

BEFORE THE TEXAS BOARD OF NURSING

| | | |
|--|---|-----------------------|
| In the Matter of | § | AGREED ORDER |
| Registered Nurse License Number 771285 | § | FOR |
| issued to CLARA L NG | § | DEFERRED DISCIPLINE & |
| | § | KSTAR PROGRAM |

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of CLARA L NG, Registered Nurse License Number 771285, 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)(effective through 8/31/2021), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order for Deferred Discipline & KSTAR Program approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on February 14, 2023.

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 for Deferred Discipline & KSTAR Program.
3. Respondent's license to practice as a professional nurse in the State of Texas is in current status.
4. Respondent received an Associate Degree in Nursing from Grayson County College, Denison, Texas, on May 9, 2009. Respondent received a Bachelor's Degree in Nursing from Texas Tech University Health Science Center, Lubbock, Texas, August 21, 2010. Respondent was licensed to practice professional nursing in the State of Texas on June 30, 2009.

5. Respondent's nursing employment history includes:

| | | |
|------------------|-----------|---|
| 6/2009 – 9/2013 | RN | Baylor Specialty Hospital Dallas, Texas |
| 4/2010 – 9/2013 | RN | Baylor University Medical Center Dallas, Texas |
| 9/2013 – 9/2020 | RN | UT Southwestern Medical Center Dallas, Texas |
| 10/2020 – 5/2022 | RN | Memorial Hermann Health System Houston, Texas |
| 3/2022 – 5/2022 | Travel RN | Norton Hospital Louisville, Kentucky |
| 6/2022 – 6/2022 | Unknown | |
| 7/2022 – 8/2022 | Travel RN | Baptist Health Louisville Louisville, Kentucky |
| 9/2022 – 10/2023 | RN | Texas Health Harris Methodist Hospital Fort Worth, Texas |
| 10/2023-Present | RN | 802 Esthetics Plano, Texas |

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with UT Southwestern Medical Center, Dallas, Texas, and had been in that position for six (6) years and one (1) month.
7. On or about October 23, 2019, while employed as a Registered Nurse with UT Southwestern Medical Center, Dallas, Texas, Respondent removed one (1) Tramadol 50mg tablet from the medication dispensing system for Patient Number 92964918 but failed to scan and document the administration of the medication in the patient's medication administration record. Respondent's conduct could have contributed to injury in that the patient in that subsequent care givers would rely on her documentation to further medicate the patient, which could result in an overdose.
8. On or about October 23, 2019, November 4, 2019, and December 6, 2019, while employed as a Registered Nurse with UT Southwestern Medical Center, Dallas, Texas, Respondent withdrew one (1) Tramadol 50mg tablet and two (2) Dilaudid 0.5mg syringes from the

medication dispensing system for Patient Numbers 92964918, 90607947, and 93455155, but failed to follow the facility's policy and procedure for wastage of any used portions of the medications. Respondent's conduct left medications unaccounted for.

9. On or about November 3, 2019, while employed as a Registered Nurse with University of Texas Southwestern Medical Center, Dallas, Texas, Respondent instructed a patient care technician (PCT) to discontinue the peripheral intravenous catheter (PIV) for Patient Number 94443486, but failed to ensure it had been removed prior to providing discharge instructions and discharging the patient from the hospital. Subsequently, the patient went to a local emergency room in order to have the PIV removed. Respondent's conduct could have created an unnecessary financial burden for the patient and unnecessarily exposed the patient to a risk of injury to the IV site.
10. On or about February 18, 2020, while employed as a Registered Nurse with University of Texas Southwestern Medical Center, Dallas, Texas, Respondent failed to ensure that the chair alarm was turned on for Patient Number 92357682, who was a high fall risk. Additionally, Respondent failed to ensure that the waffle cushion was tied to the chair. As a result, the patient slipped out of the chair while sitting on the cushion and fell to the floor. Respondent's conduct may have contributed to the patient's fall.
11. On or about May 11, 2020, while employed as a Registered with University of Texas Southwestern Medical Center, Dallas, Texas, Respondent failed to notify the physician and/or activate a Rapid Response Team (RRT) code, for Patient Number Nurse 90144364 after Respondent noted and documented blood pressure readings of 80/52 at 1640 and 88/54 at 1721. Additionally, the patient had a high Modified Early Warning (MEWS) score. The night shift nurse subsequently called an RRT at 1949. Respondent's conduct could have delayed the onset of medical interventions needed to prevent further complications for the patient.
12. On or about June 6, 2020, while employed as a Registered Nurse with University of Texas Southwestern Medical Center, Dallas, Texas, Respondent failed to provide patient education for the Jackson Pratt (JP) wound drains for Patient Number 90321091 while discharging the patient from the hospital. Additionally, Respondent failed to discontinue the patient's peripheral intravenous (PIV) catheter during discharge and the patient had to call Respondent back into the room to discontinue the PIV. Further, Respondent failed to update the patient's After Discharge Summary with the time her next medications were due. Respondent's conduct could have contributed to patient injury from incomplete information regarding the management of her wound drains and medications.
13. On or about June 16, 2020, while employed as a Registered Nurse with University of Texas Southwestern Medical Center, Dallas, Texas, Respondent failed to notify the Central Monitoring Unit (CMU) that Patient Number 71978913 had been transferred from the 6th floor to the 12th floor. The patient was on remote telemetry monitoring for heart arrhythmias. Respondent's conduct unnecessarily exposed the patient to a risk of harm in

that in the event of an emergency the CMU would not have known the correct physical location of the patient.

14. On or about September 2, 2020, while employed as a Registered Nurse with University of Texas Southwestern Medical Center, Dallas, Texas, Respondent inappropriately directed the family of Patient Number 73714952 to reset the PIV pump alarm button instead of placing the patient's arm on a padded arm board to facilitate the PIV infusion and prevent the pump from alarming as frequently. Additionally, Respondent failed to appropriately assess the patient's PIV after the family reported the patient was receiving a potassium chloride infusion and was experiencing pain at the PIV site. Respondent's conduct could have contributed to injury to the patient from unknown changes in condition and unresolved pain and discomfort.
15. In response to Findings of Fact Number Seven (7), Respondent states she did scan the tramadol, but thinks the scanner may have been faulty and not identified the bar code and that this was not an unusual occurrence in this unit for nurses and the equipment provided. Respondent states she watched the patient take the medication, and in addition, she returned to reassess the patient in forty-five minutes and did the discharge instructions at bedside. The patient was discharged from the hospital at ~ 1532. Therefore, Respondent states there were no subsequent caregivers or risk of overdose. The patient was discharged within approximately an hour after the administration. Respondent also charted the administration in the medical record.

In response to Findings of Fact Number Eight (8), regarding the wastage of Tramadol, Respondent states that this was the same patient as in Finding of Fact Number Seven (7), and that the Tramadol was given and documented as given. Respondent states there was no wastage and the appropriate dosage was pulled from the pyxis and given. Regarding the wastage of the two Dilaudids, Respondent states that the Dilaudids were withdrawn under the patients' names, but wasted under different patients' profiles, who had similar names, diagnoses, and treatment plans, and who all were Respondent's assigned patients. Regarding the wastage of the Dilaudid for Patient Number 90607947, Respondent states that before Respondent's assignment began, she expressed concern to her charge nurse about having two patients so similar next door to each other, due to the very busy environment of this unit, and that human error could occur, however, her assignment remained the same. Respondent further states that the Dilaudid later was traced by the facility and there were no unaccounted medications. Regarding the wastage of the Dilaudid for Patient Number 93455155, Respondent states she assessed the patient's pain level, patient denied the pain, then, shortly thereafter, Respondent received a phone message that Patient Number 93455155 requested Dilaudid pain medication. Respondent also received several phone calls that another patient requested Dilaudid medication. Respondent states she pulled the pain medication from the pyxis, but when she walked to the patient's room, he now said he did not want the Dilaudid. Respondent states that she documented in the Medication Administration Record that the patient refused the Dilaudid. Respondent had the medication in her hand, while she continued to receive several phone calls on several of her patients.

Respondent states that the Secretary called to remind Respondent that the other patient still was waiting for pain medication, and Respondent then gave the other patient the Dilaudid that she pulled from the profile of Patient Number 93455155. Respondent states she never received a message from the pyxis that she had an unreconciled medication, which confirmed to her that the unused portion of the pulled medication was recorded as wasted. On that day, Respondent was very busy, and when she would call for help, no one was available. Respondent did not know there was an issue until, about one month later, and Respondent and her manager determined what had occurred.

After these two incidents, Respondent instituted safety checks to assure there were no similar incidents and there have not been further incidents of this sort, in Respondent's ensuing years of practice.

In response to Findings of Fact Number Nine (9), Respondent states that upon learning that the PCT had failed to remove the PIV before the patient went home, she talked to the house supervisor and charge nurse, who told her to ask the patient to go to the nearest ER or come back to UTSW to have the PIV removed. Respondent states that after this incident she no longer delegates the removal of PIV's to PCT's.

In response to Findings of Fact Number Ten (10), Respondent states the patient asked to sit up in a chair in the afternoon, so Respondent asked the PCT to gather all of the chair alarm equipment and Respondent placed the belt on patient; both she and the PCT thought that the chair alarm was on. Respondent states that she had frequently been in and out of the room and checking on the patient and that she had explained the UTSW fall precautions to both the patient and his wife and that the reason for the chair alarm was to decrease the risk of a fall, for the patient's safety. Both the patient and his wife verbalized understanding. Respondent also requested the patient's wife to call her, if she left the room. Respondent states that when the patient's wife left the unit, without notifying Respondent, the patient unbuckled the belt and tried to get out of the chair. Respondent found the patient sitting on the floor on the waffle cushion, which had slipped off the chair when patient slipped out of chair. Respondent then discovered the chair alarm was off. There was no harm or injury to the patient. Per policy, Respondent called RRT and the physician at that time. Respondent states that this was the only patient fall that has occurred to one of her patients in approximately fourteen years of nursing practice. Respondent states that she now checks and ensures the alarm is on and working properly every time it is set.

In response to Findings of Fact Number Eleven (11), Respondent acknowledges the patient's blood pressure readings were low, but states the patient was asymptomatic during her shift and denied pain or discomfort. Respondent further states that the MEWS score on Respondent's shift was not high, according to UTSW policy. Respondent acknowledges that at shift change the oncoming nurse called the physician and RT, and records indicate that the patient was seen by RRT, MD and other providers, but was not transferred until approximately eight hours later. After this, Respondent very carefully reports low BP to physicians every time.

In response to Findings of Fact Number Twelve (12), Respondent states she provided verbal patient instructions for the wound drain and states the patient told her she already knew how to do drain care at home. Respondent acknowledges she did not provide the Jackson Pratt drain care log sheet and instruction sheets to the patient. However, Respondent states she clearly gave instructions on how the patient should keep a written record and write down the drain output on a paper and bring it to the follow up visit. Respondent also acknowledges the patient's daughter called her to remind her that the IV was still in the patient's arm, and Respondent informed the daughter that she would remove the IV when it was completed and she did so. Respondent further acknowledges she did not enter the specific date and time on the computer medication list, but states she verbally discussed the medications with the patient and when to take the next dosage and the patient expressed understanding. After this incident, Respondent ensures to write the dates/time and when/how to take medications, ensuring the patient fully understands, prior to discharge.

In response to Findings of Fact Number Thirteen (13), Respondent acknowledges she failed to notify the CMU that the patient had left the unit. Respondent received a physician order to transfer this patient to the medicine unit. Respondent states she gave a report to the receiving RN on the medicine unit on day shift, which included that the patient was on telemetry. The patient was transferred by Respondent and a transport person. Respondent further states that when the receiving nurse was in the room, Respondent again reported to her that the patient was on remote telemetry monitoring. Respondent states that she checked the telemetry box, and checked the patient's rhythm to assure the patient was safe before leaving the patient's new room. Respondent states that at the time of this incident, the policy was for the transferring nurse, or designee, to notify CMU of the patient's new location and the receiving nurse, or designee, to notify CMU of the new room number and the receiving nurse's information. Respondent states that the receiving nurse failed to notify CMU. After this incident, Respondent reviewed the updated policy for transfer communications, and called the monitoring room to promptly report the status of a patient's transfer to different units/departments in a timely manner.

In response to Findings of Fact Number Fourteen (14), Respondent states she reported the beeping potassium pump to the charge nurse several times, but was told the charge nurse was busy and would not help. Respondent states that she was in another room with another patient who needed her assistance, when the patient's daughter called again later to report the pump was again beeping and that the patient's IV site was hurting. Respondent then told the patient's daughter to push the restart button to prevent further alarm noise, and to call the front desk to request another nurse to assist the patient, since Respondent could not leave the room of the other patient at that time. Respondent was aware that the patient might need assistance, and the reset suggestion was just an immediate intervention to stop the beeping, but not to stop follow-up on the patient's need for assistance. Respondent states she was unable to find another nurse to look at the patient's IV at the time. Respondent states that before she could return to the patient's room, the charge nurse told her to give a report to another nurse. Respondent frequently was in the patient's room caring for patient and responding to the patient's daughter's

requests and questions. Respondent attempted multiple times to have other nurses assist her, including the charge nurse, but Respondent was unable to get help. Respondent strives to assure that all her patients are provided safe care and that her patients feel they are receiving timely and competent interventions from her.

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),(1)(P)&(3).
4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13) (*effective through 8/31/2021*), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 771285, heretofore issued to CLARA L NG.
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, DEFERRED**, 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. Until successfully completed, RESPONDENT may not practice nursing in the State of Texas except in accordance with the terms of this Order.

- D. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

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 for Deferred Discipline & KSTAR Program.

Further, RESPONDENT SHALL not commit any violation of 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.* **for a period of three (3) years from the date of this Order.**

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

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

- A. **Within forty-five (45) days** following the effective date of this Order, apply to and enroll in the KSTAR 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 Program; and

- E. Provide written documentation of successful completion of the KSTAR 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 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. EFFECT OF DEFERRED DISCIPLINE

Upon successful completion of the stipulated requirements of this Agreed Order for Deferred Discipline & KSTAR Program, 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.

Upon the successful completion of the required three (3) year period of deferral, the complaint or complaints which formed the basis for this action will be dismissed and this Order will be made confidential to the same extent as a complaint filed under Section 301.466, Texas Occupations Code.

Until such time that this Order is made confidential, this Order is subject to disclosure in accordance with applicable law.

Should an additional allegation, complaint, accusation, or petition be reported or filed against RESPONDENT prior to the time this Order is made confidential, the deferral period shall be extended until the allegation, accusation, or petition has been finally acted upon by the Board.

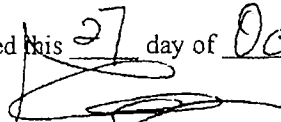
Should RESPONDENT commit a subsequent violation of the Nursing Practice Act or Board Rules, this Order shall be treated as prior disciplinary action.

BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE.

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.

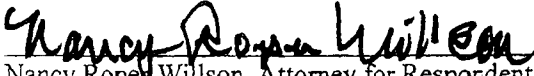
Signed this 27 day of October, 2023

CLARA L NG, 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. ^{YRM}


Nancy Roper Willson, Attorney for Respondent

Signed this 27th day of October, 2023

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order for Deferred Discipline & KSTAR Program that was signed on the 27th day of October, 2023, by CLARA L NG, Registered Nurse License Number 771285, and said Agreed Order for Deferred Discipline & KSTAR Program is final.

Effective this 14th day of November, 2023.

Kristin K. Benton, DNP, RN

Kristin K. Benton, DNP, RN
Executive Director on behalf
of said Board