

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of	§	AGREED ORDER
Vocational Nurse License Number 175891	§	
issued to ARLENE V. KELLEY	§	
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of ARLENE V. KELLEY, Vocational Nurse License Number 175891, 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 Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on February 20, 2020.

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 Agreed Order.
- 3. Respondent's license to practice as a vocational nurse in the State of Texas is in current status.
- 4. Respondent received a Certificate in Vocational Nursing from Schreiner College, Kerrville, Texas, on February 18, 2000. Respondent was licensed to practice vocational nursing in the State of Texas on April 18, 2000.
- 5. Respondent's nursing employment history includes:

4/2000 - 2/2017

Unknown

3/2017 - 1/2018

Staff Nurse

Department of Veterans Affairs Hospital

Kerrville, Texas

Respondent's nursing employment history continued:

2/2018 - Present

Unknown

- 6. At the time of the incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff Nurse with the Department of Veteran Affairs Hospital, Kerrville, Texas, and had been in that position for two (2) months.
- 7. On or about March 6, 2017, while employed as a Staff Nurse with the Department of Veteran Affairs Hospital, Kerrville, Texas, Respondent failed to verify the correct insulin ordered on the medication administration record (MAR), and attempted to scan a bottle of Lantus insulin to administer to a patient. The patient was ordered Aspart insulin to treat his elevated blood glucose reading of 317mg/dl. Respondent's conduct could have exposed the patient to a risk of harm from failure to follow safe medication administration processes.
- 8. On or about March 16, 2017, while employed as a Staff Nurse with the Department of Veteran Affairs Hospital, Kerrville, Texas, Respondent failed to verify the correct insulin ordered on the MAR, failed to scan the selected insulin, and failed to have a second nurse verify the insulin prior to administering the insulin to a patient. Subsequently, Respondent incorrectly administered three (3) units of Lantus insulin to a patient instead of three (3) units of the ordered Aspart insulin for a pre-meal blood glucose reading of 391mg/dl. Respondent's conduct was likely to injure the patient from ineffective treatment.
- 9. On or about April 28, 2017, and April 29, 2017, while employed as a Staff Nurse with the Department of Veteran Affairs Hospital, Kerrville, Texas, Respondent failed to administer Aspart insulin to a patient for elevated pre-meal blood glucose readings as ordered per sliding scale parameters. On April 28, 2017, Respondent failed to administer three (3) units of Aspart insulin to a patient for a pre-meal blood glucose reading of 200 mg/dl as ordered per sliding scale parameters. On April 29, 2017, Respondent failed to administer five (5) units of Aspart insulin to a patient for a pre-meal blood glucose reading of 336 mg/dl as ordered per sliding scale parameters. Respondent's conduct was likely to injure the patient from complications of untreated elevated blood sugar, including frequent urination, increased thirst, ketoacidosis, diabetic coma, and possible demise.
- 10. In response to the incidents in Findings of Fact Numbers Seven (7) through Nine (9), Respondent states that when she returned to work in January 2017 after being out since October 2016 for surgery, she didn't get assigned to the medication cart very often, so wasn't as comfortable with medication administration. Respondent adds that the unit was often understaffed especially on her 3:30 pm to midnight shift. Respondent states that on March 6, 2017, she scanned an insulin bottle, but the computer didn't accept the scan, so Respondent immediately replaced the insulin bottle into the top drawer of the medication cart where it is normally kept. Respondent indicates that she hadn't pulled up any medication to be administered, or gone into a patient's room. Respondent explains that she was still getting used to the generic insulin names that the Veteran Administration used

instead of the brand names. Respondent states that on March 16, 2017, she was surprised to be assigned to the medication cart as she was usually assigned to work the floor. Respondent states the Nurse Educator was observing Respondent during medication administration when the wrong insulin was administered. Respondent also points out she became nervous when she was being followed with the medication cart. Respondent states that on April 28, 2017 and April 29, 2017, the unit was especially short staffed. Respondent indicates that the 8 pm medications were changed to be given at 5 pm. Respondent adds that management didn't adjust staffing to help with dinner since the medication pass was changed to 5 pm and occurring at the same time the food conveyors were rolled to the unit. Respondent states that the Certified Nurse Assistant kept interrupting her, asking if she was finished passing medications so she could help him with preparing the trays, passing out trays to over twenty (20) patients and patient feeding for patients unable to feed themselves. It is up to the medication nurse to enter into the PRN medication of the MAR and click the PRN medication needing to be administered. Respondent admitted to failing to do this, being so involved in patient care. Respondent points out that a staff member, usually someone working on the floor, was assigned to obtain patients' blood sugars and this staff member would document the blood sugar readings on any piece of paper, which was placed on one med cart or both carts. Respondent states she remembers seeing paper at least one of these days. The blood sugar readings were entered into the computer only after the glucometer was docked for charging. The results were documented to an unseen area in the computer.

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)&(2)(A) and 22 Tex. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C)&(4).
- 4. The evidence received is sufficient cause pursuant to Section 301.452(b) (10)&(13), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 175891, heretofore issued to ARLENE V. KELLEY.
- 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 Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 et seq., and this Agreed Order.

III. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp. Upon successful completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

IV. 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 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 must 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 <u>not</u> being offered by a pre-approved provider. Information about Board-approved courses and Verification of Course Completion forms are available from the Board at <u>www.bon.texas.gov.compliance</u>.

V. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

- A. Notifying Present and Future Employers: RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.
- B. Notification of Employment Forms: RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.
- C. Indirect Supervision: RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

D. Nursing Performance Evaluations: RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for four (4) quarters [one (1) year] of employment as a nurse.

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed Order, all encumbrances will be removed from RESPONDENT'S license(s) and/or privilege(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 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 this Order is subject to ratification by the Texas Board of Nursing and a copy of this Order will be mailed to me once the Order becomes effective. 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) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 3 day of lepul, 2020
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ARLENE V. KELLEY, RESPONDENT

Sworn to and subscribed before me this $\frac{3}{2}$

day of Apre

SEAL

Notary Public, State of Texas Comm. Expires 08-21-2022

Notary ID 17471-4

Notary Public in and for the State of ___

Approved as to form and substance.

Taralynn R. Mackay, Attorney for Responden

Signed this $\frac{84}{20}$ day of $\frac{1}{20}$, $\frac{20}{20}$

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the <u>3rd</u> day of <u>April</u>, 20 20, by ARLENE V. KELLEY, Vocational Nurse License Number 175891, and said Agreed Order is final.

Effective this 12th day of May . 20 20.

Katherine A. Thomas, MN, RN, FAAN

Executive Director on behalf

of said Board