BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 667010	§	
and Vocational Nurse	§	
License Number 141930	§	
issued to FREDERICK D. SPENCER	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of FREDERICK D. SPENCER, Registered Nurse License Number 667010 and Vocational Nurse License Number 141930, 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 proceedings, notice and hearing, and agreed to the entry of this Order offered on June 3, 2012, by Katherine A. Thomas, MN, RN, FAAN, 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(s).

2. Respondent waived representation by counsel, informal proceedings, 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 and his vocational license is in delinquent status.

4. Respondent received a Certificate in Vocational Nursing from Baptist Memorial Hospital, San Antonio, Texas, on February 19, 1993, and received an Associate Degree in Nursing from San Antonio College, San Antonio, Texas, on October 1, 1999. Respondent was licensed to practice vocational nursing in the State of Texas on May 25, 1993, and was licensed to practice professional nursing in the State of Texas on February 15, 2000.

5. Respondent's nursing employment history includes:

1993-1995	Unknown	
1996-1997	LVN Charge Nurse	Memorial Medical Nursing Home San Antonio, Texas
1997-1998	LVN Home Health	Home Town Home Health San Antonio, Texas
1998-2000	LVN Level II	Compass Hospital San Antonio, Texas
2000-2001	RN Charge Nurse	Compass Hospital San Antonio, Texas
2001-2003	RN Level III Dialysis Nurse	Metropolitan Hospital Dialysis Unit San Antonio, Texas
2003-2007	RN Level V Dialysis Nurse	Metropolitan Hospital Dialysis Unit San Antonio, Texas
2007-2008	RN Charge Nurse Dialysis Nurse	Davita at Marymont Dialysis Center San Antonio, Texas
10/2008-1/2011	RN Staff Nurse	Northeast Methodist Hospital Live Oak, Texas
2/2011-Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a RN Staff Nurse with Northeast Methodist Hospital, Live Oak, Texas, and had been in this position for two (2) years and three (3) months.

7. On or about April 12, 2010, while employed with Northeast Methodist Hospital, Live Oak, Texas, Respondent failed to appropriately intervene for Patient Medical Record Number V00245852, when he received a critical potassium value report from the laboratory. Respondent accepted the test results because the patient's primary nurse was not available at that time but then failed to inform the patient's physician, instead Respondent wrote a note on a sticky note and place it on the patient's chart. Consequently, the patient's primary nurse was not aware of the critical value for several hours. Respondent's conduct exposed the patient unnecessarily to risk of harm from ineffective treatment which could result in a delay in the patient's recovery and was likely to deceive subsequent care givers who relied on the information while providing care to the patient.

8. On or about December 20, 2010, and December 21, 2010, while employed with Northeast Methodist Hospital, Live Oak, Texas, Respondent failed to note and follow physician orders in a timely manner for two patients assigned to his care. Respondent's conduct exposed the patients unnecessarily to risk of harm from ineffective treatment which could result in a delay in the patient's recovery.

9. On or about January 9, 2011, while employed with Northeast Methodist Hospital, Live Oak, Texas, Respondent failed to assess, intervene, or appropriately document for Patient Medical Record Number V00363915, after the patient suffered a fall. While Respondent was on a break, and his assigned patients were being watched by another staff nurse, Patient Medical Record Number V00363915 fell while attempting to self transfer. Respondent received report from the staff nurse that she and the Charge Nurse had assisted the patient up and found no injuries. Respondent assumed that the other nurse would complete the required documentation and so he did not and Respondent failed to reassess the patient or put in place interventions to ensure the patient's safety upon his return to his assignment. Respondent's conduct resulted in an incomplete medical record and exposed the patient unnecessarily to a risk of harm in that subsequent care givers would rely on his documentation to provide further care.

10. On or about January 14, 2011, while employed with Northeast Methodist Hospital, Live Oak, Texas, Respondent failed to note and follow physician orders for Medical Record Number V00127757 and failed to assess or document an assessment of the patient through out his shift. Respondent's conduct resulted in an incomplete medical record and exposed the patient unnecessarily to a risk of harm in that subsequent care givers would rely on his documentation to provide further care.

11. In response to Findings of Fact Numbers Seven (7), through Ten (10), Respondent states he took the call from the lab stating to them that he was not the patient's primary nurse, but that he would take the information and pass it on to the nurse caring for the patient. Respondent states that he wrote the information down and when he had to leave the nurses station he put the information on the other nurses BRAIN and on the patient's chart so she would not miss it when she returned to the station. The next day, Respondent states, he was told that he should have called the patient's physician because he took the call from the lab. Regarding not noting the physicians order, Respondent states that when he was told about this he realized that the physician had written the order and put the chart back in the rack rather than on the chart rack for pending orders. Respondent states that it had not been his practice to pull all his charts at the end of his shift to make sure he had not missed any orders, but that he now does. Respondent states, regarding the patient who fell, Respondent states he went to see the patient and re-assessed and made sure she was alright. Respondent states that he had understood that whoever found a patient who had fallen completed the incident report. Regarding MR#V00127757, Respondent states that the physician came in while report was being done at 0630 and wrote orders on the patient's paper chart and racked the chart in the wrong place, not in the rack for pending orders, and did not let anyone know she had been there. Respondent states that at 1330 he saw on the electronic record an acknowledge icon

lit up for new orders so he opened the file and checked the orders and checked for lab results from the ordered labs. Respondent states that the lab results were not posted so he called the physician to inform her that the labs she had ordered had not been posted yet. Respondent states that it was at that time he learned that she had written the orders at 0630 that morning.

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)(D),(1)(M)& (3)(A) and 217.12(1)(B),(1)(C)&(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 667010 and Vocational Nurse License Number 141930, heretofore issued to FREDERICK D. SPENCER, including revocation of Respondent's license(s) to practice 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, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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

IT IS FURTHER AGREED that:

(1) 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) 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. 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. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in physical assessment. RESPONDENT SHALL obtain Board approval of the

course prior to enrollment. 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. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of twenty-four (24) hours. The clinical component SHALL focus on tasks of physical assessment only and shall be provided by the same Registered Nurse who provides the didactic portion of this course. To be approved, the course shall cover all systems of the body. Performing assessments on mock patients or mannequins WILL NOT be accepted. 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.texas.gov/disciplinaryaction/stipscourses.html.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. 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. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of

recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office 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.texas.gov/disciplinaryaction/stipscourses.html.*

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(S) 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) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(4) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). 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(s). 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.

(5) 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.

(6) RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

(10) 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 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, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT shall 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 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(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 25th day of June, 2012.

FREDERICK D. SPENCER, Respondent

Sworn to and subscribed before me this 25 day of June, 2012.

SEAL
SUSAN MCREE
Notary Public, State of Texas
My Commission Expires
March 24, 2015

Susan McRee

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 25th day of June, 2012, by FREDERICK D. SPENCER, Registered Nurse License Number 667010 and Vocational Nurse License Number 141930, and said Order is final.

Effective this 14th day of August, 2012.

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