September 4, 201x

*Name of Investigator*  **Via Fax: 512-305-7401**

Texas Board of Nursing

333 Guadalupe Street, Ste 3-460

Austin, TX 78701

Re: Susan G RN License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear *Name of Investigator*,

 Please let this letter serve as an initial response to the letter I received from the Texas Board of Nursing dated September 12, 201x. I am attaching to this response my resume, and letters of reference, and the Statistical Data Questionnaire as well as evaluations for the past 6 years.

 I take this investigation very seriously. I have always prided myself on being the best nurse that I can be, I values my career, and have had a history of delivering excellent care to my patients.

 As you can see from the records, I have worked at William Smith hospital for many years. I have studied the medical records sent to me from the Board andI have answered the allegations below to the best of my ability, but would like to make some comments about the environment for nurses on my unit at William Smith.

 I work in a unit where a majority of the nurses are of a specific ethnicity, and there is a clique in place where those of the same ethnicity stick together. The members of the clique look out for one another and most of the time they speak in their native language, making it difficult to communicate or understand what is going on. A majority of these individuals are charge nurses for morning and night shifts. They schedule cases to favor their friends and those of us not a part of the clique are given the most difficult cases.

I managed to survive for the past 20 years dealing with this kind of atmosphere because I am a hard working Nurse devoted to my patients and loyal to my employer. There have been instances where individuals will go to the supervisor with complaints that have no validity with the goal of tainting your record. I can say I have been one of the fortunate Nurses on that unit not a part of the cliques to be able to stay as long as I did. I have been vocal in expressing my opinion when I feel I am wronged and once I express myself, I move on.

 There was an instance where my Nurse Manager told me that she felt I put her on the spot when I questioned her about an assignment given to me. She held that against me for several months. I realized it when I approached her on a different issue and she revealed to me that she felt put on the spot at that time in the past and did not appreciate it. I apologized and informed her it was not intentional or personal but I wanted to understand the reason for her decision at that time. I feel that after that incident, I was on her radar and was written up for every minor offense that would not normally be an issue. I felt I was being monitored for the purpose of gathering information and eventually I was asked to resign for the listed offenses sent to the Board.

 What follows is my explanation for the allegations in the letter of investigation:

1. 2/30/20xx poor job performance (page 28 of pdf. doc. Departmental records-2)

 On January 16th 20xx I was assigned to two labor patients in separate rooms that were approximately 15-20 feet apart.

 The patient in question was in bed with the side rails up and she was stable. I was called to attend to another patient and asked the team leader to assist by keeping watch of the patient in question while I attended to my other assigned patient.

 I was called and informed that my patient (the one I had asked the team leader to watch for a brief time) had gotten out of bed and attempted to go to the restroom. Apparently the patient used the call button but was unable to get any attention. Because I was attending to the patient in the other room I was unable to document reassessment of the patient in question at that moment. Apparently when patient was discovered the rails were still up but she managed to get out of bed. No harm came to the patient, she was back in bed and comfortable.

 The charge nurse on that day was not one that assisted other staff when it was needed. For example, there was an instance where I called for help because one of my patients was seriously bleeding after surgery, she was the team leader and despite calling numerous times for her aid she never came to help. I was able to manage, the patient did have to go back to the OR, but it would have been better if she had assisted me, and perhaps we could have gotten to the OR quicker.

1. 9/29/20xx Failure to maintain neonatal resuscitation provider licensure (page 22 of pdf. doc Departmental records 2)

 My NRP certification did expire while I was on the schedule. I know it is my responsibility to keep track of that, but at this time, I was unaware of the expiration date for several reasons. I have several certifications that I renew every two years and two of them are scheduled for renewal at the end of February. Being that I was in school and working full time I honestly did not remember the date of expiration. I know and understand it is my responsibility to renew my certifications, and it was my error not to have done that. Usually managers on the unit are alerted by a tickler system regarding certifications that are coming due. For some reason, this did not occur and I never received a verbal reminder. This is not an excuse but it certainly was a help to remember in the past. This is the first time that this had ever happened to me, and of course I renewed immediately, I don’t think it merits reporting to the Board of Nursing.

1. 9/14/20xx Poor job performance: Failure to document critical patient data within the shift the care occurred- did not document patient data related to postpartum hemorrhage until the following day. (page 23 pdf. doc. Departmental record 2/ William Smith medical records page. 2, 22-24)

 On August 13, 20xx I was assigned a patient for a repeat c-section with an undiagnosed Acretia. During the procedure, the patient experienced severe bleeding. Under those circumstances, the circulating nurse (me) is responsible for multiple tasks including patient assessment, making available whatever equipment and/or medical supplies the surgeon and anesthesiologist need. I also was responsible for the recording of events at the same time by documenting the progression of the case in the computer.

 At some point, the case became so serious that I could not turn away from assisting the surgeon and the anesthesiologist to contemporaneously type notes into the computer, but I continued documentation of notes on a sheet of paper so that I could later transcribe the notes into the computer.

 This case started around about 10 am and did not end for me until 7:06 pm. I only received a break during the entire case at about 4:23- returning at 5:02 pm (page 21- 24). At the end of my shift I gave the verbal onsite report to the incoming nurse, which included the fact that this patient was stabilized. I also mentioned that the documentation was incomplete because of the severity and the circumstances surrounding the case. I informed that nurse that I would be returning the following morning to complete my note. This is a practice that is acceptable on our unit. It is stated that the nurse has 24 hours to complete documentation. I believe that that is a written policy at William Smith, but it was not sent to us in the documents.

 The next morning when I returned to work, I was immediately assigned a labor case before I was able to complete my documentation from the previous shift. Within that time I was called into the nursing director’s office and was informed that that patient had had postpartum bleeding after I left. I informed the nurse director and manager of the situation and that I intended to complete the documentation upon returning to work.

 I did finish the documentation on that day.

1. 3/12/20xx – Failure to maintain CPR licensure (suspension)

 There is no excuse for allowing my CPR certification to expire. This was my mistake again due to being a full time student and a full time nurse. I overlooked the dates and for that I was sorry, I apologized, I was suspended, and I renewed my CPR certification before returning to work. I currently have an updated CPR, ACLS, and NRP certification.

1. 2/13/20xx – Substandard patient care (Departmental records 2, page 7-9)

 On January 30, 20xx at 7 am, I received the patient report from the outgoing nurse and there was nothing done for this patient by that outgoing nurse, even though the patient had arrived prior to shift change. There was no blood drawn, vital signs were not recorded, no IV was started, there was no Foley catheter placed, and her abdomen was not prepped. This all had to be done upon receiving this patient report; therefore it all had to be done based on priority. The patient was placed on the monitor, while I started the IV. I drew the patient’s blood, awaiting orders from the OB resident. Per unit policy, Nurses cannot send blood work to the lab without an written order from the Physician. The blood work was drawn by me and I was awaiting orders from the physician. While completing all procedures necessary for the patient I continued to call for the MD to write the order for the blood work. At that time, the OB physicians were on rounds. When the MD finally wrote the order in the computer, the blood work was then sent in to the lab. This was not done late, but done immediately after orders were received from the physician, as per hospital policy.

 As with any type of elective surgery, While prepping the patient for the OR it is not unusual for a STAT or emergency case to come in and bump a scheduled case from going forward; therefore we always wait until the team is ready and we have confirmation that the patient will be going to the OR before starting the Antibiotics. This particular patient had not yet been seen by the OB resident and therefore had not yet signed the not consent.

 I am not responsible for consenting the patients, and in fact cannot obtain a consent without the physician. If a patient has not been consented by the physician, I cannot administer antibiotics or other medication for surgery.

 Usually the Anesthesia team is responsible for starting the second IV for surgery. The SRNA student who reported me to the Dr. T (the lead Anesthesiologist) tried twice to start the IV but was unsuccessful. The patient was unhappy and I had to go back and restart both IVs, which I did successfully, however, this resulted in me being behind in completing the process.

In reference to the blood glucose not being done, the blood glucose was done and was within normal range. See PDF File , p. 44

 In reference to the patient being transferred to the floor with IV fluid infusing per blood tubing, this act was done by the Anesthesia team not done by the nurse. This IV fluid was in fact a continuation of initial fluid hung by the anesthesiologist from the OR. It was still running when the patient was transferred. See PDF file, p. 64

 In reference to the patient in need of peri-care; Peri-care was given prior to transferring the patient to the post-partum unit. During the transfer from the stretcher to the bed there is often some blood that has gathered in the vagina that may ooze out from the vagina. I know that I always give peri-care to my patients prior to transfer, that is my habit and practice and this patient was not different.

 In reference to the report of poor communication skills by the student SRNA, all I can say is that this student came in with major deficiencies. He was unable to start a good IV and made the patients restless and unhappy. Instead of assisting me in checking the vitals while I was starting the IV which he was unable to do, he continued to question me on other things that were not yet completed. He could have assisted the nurse (me) while I was doing what he was unable to do. Instead he made the already complicated situation more stressful by reporting me to his chief. This action on his part was the easiest thing she could do to avoid ridicule from her chief, Dr. T, who is very strict and often impatient with the students.

 For a bit of background on the relationship between me and Dr. T (lead Anesthesiologist):

 Because the infection rate increased in our unit, all nurses were told to follow a strict dress code in the operating room. This meant that no one was allowed to wear clothing that is worn outside, including OR head gear. I am sure we have all seen staff from an OR wearing OR clothing/uniforms, sometimes even booties, outside the OR and then think they can just walk back into the OR with the same clothing/uniform/booties that they have worn outside. One day Dr. T came into the OR not properly attired according to our dress code. He came in wearing OR headgear which we are not allowed to do. I offered him new OR head gear that was appropriate for the OR and he became angry at me for causing him maybe to be embarrassed regarding his head gear. Since then, Dr. T began to report me for everything that went on in the OR. He carries a lot of pull on our unit and no one crosses him or questions him. At times, nurses may complain about Dr T, but we are told by the Managers, to simply “do whatever he wants to keep the peace”. I did not intend to offend Dr. T but was simply implementing a directive from my Nurse Manager for the safety of the patients.

 In closing I would like to ad that Nursing is a profession where if someone in your work environment is out to get you they can make in possible to negatively impact a person’s job. With regard to the reported offenses in the documents that we have received, I was never once taken to peer review, I have never been written up due to a patient complaint, and a week or two before being asked to resign I was given an award/ certificate for High Quality Care from Human Resources at the William Smith System, which was not in the personnel file that William Smith sent to the BON. Each of the offenses listed for this investigation were based on circumstances that were not completely of my doing or under my total control, and/or, at least in my opinion, were not warranted for write ups. I do feel I have been targeted, but will continue always to strive to be a great nurse.

 I do take responsibility for my nursing care, I think that I give good care to my patients, I try the very best I can.

Thank you for listening to me.

Susan G

 These allegations above never resulted in any Peer Review, and did not a result in patient harm, nor patient or family complaints. I feel that I have been a victim of bullying, or of singling out for criticism on my unit. As seen on my resume, I worked at William Smith for over twenty years, delivering care to thousands of patients.

 I hope that the Board will view this investigation as one that can be resolved and closed with no further action.

 Please call me at xxx-xxx-xxxx, or e mail me at susang@xxxx.com to confirm you have received this response and attachments.

 Very truly yours,