

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse § AGREED
License Number 569976 §
issued to ABEL LABRE ABAD § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of ABEL LABRE ABAD Registered Nurse License Number 569976, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal conference, notice and hearing, and agreed to the entry of this Order offered on July 8, 2008, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

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.
2. Respondent waived representation by counsel, informal conference, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas.
4. Respondent received a Baccalaureate Degree in Nursing from Quezon City Medical Center and Colleges, Quezon City, Philippines, in March 1982. Respondent was licensed to practice professional nursing in the State of New York on April 10, 1991, and was licensed to practice professional nursing in the State of Texas on June 18, 1991.
5. Respondent's nursing employment history includes:

04/1991	Staff Nurse	Brookdale Hospital New York, New York
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Respondent's nursing employment history continued:

1991	Charge Nurse	Sharpstown General Hospital Houston, Texas
10/1991 - 01/1992	Staff Nurse	Memorial Hermann Southwest Memorial Hospital Houston, Texas
02/1992	Unknown	
03/1992 - 05/1993	Staff Nurse	Sunbelt Regional Medical Center Channelview, Texas
06/1993	Unknown	
07/1993 - 11/2000	Charge Nurse	Bellaire Hospital Bellaire, Texas
12/2000	Unknown	
01/2001 - 03/2006	Charge Nurse	Christus St. Joseph Hospital Houston, Texas
04/2006 - Present	Unknown	

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Charge Nurse with Christus St. Joseph Hospital, Houston, Texas, and had been in this position for five (5) years.
7. On or about January 2, 2006, while employed as a Charge Nurse with Christus St. Joseph Hospital, Houston, Texas, Respondent failed to insure the safety of Patient Number 116-23-87. The patient had been hostile, intrusive, and aggressive towards peers and staff, which resulted in a physical altercation with another patient, so for the protection of the patient and peers, the physician placed the patient on one to one (1:1) observation on January 1, 2006. The next day the physician noted at 1045 hours that the patient continued to be quite intrusive and ordered (1:1) observation to be continued until the night shift. Even though Respondent documented during the day shift on January 2, 2006, that the patient continued to be disruptive, he let the patient go to the patio accompanied by a staff person to smoke a cigarette, without having obtained an order to have the patient's level of care changed. Respondent's failure to follow physician's orders exposed the patient unnecessarily to a risk of harm.

8. On or about February 16, 2006, while employed as a Charge Nurse with Christus St. Joseph Hospital, Houston, Texas, Respondent failed to provide a safe environment for patients in that he left the medication room unlocked and unattended. When the Administrative Director visited the unit, she found the medication room door "wide open" and there was no staff in the immediate area. A staff person's purse was on the counter and a bottle of Maalox and medical items were readily available. It was "several minutes" before Respondent appeared. Respondent was unable to shut and lock the door because he did not have the keys and he did not know where they were, had not seen the keys the entire shift, and had taken no action to secure the keys. About thirty (30) minutes later, Respondent located the keys in a desk drawer. Respondent's conduct created an unsafe environment and unnecessarily exposed the patients to risk of injury.
9. On or about February 27, 2006, while employed as a Charge Nurse with Christus St. Joseph Hospital, Houston, Texas, Respondent failed to transcribe an order to discontinue Depakote in the medical record of Patient Number 100-61-44, who was diagnosed with Schizophrenia. Consequently, the patient erroneously received Depakote at 2100 hours that evening. When Respondent realized the error, he failed to notify the physician, failed to initiate a medication error report form, and failed to notify the supervisor. Instead, Respondent handed the physician's order to the night nurse and instructed her to pass along the order to the Medication Nurse and the Charge Nurse scheduled to work the following day shift. Respondent's conduct was likely to injure the patient in that failure to note and implement physicians' orders could have resulted in non-efficacious treatment.
10. In response to the incidents in Findings of Fact Numbers Seven (7) through Nine (9), Respondent states that per his review of the patient's record, and per report from the Charge Nurse, the patient was allowed to go smoke on both the 3-11 shift and the night shift. According to Respondent, the following morning he sent the patient with an escort to have diagnostic procedures performed, which were completed without incident, so during the designated smoke time Respondent let the patient smoke with an escort, "just like the previous shifts had done." Respondent asserts that as a prudent nurse, patient safety is a priority for him and he would not in any way "knowingly compromise that," and adds that it is unfortunate that there is inconsistent enforcement of policies in the facility. Respondent states that two units were sharing the medication room and narcotic keys at the time of the incident on February 16, 2006. According to Respondent, the medication room back door had been locked during the night, but a physician obtained his prescription pads from the medication room at the same time Respondent went to the restroom and may have left the door open. Respondent asserts that when the Administrative Director asked for the key, he had assumed that because the 3-11 shift did not give the key to him, it was in the medication cart, where it was usually kept; however, the key was not in the cart and after searching for the key it was located in the Nurses' Station drawer. Respondent further asserts that the medications were counted and all were accounted for. Respondent states that while he was working the 3-11 shift on February 28, 2006, he reviewed charts before the end of shift, as was his custom, and noticed that a physician's order had not been "carried out," so he immediately faxed it to the Pharmacy, made a copy of the missed order, handed the original

Physician's Order to the Medication Nurse, who customarily makes the necessary changes in the MAR, and proceeded to give report to the oncoming shift. Respondent asserts he made "special mention" of the missed order and "his interventions" to the oncoming RN and then proceeded to the Open Adult Unit where he was the Charge Nurse for the 11-7 shift, but did not call the physician to report the medication error or initiate a variance report because of "time restraints." Moreover, since he had given report to the oncoming nurse, he expected she would have followed up.

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 violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§ 217.11(1)(A),(1)(B),(1)(C), (1)(D),(1)(M)&(1)(P) and 217.12(1)(A),(1)(B)&(4).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 569976, heretofore issued to ABEL LABRE ABAD, including revocation of Respondent's license to practice professional nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS, and RESPONDENT SHALL 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.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate licensure privilege, if any, to practice nursing in compact states.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to ABEL LABRE ABAD, to the office of the Texas Board of Nursing within ten (10) days from the date of ratification of this Order for appropriate notation.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) contact 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 Chemical Dependency, and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Information regarding Board-approved courses in Texas Nursing Jurisprudence may be found at the Board's website Board-approved courses may be found*

at the following Board website address:

<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. 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. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*

<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete 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 program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address:*
<http://www.learningext.com/products/generalce/critical/ctabout.asp>.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(5) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT

SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(6) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(7) RESPONDENT SHALL be supervised by a Registered 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 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.

(8) 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 Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license and multistate licensure privileges, if any, to practice nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, 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 Board. When this Order is ratified, the terms of this Order become effective, and 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 revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 10 day of September, 2008.

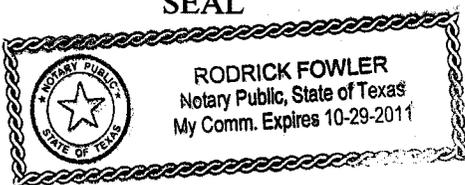
Abel Abad

ABEL LABRE ABAD, Respondent

Sworn to and subscribed before me this 10th day of September, 2008.

Rodrck Fowler

Notary Public in and for the State of TEXAS



WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the day of 10th day of September, 2008, by ABEL LABRE ABAD, Registered Nurse License Number 569976, and said Order is final.

Effective this 23rd day of October, 2008.



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

