayed urine test results.
8. On or about September 21, 2017, while employed as a Surgical Staff Nurse with Covenant Children's Hospital, Lubbock, Texas, Respondent failed to label a type and cross blood specimen on Patient Medical Account Number PA0082940286, and the lab would not accept it for processing. The anesthesiologist submitted emergency paperwork so the operating room (OR) could receive units of blood before the surgery began. In addition, Respondent failed to insert a Foley catheter far enough into the (4) year old male patient, and inflated the catheter balloon in the urethra instead of in the bladder, causing bleeding. Respondent's conduct and was likely to injure the patient from lack of appropriate nursing care.
9. On or about December 28, 2017, while employed as a Surgical Staff Nurse with Covenant Children's Hospital, Lubbock, Texas, Respondent removed the intravenous (IV) line containing Potassium Chloride from the infusion pump and allowed it to infuse freely in a seven (7) month old, Patient Medical Account Number MU01260736, before the anesthesiologist noticed the fluids running off the IV pump and clamped the IV line. Respondent's conduct exposed the patient to a risk of harm from adverse effects of receiving Potassium Chloride in excess of what was ordered by the physician including possible cardiac arrest.
10. On or about December 28, 2017, while employed as a Surgical Staff Nurse with Covenant Children's Hospital, Lubbock, Texas, Respondent left Patient Medical Account Number PA0083294213 unattended, not strapped down sitting on the edge of the OR table while the patient was and under the influence of a benzodiazepine, and at risk for falling. Respondent's conduct created an unsafe environment and exposed the patient unnecessarily to a risk of injury.

11. In response to the incidents in Findings of Fact Numbers Seven (7) through Ten (10), Respondent states that the surgeon requested that the OR lights be turned off, and the aide picked up the specimen which hadn't yet been labeled with a patient sticker. Respondent relates that the surgeon ordered a specimen to be obtained on the floor. Respondent states that regarding Finding of Fact Number Eight (8), the surgeon asked for labs to be drawn from the IV, he was given the syringe with blood which he labeled, placed in the biohazard bag, filled out the lab paperwork, but didn't place the patient blood label on the paperwork. Respondent states that regarding the foley, he inserted the catheter all the way to the hub of the catheter, and noted a small amount of clear urine pass. Respondent indicates that he proceeded to push the syringe of water to inflate the balloon, and noted no resistance or problems with inflating the balloon. Respondent relates that after inflation he noted more clear urine, and then blood flowing through the catheter; he deflated the balloon, removed the foley, and requested the surgeon's help. Respondent states that there was a complication with the catheter insertion even though he followed the correct procedure. Respondent states that regarding Finding of Fact Number Nine (9), he noticed that this patient had fluids running on an IV pump that also contained Potassium, and he asked the surgeon if he wanted him to take the fluids off the pump and clamp it due to it being a short case. Respondent explains that he proceeded to take the fluid off the pump, turned his attention to the parents to answer a questions, and failed to return his attention to the fluids, and didn't clamp the IV. Respondent explains that he then brought the patient to the OR, and the surgeon noticed the fluid running off the pump and clamped it. Respondent states that regarding Finding of Fact Number Ten (10), he brought the patient to the OR table before her spinal block, and then went to the computer which was several steps away to update the patient's status. Respondent relates that in that brief time, the surgeon administered a benzodiazepine via IV without notifying him or the patient. Respondent states that he immediately moved back to the OR table.

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)&(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 913521, heretofore issued to ANDREW SCOTT VOLAND.
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 **WARNING WITH STIPULATIONS** 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. As a result of this Order, Respondent's license(s) will be designated "single state" and Respondent may not work outside the State of Texas in another nurse licensure compact party state.

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. KNOWLEDGE, SKILLS, TRAINING, ASSESSMENT AND RESEARCH (KSTAR) PILOT PROGRAM

IT IS AGREED and ORDERED that RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the Knowledge, Skills, Training, Assessment and Research (KSTAR) Pilot Program and RESPONDENT SHALL:

- (A) Within forty-five (45) days of entry of this Order, apply to and enroll in the KSTAR Pilot Program, including payment of any fees and costs, unless otherwise agreed in writing;
- (B) Submit to an individualized assessment designed to evaluate RESPONDENT'S nursing practice competency and to support a targeted remediation plan;

- (C) Follow all requirements within the remediation plan, if any;
- (D) Successfully complete a Board-approved course in Texas nursing jurisprudence and ethics as part of the KSTAR Pilot Program; and
- (E) Provide written documentation of successful completion of the KSTAR Pilot Program to the attention of Monitoring at the Board's office.

IV. FURTHER COMPETENCY ISSUES AND VIOLATIONS

IT IS FURTHER AGREED, SHOULD RESPONDENT'S individualized KSTAR Pilot Program assessment identify further competency issues and violations of the Nursing Practice Act, including inability to practice nursing safely, further disciplinary action, up to and including revocation of Respondent's license(s) to practice nursing in the State of Texas, may be taken based on such results in the assessments.

V. 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, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, 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.

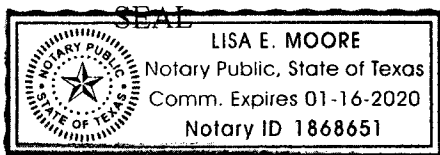
Signed this 26th day of July, 2018.



ANDREW SCOTT VOLAND, Respondent

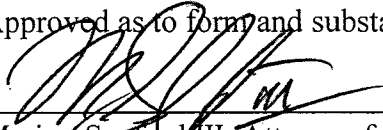
Sworn to and subscribed before me this 26th day of July, 2018.





Notary Public in and for the State of Texas

Approved as to form and substance.



Marion Sanford III, Attorney for Respondent

Signed this 26th day of July, 2018.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 26th day of July, 2018, by ANDREW SCOTT VOLAND, Registered Nurse License Number 913521, and said Order is final.

Effective this 21st day of August, 2018.

A handwritten signature in black ink, appearing to read "Katherine A. Thomas".

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