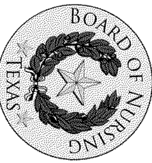

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED ORDER
Registered Nurse License Number 913366	§	FOR
issued to BROOKLYN RAE DUKE	§	KSTAR PILOT PROGRAM

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of BROOKLYN RAE DUKE, Registered Nurse License Number 913366, 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 July 12, 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 Baccalaureate Degree in Nursing from Texas Tech University, Lubbock, Texas, on December 1, 2016. Respondent was licensed to practice professional nursing in the State of Texas on January 10, 2017.

5. Respondent's professional nursing employment history includes:

01/17 - 11/17	RN	Covenant Medical Center Lubbock, Texas

Respondent's professional nursing employment history continued:

12/17 - Present Unknown

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Covenant Medical Center, Lubbock, Texas, and had been in that position for six (6) months.

7. On or about June 8, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent incorrectly documented that she administered Morphine 4mg to Patient Number MA00952037 52, for a pain level of 8, in the patient's medication administration record (MAR). Instead, Respondent taped a Morphine carpuject to a syringe and gave it to a transportation aide prior to the patient being transferred to the floor. Respondent's conduct created an inaccurate medical record.

8. On or about July 1, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent discharged Patient Number MA0095371442 with a prescription that contained the name, date of birth, medical record number, and account number of Patient Number MA0095371779. Patient Number MA0095371442 returned to the ED the following day, requesting a corrected prescription. Respondent's conduct placed the facility in violation of the Health Insurance Portability and Accountability Act (HIPAA).

9. On or about July 11, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent failed to notify the physician, and/or document that she notified the physician, of the critical value lab result for potassium for Patient Number MA0095423132. Respondent's conduct was likely to injure the patient by depriving the physician of medical information required to stabilize the patient and prevent further complications, and created an incomplete medical record.

10. On or about July 21, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent discharged Patient Number MA0095502806 with a prescription that contained the name, date of birth, medical record number, and account number of Patient Number MA0095503349. Respondent's conduct placed the facility in violation of the Health Insurance Portability and Accountability Act (HIPAA).

11. On or about August 19, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent failed to timely obtain a blood specimen for Troponin and BNP lab tests for Patient Number MA0095705367, who was in critical condition after a full cardiopulmonary arrest. Respondent's conduct unnecessarily delayed the onset of medical treatment required to prevent further complications.

12. On or about October 22, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent failed to properly clean and prep a room for a new patient in that after she indicated that the room had been cleaned, a dirty CPAP mask was discovered in the hospital bed. Respondent's conduct unnecessarily exposed future patients to a risk of harm from infectious pathogens and/or communicable conditions.

13. On or about October 22, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent left a vial of Ativan unattended on the keyboard in the room of Patient Number MA0096152302. Respondent's conduct placed the facility in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

14. On or about October 23, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent failed to assess, and/or document her assessment of the respiratory status of Patient Number MA0096154534, who had arrived to the ED with confusion and low oxygen saturation on room air. Respondent's conduct unnecessarily exposed the patient to a risk of harm from undetected complications, and created an incomplete medical record.

15. On or about October 23, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent failed to document her communication with the physician regarding administering an additional liter of fluids for Patient Number MA0096155883, in the patient's medical record. Respondent's conduct created an incomplete medical record and was likely to injure the patient in that subsequent care givers would rely on her documentation to base their decisions for further care.

16. On or about October 30, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent failed to timely recheck the blood glucose of Patient Number MA0096204396 after the lab notified her that the patient had a critical glucose result of 22. The patient's blood glucose was re-checked approximately fifteen (15) minutes later, with a result of 54, and the patient was given orange juice and a sandwich. Respondent's conduct unnecessarily delayed the onset of medical care needed to prevent complications associated with hypoglycemia.

17. On or about October 30, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent failed to check, and/or document, the blood glucose levels of Patient Number MA0096204396 at 1342, 1533, and 1743, as ordered by the physician. Respondent's conduct unnecessarily exposed the patient to a risk of harm from undetected complications associated with uncontrolled blood glucose levels, and created an incomplete medical record.

18. On or about October 30, 2017, while employed as a Registered Nurse (RN) in the Emergency Department (ED) of Covenant Medical Center, Lubbock, Texas, Respondent stopped the

infusion of dextrose (D10) for Patient Number MA0096204396, who had a blood glucose level of 46, without authorization from the physician. Respondent's conduct unnecessarily exposed the patient to a risk of harm from complications associated with hypoglycemia.

19. In response to Findings of Fact Numbers Seven (7) through Eighteen (18), regarding Patient Number MA0095203752, Respondent states she was never taught how to undo a medication scanning/administration if the patient refused the medication. Respondent further states she had drawn up the medication and sent it with the aide to expedite patient care. Regarding the July 1st incident, Respondent states the physician handed her the correct patient's chart, but had placed the incorrect patient label on the correct prescription. Respondent admits she should have doubled-checked the paper before handing it to the patient. Regarding Patient Number MA0095423132, Respondent states she informed the physician that the patient was refusing to be stuck again and the IV was not working. Regarding the July 21st incident, Respondent states that the physician printed out the discharge instructions for a different patient, and admits she did not review the instructions prior to handing them to her patient. Regarding Patient Number MA0095705367, this patient was a transfer from another facility and she was told the blood had already been drawn and sent off. Respondent states she would have drawn the specimen if she knew it had not been done; however, Respondent admits she should have double-checked what had been done. Regarding the October 22nd incident, Respondent admits she missed the CPAP mask since it was under the head of the bed. Regarding Patient Number MA0096152302, Respondent states she kept the vial of Ativan in the patient's room for easy retrieval in case the patient had another seizure. Regarding Patient Number MA0096154534, Respondent states she did auscultate the patient's lungs and heart, but did so when her preceptor was not in the room. Regarding Patient Number MA0096204396, Respondent states that the vial of blood sent to the lab was blood EMS had drawn prior to the administration of glucose, so she knew the result was going to be low. Respondent states the 15 minute delay includes the time for the result to appear, the time she was notified, and the time it took for her to obtain and access a glucometer. Respondent adds that her badge was not authorized for use of glucometer. Regarding the D10, Respondent states that her preceptor told her to stop all EMS infusing medications and inform the doctor immediately to see if he wants the medication continued or not.

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)(E),(1)(M),(1)(N),(1)(O),(1)(P)&(3)(A) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C),(4)&(11)(B).

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 913366, heretofore issued to BROOKLYN RAE DUKE.

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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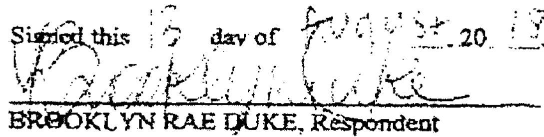
RESPONDENT'S CERTIFICATION

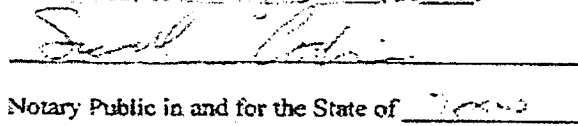
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary 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.



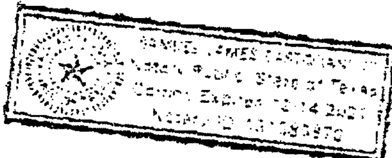
Signed this ___ day of ___, 20___.

BROOKLYN RAE DUKE, Respondent

Sworn to and subscribed before me this ___ day of ___, 20___.

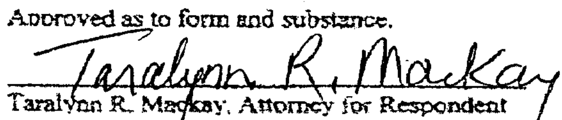


SEAL



Notary Public in and for the State of ___

Approved as to form and substance.



Taralynn R. Mackay, Attorney for Respondent

Signed this 20th day of August, 2018.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 13th day of August, 2018, by BROOKLYN RAE DUKE, Registered Nurse License Number 913366, and said Order is final.

Effective this 11th day of September, 2018.

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