June16, 20XX

Enforcement Department

Texas Board of Nursing

333 Guadalupe Street, Ste 3-460

Austin, TX 78701

Re: Glynn , RN

Dear M:

Please consider this letter an initial response on behalf of Glynn RN, who received a letter of investigation from you dated November 23, 20XX. At the outset, let me stress that Ms. Glynn takes this process very seriously, she has been a Registered Nurse for over 40 years, and until this time has never had any questions raised or criticisms leveled regarding her delivery of nursing care to her patients. We are attaching here her rebuttal statement to the peer review committee who undertook the 2009 incident, a current resume, and several letters from colleagues written in support of Glynn. We may gather additional documents to supplement this response in the future.

With regards to the first allegation, which took place in August of 20xx, Glynn assures the BON that the response that she gave to the Peer Review Committee and their findings at that time, corroborate that she did nothing wrong in the delivery of care, the assessments and monitoring of this patient. The Peer Review Committee of Middle Regional noted that all the staff involved with the incident reported to the Committee that “there were no signs of respiratory distress prior to the incident”, and that Glynn assessed and treated the patient meeting the Standards of Care as stated in the Texas Administrative Code 217.11.

After completing their investigation the Committee determined that “it is apparent that Glynn was carefully monitoring the situation and responded appropriately to the crisis situation.” Glynn has recently been deposed in a lawsuit that the wife of this patient brought against the treating physician and the hospital, her deposition is attached and documents her statements under oath that she responded in an appropriate manner to the patient’s concerns and to his objective and subjective symptoms. The Ativan dose that was given to the patient is not an amount that any nurse would question under those circumstances, Ativan may be given for anxiety, a one milligram dose is a typical dose, and in addition to these facts, she did call the treating physician, Dr. N, to confirm the medication because it had been ordered by another physician who had been covering. She stated in her deposition that it is the practice on that unit that when a medication is ordered by another physician, Dr. N requires the staff to double check with him, which she did, as was her habit.

Glynn’s Professional Evaluations, since 1995 have always without exception shown her to be an excellent clinician, consistent team player, and superior nurse, with scores exceeding expectations. I have attached here dates and page numbers so that you may look at each year’s reports. The language used is seen throughout:

* 1990 p. 99… well above average
* 1993 p. 95...give 100%, never ending reliability, role model
* 1994 p. 136... responsible, available, role model
* 1995 p. 190... excellent for medications, assessments, evaluations, communication; true patient advocate
* 1996 p. 234... safe, prudent CCU skills, excels in care of cardiac patient, proficient in use of cardiac pump, always provides “extra something”, fortunate to have her in the CCU
* 1997 p. 296...quality, exceptional, undivided attention and dedication
* 1998 p. 327... one of the strongest and most experienced nurses at CCRMC; functions with confidence in the most unstable and unpredictable conditions; proficient in the recovery of the CCU patient; vast clinical knowledge base
* 1999 p. 393... consistently provides expert care; role model, reacts quickly and efficiently to emergencies;
* 2000 p. 457...one of the most capable and proficient nurses in CCU; looked to as a resource and authority; communicates effectively with physicians keeping them informed of changes;
* 2001 p. 483... administrative, technical, interactive and customer service modalities all “exceeds expectations”
* 2002...p. 562...consistently exceeds expectations
* 2004 p. 822...backbone of night shift, caring compassionate, respected by MD’s and peers
* 2006 p. 1108... consistently exceptional solid performance; 100% compliance with CCU measures
* 2007 p. 903...looked up to as a resource for new nurses, excellent communication, consistently exceeds expectations in physician satisfaction
* 2008 p. 1436... exceeds, always, consistently excellent critical thinking, excellent follow through; bright, great rapport with physicians, well organized, sets priorities; greatly value her as part of the team

It is noteworthy that the 20xx evaluation obviously was done after the November 2007 incident that was peer reviewed; there is absolutely no mention of that incident in the evaluation, most probably because there was no finding of fault on Glynn’s part.

The second issue under investigation by the Board is one regarding the patient who allegedly was not monitored appropriately by Glynn. She gave a response to the peer review committee accepting responsibility for some of her actions which she stated were not her typical habit. I have attached to this response her rebuttal statement to the peer review committee and will summarize some of her comments here:

* At the outset, Glynn accepted responsibility for her actions, stating that she did not notify her charge nurse of the patient’s condition and she did fail to do a follow up ABG. She actually stated that there was no excuse for those actions, and pointed out that this was uncharacteristic of her practice.
* She pointed out that if the persons in charge really thought that she was dangerous, then why did they allow her to continue to care for CCU patients, and especially why did they assign her to the very same patient the following week?
* The peer review committee stated in their findings after the 20XX event that this was the second occurrence in which Glynn had a patient that received a large dose of sedation and experienced untoward outcomes. Yet, Glynn was totally exonerated for that 2007 incident, in fact the committee found that “it is apparent that Glynn was carefully monitoring the situation and responded appropriately to the crisis situation.” For this committee to come two years later and do a complete about face and count that incident as “the first”, and the 20xx incident “the second” is untrue, unfair, and not believable.
* As Glynn stated in her rebuttal, although she did not document the doctor’s order for the increase in oxygen, she has worked on the CCU for 20 years, and always would get an order for an increase in oxygen, so although it was not documented, she is confident that she did get an order, but failed to document that order, a mistake for which she takes responsibility.
* With regards to the pacemaker, as Glynn stated in her rebuttal, the CCU operates under ACLS protocol which state that, when indicated, the re-initiation of a pacemaker is to be “without hesitation”. It is standard protocol in the CCU that all the nurses in the CCU follow ACLS protocol, which mandates the action be “without hesitation” and does not mandate obtaining physician’s orders prior to restarting a pacemaker. This point was confirmed by Glynn’s charge nurse during the peer review meeting.

Dr. L who was the attending physician for this patient has written a letter of support on Glynn’s behalf. We ask that you consider that his support and description of Glynn’s exceptional nursing care for his patients weighs heavily in her favor. The other letters from colleagues, and the strikingly consistent evaluations noted above also speak to her professionalism throughout her distinguished career.

Glynn has been an excellent nurse for more than forty years. This fact is attested to by all who have worked with her; staff members, supervisory persons, and physicians. Never has she been involved as a subject in a peer review where fault was found until the recent 2009 incident. Her actions in the care of this patient are not indicative of a pattern to deliver unsafe care, and her actions did not cause the death of that patient.

Glynn knows and understands that the role of the Texas Board of Nursing is to protect the citizens of Texas from unsafe practice. She is hopeful that the persons reviewing this response will realize that she has been and continues to be an excellent nurse and constantly strives to give the best care to her patients and their families.

On behalf of Glynn, I want to thank the Texas Board of Nursing for their attention to this response. We hope that the Board will see fit to consider the lack of obtaining the ABG of June 24, 20XX to be an occurrence that is not reflective of this nurse’s practice, but an example of an oversight on one night out of thousands, and that the documentation which Glynn admits was less than her norm, while not adequate, is something that again is not reflective of her typical practice.

I am hopeful that the Board will close this investigation with no further action.

Respectfully,

Attachments