WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

BETH S. DITTMANN,
HOLLY A. MEIER,
RESPONDENTS.

FINAL DECISION
AND ORDER
Case No. LS-9601182-NUR

PARTIES

The parties in this matter under § 227.44, Stats., and for purposes of review under § 227.53, Stats., are:

Beth S. Dittmann, R.N.
9 Lori Court
Waupun, Wisconsin 53963

Holly A. Meier, R.N.
605 N. Lockin Street
Brandon, Wisconsin 53919

Board of Nursing
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation & Licensing
P.O. Box 8935
Madison, Wisconsin 53708

This matter was commenced by the filing of a Notice of Hearing and Complaint on January 18, 1996. Respondents' Answer was filed on February 12, 1996. A hearing was held on June 18, 1996. Atty. James E. Polewski appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Nurses Dittmann and Meier appeared in person and by their attorneys, Helen Marks Dicks and Karl Kliminski, Boushea, Segall & Joanis. Legal briefs were filed by the parties in July and August 1996. The hearing was closed on August 5, 1996.

The administrative law judge filed her Proposed Decision in the matter on February 11, 1997. Ms. Dicks filed Respondents' Objections to the Proposed Decision on February 26, 1997, and Mr. Polewski filed his Response to Respondents' Objections on March 5, 1997. The board considered the matter at its meeting of May 1, 1997.

Based upon the entire record herein, the Board of Nursing makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Beth S. Dittmann, R.N., d.o.b., 12/13/63, is licensed to practice as a registered nurse in the state of Wisconsin pursuant to license 88411, which was granted on August 21, 1984. Her most recent address known to the Department of Regulation and Licensing is 9 Lori Court, Waupun, WI 53963.

2. Holly A. Meier, R.N., d.o.b., 12/8/55, is licensed to practice as a registered nurse in the state of Wisconsin pursuant to license 94891, which was granted on August 22, 1986. Her most recent address known to the Department of Regulation and Licensing is 605 N. Lockin Street, Brandon, Wisconsin 53919.

3. On September 8, 1990 and September 9, 1990, Nurse Dittmann and Nurse Meier were employed as registered nurses at Waupun Correctional Institution, Waupun, Wisconsin. Nurses Dittmann and Meier were assigned to the Health Services Unit. Nurse Dittmann worked during the 6:30 a.m., to 6:30 p.m., shift. Nurse Meier worked during the 6:30 p.m., to 7:00 a.m., shift.

4. In September 1990, DW was an inmate at the Institution. He was 35 years old; had a history of "HIV positivity" and a history of psychiatric problems. At approximately 6:00 p.m., on September 8, 1990, he was placed in a segregated area in the Institution called the Adjustment Center. Leather restraints were placed on his wrists, ankles, and across thighs and chest.

5. In September 1990, the Institution had a policy in effect which required that an inmate placed in restraints be checked by a nurse initially and every 8 hours thereafter.

6. At approximately 6:15 p.m., Nurse Dittmann was called to check the restraints which had been placed on DW by security officers. When she arrived at the cell where DW was confined, she observed that he was lying on his back, on a bed. Leather restraints were placed on his wrists, ankles, and across his thighs and chest. An officer was kneeling at DW's head, with a towel placed across DW's mouth which the officer held at both ends.

7. At approximately 6:25 p.m., while checking the restraints, Nurse Dittmann spoke to DW, but he did not respond. She determined that DW's hands, feet, chest and neck were warm to the touch and that his pulse was palpable. She felt his chest rising and falling. She observed that his eyes were partially open and that he did not move, except to breathe. She did not observe any bruising or cuts on DW or anything out of the normal. She determined that one restraint was too loose and informed the security officers who were present in DW's cell. After the restraint was readjusted, she checked it again and found it to be adequate. She existed the cell where DW was confined and went to a workstation in the Adjustment Center to chart her findings.

8. While charting her findings relating to DW, a security supervisor in the Adjustment Center informed Nurse Dittmann that DW's eyes had closed and asked her if she wanted to recheck him. Nurse Dittmann went back into DW's cell, placed her hand on his chest and called him by name. She determined that his chest was rising and falling and that he had a nice strong carotid pulse. She then left the cell and returned to her workstation at the Health Services Unit, where she informed Holly Meier, the relief nurse, that she had checked DW's restraints and that he did not respond to her verbally. She left the Institution at approximately 6:30 p.m.

9. At the time of Nurse Dittmann's visits to DW's cell, he did not move, except to breathe, and he did not respond to her verbal stimulation.

10 Nurse Dittmann did not conduct a complete neurological assessment of DW's physical condition at the time of her contacts with him, in that she failed to employ tactile and painful stimulation to assess his neurological status.

11. At approximately 2:00 a.m., on September 9, 1990, Nurse Meier entered the cell in which DW was restrained, and checked the restraints which had previously been applied.

12. At the time Nurse Meier checked DW's restraints, she asked him how he was doing. DW did not respond to her and did not move, except to breathe. She checked DW's pulse on his feet and wrists and also capillary refill time. She documented that his eyes were partially open; his breathing seemed very shallow; that when checking his breathing with a stethoscope she heard "faint breath sounds", and that he had some rigidity in his left hand. She existed DW's cell; went to a workstation in the Adjustment Center to chart her findings; left the around 2:10 a.m., and returned to the Health Services Unit, where she did some research on catatonia.

13. At some point in time after returning to the Health Services Unit, Nurse Meier spoke with Sgt. Kuske, who was stationed at the sergeant's desk in the Adjustment Center, to find out whether DW was breathing and whether he had changed position since her 2:00 a.m., check. Sgt. Kuske informed Nurse Meier that DW had not changed position since her 2:00 a.m., check.

14. At approximately 3:33 a.m., on September 9, 1990, Nurse Meier returned to the cell in which DW was restrained to assess his medical condition. She took along an emergency bag, a penlight and some ammonia capsules. Upon examination of DW, Nurse Meier determined that his head was cold and stiff, his pupils were fixed and dilated and that he did not have a pulse. She and a security officer commenced CPR which each performed for about 15 minutes. Nurse Meier continued to check compressions until DW was placed in an ambulance. At 4:05 a.m., on September 9, 1990, DW was pronounced dead.

15. Nurse Meier did not conduct a complete neurological assessment of DW's physical condition at the time she checked his restraints, in that she failed to employ tactile and painful stimulation to assess his neurological status.

16. It is below the standards of the profession for a registered nurse to fail to conduct a complete neurological assessment of a patient who is non-responsive to verbal stimulation, and in failing to do so, Nurses Dittmann and Meier exposed DW to a risk of harm to which a minimally competent nurse would not expose a patient, including, if unconscious, the possibility of DW causing harm to himself, and the possibility of DW being deprived of prompt medical attention.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to s. 441.07 (1), Wis. Stats.

2. Nurse Beth Dittmann's failure to conduct a complete neurological assessment of DW as described in Findings of Fact 6-10 and 16 herein, was below the minimum standards of the profession of a professional nursing; exposed DW to a risk of harm to which a minimally competent nurse would not expose a patient, and constituted practice which violated the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient, in violation of s. N 6.03 (1) and N 6.05, Code.

3. Nurse Holly Meier's failure to conduct a complete neurological assessment of DW as described in Findings of Fact 11-16 herein, was below the minimum standards of the profession of professional nursing; exposed DW to a risk of harm to which a minimally competent nurse would not expose a patient, and constituted practice which violated the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient, in violation of s. N 6.03 (1) and N 6.05, Code.

4. There is insufficient evidence in the record to establish by a preponderance of the evidence that the conduct of Nurse Dittmann and Nurse Meier in failing to conduct a complete neurological assessment of DW or to obtain medical attention for DW in a timely manner, constituted negligence, under s. 441.07 (1)(c), Stats., or s. N 7.03 (1), Code.

ORDER

NOW, THEREFORE, IT IS ORDERED, that the licenses of respondents Beth Dittmann and Holly Meier to practice as registered nurses in the state of Wisconsin be, and hereby are, suspended for a period of not less than 30 days.

IT IS FURTHER ORDERED that the licenses of respondents Dittmann and Meier be, and hereby are, LIMITED for an INDEFINITE period of time as follows:

(1) Limitations and Conditions

(a) Respondents shall, within 90 days of the effective date of this Order, participate in an evaluation of their knowledge and skills in the area of nursing assessment conducted by an individual approved in advance by the Board. The evaluator shall consider and render an opinion as to whether respondents are capable of practicing with skill and safety to patients and the public, and whether any training is necessary to permit them to do so. If the evaluator identifies deficiencies in respondents' knowledge and skills in the area of nursing assessment, respondents shall participate in and successfully complete, in a timely manner, any training recommended by the evaluator. Such training shall be pre-approved by the Board. Until the evaluator certifies to the Board that such deficiencies have been corrected, respondents may not engage in nursing practice, except under the general supervision of a licensee approved in advance by the Board.

(b) Within six (6) months of the effective date of this Order, each respondent shall certify to the Board the successful completion of 30 hours of professional nursing education in the areas of nursing assessment, planning, intervention and evaluation, which shall be pre-approved by the Board. Respondents shall submit course outlines for approval by a Board designee within 30 days of the effective date of this Order. The outlines shall include the name of the institution (s) providing the instruction, the name of the instructor (s), and a summary of the course content.

(c) Respondents shall be responsible for all costs associated with the completion of the evaluations, training and educational coursework required under paragraph (a) and (b) above.

(2) Petition for Modification of Terms

Respondents may petition the Board at any time for modification of the above conditions. Denial in whole or in part of a petition under this paragraph shall not constitute denial of a license and shall not give rise to a contested case, as defined in ch. 227, Stats.

(3) Petition for Removal of Limitations

Upon a showing by respondents of complete, successful and continuous compliance for a period of one (1) year with the limitations and conditions set forth in paragraph (1) above, the Board may grant a petition by respondents for return of full licensure if it determines that respondents may safely and competently engage in practice as registered nurses.

IT IS FURTHER ORDERED that pursuant to s. 440.22, Stats., the cost of this proceeding shall be, and hereby is, assessed against respondents Beth Dittmann and Holly Meier.

This order is effective on the date on which it is signed by the Board of Nursing.

EXPLANATION OF VARIANCE

The board has accepted the Findings of Fact and Conclusions of Law proposed by the administrative law judge in their entirety. The board has modified the recommended order, however, in two particulars. First, the board has reduced the period of suspension of the licenses from 90 days to 30 days. Based upon the accepted disciplinary considerations of rehabilitation, deterrence, and public protection, and in light of the fact that seven years have passed since the conduct in question without apparent incident, an extended suspension of the licenses is deemed by the board to be inappropriate.

The second modification to the proposed discipline is to remove the requirement that respondents submit the names of three proposed evaluators and three proposed practice supervisors, and require simply that the persons carrying out those responsibilities be approved in advance by the board. This simplification of the process may serve to facilitate compliance with the order.

Dated this 9th day of May, 1997.

STATE OF WISCONSIN BOARD OF NURSING

by Timothy D. Burns CRNA
Timothy D. Burns, RN
Chairman

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STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING
BEFORE THE BOARD OF NURSING

In the Matter of the Disciplinary Proceedings Against

Beth S. Dittman,
Holly A. Meier,

AFFIDAVIT OF MAILING

Respondents.

STATE OF WISCONSIN)
)
COUNTY OF DANE)

I, Kate Rotenberg, having been duly sworn on oath, state the following to be true and correct based on my personal knowledge:

1. I am employed by the Wisconsin Department of Regulation and Licensing.

2. On May 13, 1997, I served the Final Decision and Order dated May 9, 1997, LS9601182NUR, upon the Respondents Beth S. Dittman and Holly A. Meier's attorney by enclosing a true and accurate copy of the above-described document in an envelope properly stamped and addressed to the above-named Respondents' attorney and placing the envelope in the State of Wisconsin mail system to be mailed by the United States Post Office by certified mail. The certified mail receipt number on the envelope is P 201 374 232.

Helen Marks Dicks, Attorney
124 W. Broadway, Suite 100
Monona WI 53716-3902

Kate Rotenberg

Kate Rotenberg
Department of Regulation and Licensing
Office of Legal Counsel

Subscribed and sworn to before me

this 13th day of May, 1997.

John Schweitzer

Notary Public, State of Wisconsin
My commission is permanent.

NOTICE OF APPEAL INFORMATION

Notice Of Rights For Rehearing Or Judicial Review. The Times Allowed For Each. And The Identification Of The Party To Be Named As Respondent.

Serve Petition for Rehearing or Judicial Review on:

STATE OF WISCONSIN BOARD OF NURSING

1400 East Washington Avenue
P.O. Box 8935
Madison. WI 53708.

The Date of Mailing this Decision is:

May 13, 1997

1. REHEARING

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

A petition for rehearing should name as respondent and be filed with the party identified in the box above.

A petition for rehearing is not a prerequisite for appeal or review.

2. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in sec. 227.53, *Wisconsin Statutes* a copy of which is reprinted on side two of this sheet. By law, a petition for review must be filed in circuit court and should name as the respondent the party listed in the box above. A copy of the petition for judicial review should be served upon the party listed in the box above.

A petition must be filed within 30 days after service of this decision if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30-day period for serving and filing a petition commences on the day after personal service or mailing of the decision by the agency, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing this decision is shown above.)

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	NOTICE OF FILING PROPOSED DECISION LS9601182NUR
BETH S. DITTMANN, R.N., and HOLLY MEIER, R.N., RESPONDENTS.	:	

TO: Helen Marks Dicks, Attorney
Boushea, Segall & Joanis
124 West Broadway, Suite 100
Monona, WI 53716-3902
Certified # P 213 340 403

James E. Polewski, Attorney
Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708

PLEASE TAKE NOTICE that a Proposed Decision in the above-captioned matter has been filed with the Board of Nursing by the Administrative Law Judge, Ruby Jefferson-Moore. A copy of the Proposed Decision is attached hereto.

If you have objections to the Proposed Decision, you may file your objections in writing, briefly stating the reasons, authorities, and supporting arguments for each objection. If your objections or argument relate to evidence in the record, please cite the specific exhibit and page number in the record. Your objections and argument must be received at the office of the Board of Nursing, Room 174, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, on or before February 20, 1997. You must also provide a copy of your objections and argument to all other parties by the same date.

You may also file a written response to any objections to the Proposed Decision. Your response must be received at the office of the Board of Nursing, no later than seven (7) days after receipt of the objections. You must also provide a copy of your response to all other parties by the same date.

The attached Proposed Decision is the Administrative Law Judge's recommendation in this case and the Order included in the Proposed Decision is not binding upon you. After reviewing the Proposed Decision, the Board of Nursing will issue a binding Final Decision and Order.

Dated at Madison, Wisconsin this 11th day of February, 1997.

Ruby Jefferson-Moore
Ruby Jefferson-Moore
Administrative Law Judge

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

PROPOSED DECISION

Case No. LS-9601182-NUR

BETH S. DITTMANN,
HOLLY A. MEIER,
RESPONDENTS.

PARTIES

The parties in this matter under § 227.44, Stats., and for purposes of review under § 227.53, Stats., are:

Beth S. Dittmann, R.N.
9 Lori Court
Waupun, Wisconsin 53963

Holly A. Meier, R.N.
605 N. Lockin Street
Brandon, Wisconsin 53919

Board of Nursing
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation & Licensing
P.O. Box 8935
Madison, Wisconsin 53708

This matter was commenced by the filing of a Notice of Hearing and Complaint on January 18, 1996. Respondents' Answer was filed on February 12, 1996. A hearing was held on June 18, 1996. Atty. James E. Polewski appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Nurses Dittmann and Meier appeared in person and by their attorneys, Helen Marks Dicks and Karl Kliminski, Boushea, Segall & Joanis. Legal briefs were filed by the parties in July and August 1996. The hearing was closed on August 5, 1996.

Based upon the record herein, the Administrative Law Judge recommends that the Board of Nursing adopt as its final decision in this matter, the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Beth S. Dittmann, R.N., d.o.b., 12/13/63, is licensed to practice as a registered nurse in the state of Wisconsin pursuant to license 88411, which was granted on August 21, 1984. Her most recent address known to the Department of Regulation and Licensing is 9 Lori Court, Waupun, WI 53963.

2. Holly A. Meier, R.N., d.o.b., 12/8/55, is licensed to practice as a registered nurse in the state of Wisconsin pursuant to license 94891, which was granted on August 22, 1986. Her most recent address known to the Department of Regulation and Licensing is 605 N. Lockin Street, Brandon, Wisconsin 53919.

3. On September 8, 1990 and September 9, 1990, Nurse Dittmann and Nurse Meier were employed as registered nurses at Waupun Correctional Institution, Waupun, Wisconsin. Nurses Dittmann and Meier were assigned to the Health Services Unit. Nurse Dittmann worked during the 6:30 a.m., to 6:30 p.m., shift. Nurse Meier worked during the 6:30 p.m., to 7:00 a.m., shift.

4. In September 1990, DW was an inmate at the Institution. He was 35 years old; had a history of "HIV positivity" and a history of psychiatric problems. At approximately 6:00 p.m., on September 8, 1990, he was placed in a segregated area in the Institution called the Adjustment Center. Leather restraints were placed on his wrists, ankles, and across thighs and chest.

5. In September 1990, the Institution had a policy in effect which required that an inmate placed in restraints be checked by a nurse initially and every 8 hours thereafter.

6. At approximately 6:15 p.m., Nurse Dittmann was called to check the restraints which had been placed on DW by security officers. When she arrived at the cell where DW was confined, she observed that he was lying on his back, on a bed. Leather restraints were placed on his wrists, ankles, and across his thighs and chest. An officer was kneeling at DW's head, with a towel placed across DW's mouth which the officer held at both ends.

7. At approximately 6:25 p.m., while checking the restraints, Nurse Dittmann spoke to DW, but he did not respond. She determined that DW's hands, feet, chest and neck were warm to the touch and that his pulse was palpable. She felt his chest rising and falling. She observed that his eyes were partially open and that he did not move, except to breathe. She did not observe any bruising or cuts on DW or anything out of the normal. She determined that one restraint was too loose and informed the security officers who were present in DW's cell. After the restraint was readjusted, she checked it again and found it to be adequate. She existed the cell where DW was confined and went to a workstation in the Adjustment Center to chart her findings.

8. While charting her findings relating to DW, a security supervisor in the Adjustment Center informed Nurse Dittmann that DW's eyes had closed and asked her if she wanted to recheck him. Nurse Dittmann went back into DW's cell, placed her hand on his chest and called him by name. She determined that his chest was rising and falling and that he had a nice strong carotid pulse. She then left the cell and returned to her workstation at the Health Services Unit, where she informed Holly Meier, the relief nurse, that she had checked DW's restraints and that he did not respond to her verbally. She left the Institution at approximately 6:30 p.m.

9. At the time of Nurse Dittmann's visits to DW's cell, he did not move, except to breathe, and he did not respond to her verbal stimulation.

10 Nurse Dittmann did not conduct a complete neurological assessment of DW's physical condition at the time of her contacts with him, in that she failed to employ tactile and painful stimulation to assess his neurological status.

11. At approximately 2:00 a.m., on September 9, 1990, Nurse Meier entered the cell in which DW was restrained, and checked the restraints which had previously been applied.

12. At the time Nurse Meier checked DW's restraints, she asked him how he was doing. DW did not respond to her and did not move, except to breathe. She checked DW's pulse on his feet and wrists and also capillary refill time. She documented that his eyes were partially open; his breathing seemed very shallow; that when checking his breathing with a stethoscope she heard "faint breath sounds", and that he had some rigidity in his left hand. She existed DW's cell; went to a workstation in the Adjustment Center to chart her findings; left the around 2:10 a.m., and returned to the Health Services Unit, where she did some research on catatonia.

13. At some point in time after returning to the Health Services Unit, Nurse Meier spoke with Sgt. Kuske, who was stationed at the sergeant's desk in the Adjustment Center, to find out whether DW was breathing and whether he had changed position since her 2:00 a.m., check. Sgt. Kuske informed Nurse Meier that DW had not changed position since her 2:00 a.m., check.

14. At approximately 3:33 a.m., on September 9, 1990, Nurse Meier returned to the cell in which DW was restrained to assess his medical condition. She took along an emergency bag, a penlight and some ammonia capsules. Upon examination of DW, Nurse Meier determined that his head was cold and stiff, his pupils were fixed and dilated and that he did not have a pulse. She and a security officer commenced CPR which each performed for about 15 minutes. Nurse Meier continued to check compressions until DW was placed in an ambulance. At 4.05 a.m., on September 9, 1990, DW was pronounced dead.

15. Nurse Meier did not conduct a complete neurological assessment of DW's physical condition at the time she checked his restraints, in that she failed to employ tactile and painful stimulation to assess his neurological status.

16. It is below the standards of the profession for a registered nurse to fail to conduct a complete neurological assessment of a patient who is non-responsive to verbal stimulation, and in failing to do so, Nurses Dittmann and Meier exposed DW to a risk of harm to which a minimally competent nurse would not expose a patient, including, if unconscious, the possibility of DW causing harm to himself, and the possibility of DW being deprived of prompt medical attention.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to s. 441.07 (1), Wis. Stats.

2. Nurse Beth Dittmann's failure to conduct a complete neurological assessment of DW as described in Findings of Fact 6-10 and 16 herein, was below the minimum standards of the profession of a professional nursing; exposed DW to a risk of harm to which a minimally competent nurse would not expose a patient, and constituted practice which violated the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient, in violation of s. N 6.03 (1) and N 6.05, Code.

3. Nurse Holly Meier's failure to conduct a complete neurological assessment of DW as described in Findings of Fact 11-16 herein, was below the minimum standards of the profession of professional nursing; exposed DW to a risk of harm to which a minimally competent nurse would not expose a patient, and constituted practice which violated the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient, in violation of s. N 6.03 (1) and N 6.05, Code.

4. There is insufficient evidence in the record to establish by a preponderance of the evidence that the conduct of Nurse Dittmann and Nurse Meier in failing to conduct a complete neurological assessment of DW or to obtain medical attention for DW in a timely manner, constituted negligence, under s. 441.07 (1)(c), Stats., or s. N 7.03 (1), Code.

ORDER

NOW, THEREFORE, IT IS ORDERED, that the licenses of respondents Beth Dittmann and Holly Meier to practice as registered nurses in the state of Wisconsin be, and hereby are, suspended for a period of not less than ninety (90) days.

IT IS FURTHER ORDERED that the licenses of respondents Dittmann and Meier be, and hereby are, LIMITED for an INDEFINITE period of time as follows:

(1) Limitations and Conditions

(a) Respondents shall, within 90 days of the effective date of this Order, participate in an evaluation of their knowledge and skills in the area of nursing assessment. The evaluation shall be conducted by an individual approved by the Board. The evaluator shall consider and render an opinion as to whether respondents are capable of practicing with skill and safety to patients and the public, and whether any training is necessary to permit them to do so. If the evaluator identifies deficiencies in respondents' knowledge and skills in the area of nursing assessment, respondents shall participate in and successfully complete, in a timely manner, any training recommended by the evaluator. Such training shall be pre-approved by the Board. Until the evaluator certifies to the Board that such deficiencies have been corrected, respondents may not in nursing practice, except under the general supervision of a licensee approved by the Board.

(b) Within 30 days of the effective date of this Order, respondents shall submit to the Board the names of 3 individuals who consent to evaluate their knowledge and skills in the area of nursing assessment, and the names of 3 individuals who consent to supervise their practice.

(c) Within six (6) months of the effective date of this Order, each respondent shall certify to the Board the successful completion of 30 hours of professional nursing education in the areas of nursing assessment, planning, intervention and evaluation, which shall be pre-approved by the Board. Respondents shall submit course outlines for approval by a Board designee within 30 days of the effective date of this Order. The outlines shall include the name of the institution (s) providing the instruction, the name of the instructor (s), and a summary of the course content.

(d) Respondents shall be responsible for all costs associated with the completion of the evaluations, training and educational coursework required under paragraph (a) and (c) above.

(2) Petition for Modification of Terms

Respondents may petition the Board at any time for modification of the above conditions. Denial in whole or in part of a petition under this paragraph shall not constitute denial of a license and shall not give rise to a contested case, as defined in ch. 227, Stats.

(3) Petition for Removal of Limitations

Upon a showing by respondents of complete, successful and continuous compliance for a period of one (1) year with the limitations and conditions set forth in paragraph (1) above, the Board may grant a petition by respondents for return of full licensure if it determines that respondents may safely and competently engage in practice as registered nurses.

IT IS FURTHER ORDERED that pursuant to s. 440.22, Stats., the cost of this proceeding shall be, and hereby is, assessed against respondents Beth Dittmann and Holly Meier.

This order is effective on the date on which it is signed by the Board of Nursing.

OPINION

The Complainant alleges that Nurses Dittmann and Meier are subject to discipline pursuant to s. 441.07 (1) (c), Stats., and s. N 7.03 (1) (a) and (c), N 6.03 (1) and N 6.05, Wis. Adm. Code. Nurses Dittmann and Meier deny violating these provisions.

APPLICABLE LAW

Misconduct or Unprofessional Conduct

Section N 6.03 (1) reads as follows: (1) GENERAL NURSING PROCEDURES. An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process:

> **(a) Assessment.** Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.
>
> **(b) Planning** Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis
>
> **(c) Intervention**. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.'s or less skilled assistants.
>
> **(d) Evaluation**. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.

Section N 6.05, Code states that a violation of the standards of practice constitutes unprofessional conduct or misconduct and may result in the board limiting, suspending, revoking or denying renewal of the license or in the board reprimanding an R.N., or L.P.N. [1]

Negligence

Section 441.07 (1) (c), Stats., states, in part, that the Board of Nursing may discipline a registered nurse if it finds that the nurse has committed: "Acts which show the registered nurse ... to be unfit or incompetent by reason of negligence ...."

Section N 7.03 (1), Code states, in part, that as used in s. 441.07 (1)(c), Stats., "negligence" means a substantial departure from the standard of care ordinarily exercised by a competent licensee. "Negligence" includes but is not limited to the following conduct:

> (a) Violating any of the standards of practice set forth in ch. N 6; [2]
>
> (c) Failing to observe the conditions, signs and symptoms of a patient, record them, or report significant changes to the appropriate person;

1. The term "misconduct or unprofessional conduct" is defined in s. N 7.04, Code to mean any practice or behavior which violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public. See also, s. 441 07 (1)(d), Stats.

2. The relevant standards of practice for registered nurses are set forth in N 6.03, Code.

EXPERT TESTIMONY

Denise Miller Lemke testified at the request of the Division of Enforcement. She has been a neurosurgical nurse clinician for the Medical College of Wisconsin and a practitioner at Froedtert Hospital in Milwaukee for 8 years. She works with a group of neurosurgeons and residents at a teaching hospital; provides patient family education; serves as the ethics representative for the physicians' medical quality assurance program and assesses patients in different clinical situations. She does not provide direct patient care. She obtained a B.S., degree from Carroll Columbia School of Nursing in 1989, and is enrolled at Marquette University in the master's program for adult nurse practitioners. She has practiced nursing for 18 years and is certified in neurosurgical nursing. *Tr. p. 57-58; 71-72.*

Nurse Miller Lemke testified that Nurses Dittmann and Meier's failure to perform a complete neurological assessment of inmate DW was below the minimum standards of the profession. Nurse Miller Lemke's opinion is based upon the fact that Nurses Dittmann and Meier acknowledged that DW was unresponsive to verbal stimulation, but they did not continue with the neurological assessment beyond that point. *Tr., p. 62,70; 82, lines 3-8; 90, lines 1-6; 98.*

According to Nurse Miller Lemke, a complete neurological assessment would have been important in determining DW's actual neurological status. A complete neurological assessment of a person who in unresponsive would start with verbal stimulation, then move on to the next level, which would be light pain and if the person still does not respond then move on to deep pain. Minimum standards of the profession require a nurse who is completing a neurological assessment to cover all these areas in order to fully assess a patient. *Tr., p. 61-62;103;105.*

In reference to the minimally acceptable nursing response to documentation that DW was not moving and was not responsive, Nurse Miller Lemke further stated, in part, that "When a person does not respond to verbal stimulation, .. the next step .. is .. giving them light stimulation or tactile stimulation, shaking them, tapping their chest, giving them some type of light pain. If they do not respond to that, you move on to give them noxious stimuli which is painful stimulation and there's different means of doing it. Whether it be a trapezius pinch, an ancillary pinch, or some type of pain, to see whether or not you can stimulate the cerebral cortex in responding to that input and see if they will then follow commands or do any type of neurological function for you". *Transcript p. 103.*

In reference to whether DW's failure to respond to verbal stimulation was voluntary or involuntary, Nurse Miller Lemke stated that if Nurses Dittmann and Meier knew that DW's failure to respond was voluntary there would not have been a need for them to continue with the neurological assessment beyond verbal stimulation. Nurse Miller Lemke testified that it is not acceptable practice to discontinue the assessment process before determining whether the patient's lack of response is voluntary, or to presume catatonic conditions without making a determination regarding a patient's level of function. *Transcript, p. 82, lines 13-21;105;117.*

Finally, Nurse Miller Lemke stated that the risk of harm in not knowing DW's actual neurological status is that "you don't have a full knowledge of what is going on with the patient. By him not responding, you don't know what is truly going on neurologically. He had not moved. He had not responded to her verbal stimulation. There is an unknown and the unknown could potentially be a risk for the patient". If the patient is unconscious, unable to protect himself or unaware of what is going on he may injure himself. The assessment lets you know whether or not the brain is receiving information correctly; whether the patient can protect himself, and whether or not you need to intervene. *Transcript. p. 62-63; 103-104.*

I. Misconduct or Unprofessional Conduct

BETH DITTMANN

The evidence presented establishes that, by failing to conduct a complete neurological assessment of DW, Nurse Dittmann engaged in conduct which fell below the minimum standards of the profession, in violation of s. N 6.03 (1) and N 6.05, Code.

A. Factual Overview

Beth Dittmann is a registered nurse. She worked as a nurse clinician at the Waupun Correctional Institution at least from 1988 to April 1995. In April, 1995, she became a nursing supervisor over the medical staff in the Health Services Unit at the facility.

On September 8, 1990, Nurse Dittmann was assigned to work the 6:30 a.m., to 6:30 p.m., shift. She was the only medical personnel on duty at that time. At or around 6:15 p.m., she received a call from an officer at the Institution who asked her to check restraints which had been placed on inmate DW. She said that her role in checking the restraints was to assure that the restraints were not placed on DW too tight, thereby causing a lack of circulation. *Ex. #5, p.11-12.*

Nurse Dittmann went to an area in the Institution, referred to as the Adjustment Center, where inmate DW had been confined to a cell. When she arrived at the cell where DW was confined, she observed that he was lying on his back, on a bed. He had leather restraints on both wrists, both ankles, across his thighs and across his chest. There was an officer kneeling at DW's head, with a towel placed across DW's mouth which the officer held at both ends. According to Nurse Dittmann, all of DW's clothes had been removed and a towel had been placed over the groin area. She said that:

> His chest was rising and falling. His skin was warm to the touch. I did not observe any bruising, any cuts, anything out of the normal.

Nurse Dittmann stated that she assessed all of the restraints by placing her finger under the restraints to check that they were loose enough. She checked pulses at his wrists and ankles. She assessed the leather strap that went across his legs to make sure she could freely place fingers under it, so it wasn't too tight. She checked the chest strap that was across his chest by putting her fingers under it. She said that she could feel his chest rise and fall and that she knew that he was breathing. She stated that she assumed that he was conscious because when she went in the cell his eyes were partially open, as if he was watching what she was doing. *Tr. p. 136; 154-157.*

Nurse Dittmann further testified that one restraint was too loose so she mentioned it while in the cell. She existed the cell so that security officers could readjust the restraint. After she was told that the restraint had been readjusted, she returned to the cell and checked the restraint again to see if there was an adequate amount of room under the restraint; if the pulse was still palpable and if he had good capillary refill, which she determined at that time was adequate. Thereafter, she existed the cell again and went to the sergeant's desk to fill out the "Observation of Inmate in Restraints" form.

While completing the form at the sergeant's desk, Nurse Dittmann said that Lt. Westfield, the security supervisor, stated to her that DW "has his eyes shut now. Do you want to check him again". She responded yes, indicating that she would check DW again. She went back into the cell where DW was being restrained. According to Nurse Dittmann, the officer still had the towel placed across DW's mouth. She tried to make verbal contact with DW. She placed her hand on his chest and touched him and called him by name. He did not respond. She said that his "chest was rising and falling well and that he had a nice strong carotid pulse". Thereafter, she left the cell and the Adjustment Center and returned to the Health Services Unit. *Tr., p. 158-159.*

Nurse Dittmann further stated that prior to leaving the Institution, she informed the relief nurse, Holly Meier, that she had been in the Adjustment Center to check the restraints that had been placed on DW and that he did not respond to her verbally. She said that she also logged the information in the "report book" and in his chart. *Tr., p.159; Ex. #3, p. 8; Ex. #5, p. 35-36.*

Based upon Nurse Dittmann's statements, it can be concluded that at the time she checked DW's restraints she:

1. Checked his pulses at his wrists and ankles, in addition to his carotid pulse.
2. Felt his chest rise and fall.
3. Determined that his capillary refill was adequate.
4. Did not notice any stiffness in any of his limbs.
5. Noted that DW did not speak to her. [3]
6. Visually observed that:

    (a) His eyes were partially open at the time of her first visit and closed at the time of her second visit.
    (b) He did not struggle.
    (c) He did not move, except to breathe.

6. Determined by tactile contact that:

    (a) DW's hands, feet, chest and neck were warm to touch.
    (b) His pulse was palpable.

In addition, the evidence establishes that at the time Nurse Dittmann saw DW she did not do the following:

(a) Check DW's pupils.
(b) Use a stethoscope to assess his condition.
(c) Perform any type of assessment to determine if DW was conscious.

3. According to Nurse Dittmann, during both of her visits to DW's cell an officer was holding a towel across DW's mouth. Under such circumstances, DW's ability to respond to Nurse Dittmann was compromised. There is no evidence that he made any type of voluntary sounds. Transcript, p.154,158; Exhibit 3, p. 8.

B. Analysis

The evidence establishes that Nurse Dittmann did not perform a complete neurological assessment of DW at the time of her contact with him.

At the time Nurse Dittmann checked DW's restraints, he was unresponsive and did not move, except to breathe. Nurse Dittmann admits that that DW was unresponsive to verbal stimulation. She also said that at no time during her contact with DW did he speak and that, except to breathe, he did not move at all. She also admits that it is a violation of nursing process to presume that a patient is in good health when the patient is not responding. *Transcript, p. 130, 132-133,135; Exhibit #3, p. 3 and 8.*

Nurse Miller Lemke testified that Nurse Dittmann did an incomplete neurological assessment of DW at the time she checked his restraints. According to Nurse Miller Lemke, a complete neurological assessment of a person who in unresponsive would start with verbal stimulation, then move on to the next level, which would be light pain and if the person still does not respond then move on to deep pain. Nurse Miller Lemke further stated that minimum standards of the profession require a nurse performing a neurological assessment to cover all these areas in order to fully assess a patient. *Transcript, p. 61-62;103.*

In reference to verbal stimulation, the evidence establishes that Nurse Dittmann did attempt to talk to DW, but he did not respond. *Transcript, p. 132-135; Exhibit # 5, p. 20, 24, 25 and 28.*

In reference to tactile stimulation, Nurse Dittmann testified that she gave tactile stimulation by placing her hand on DW's chest. However, based upon Nurse Miller Lemke's testimony, tactile stimulation involves much more than a nurse merely placing her hand on a patient's chest. Nurse Miller Lemke testified that when a person does not respond to verbal stimulation, the next step is to give them light stimulation or tactile stimulation, shaking them, tapping their chest, giving them some type of light pain. *Tr. p. 103; 132, lines 23-25; 133, lines 1-14; 135, lines 5-8.*

In reference to painful stimulation, Nurse Dittmann admits that she did not provide any type of painful stimuli. *Exhibit #5, p. 29.*

As to why she did not perform a complete neurological assessment, Nurse Dittmann stated that she did not feel there was a need for a neurological assessment to determine DW's level of consciousness. She said that she assumed DW was conscious at that time because when she checked his restraints his eyes were partially open as if he was watching what she was doing. She stated that she presumed that DW was choosing not to respond to her. She admits that she did not do any type of assessment to determine whether DW was conscious, and that she did not know whether he was conscious at the time she checked his restraints. *Transcript, p.134-37;138, lines 8-9, 15-16;156;163;180-181; 182, lines 11-18; 187.*

Nurse Dittmann's explanation as to why she did not do a complete neurological assessment of DW is based upon her:

(a) assumption that DW was conscious because his eyes were partially open at the time of her first visit to his cell, "as if he was watching what she was doing", and

(b) presumption that his lack of response to her verbal communication was voluntary. Her presumption is based upon her knowledge of his medical history.

The underlying facts upon which Nurse Dittmann's assumption and presumption are based are not consistent with other statements which she made while testifying at the hearing.

First, in reference to DW's level of consciousness, Nurse Dittmann testified that DW's eyes were partially open during her first visit to his cell, but "closed" during her second visit. She said that after her first visit to DW's cell, Lt. Westfield stated to her that DW "has his eyes shut now. Do you want to check him again". She went back to DW's cell within minutes of her first visit. Yet, she did not employ any type of tactile or painful stimulation to determine DW's neurological status at the time of her second visit. She admits that at no time during her contacts with DW, did she perform any type of assessment, to determine his level of consciousness. *Transcript, p.136-138,180-183; Exhibit #5, p. 25, lines 14-21; Exhibit #7.* [4]

Second, in reference to DW's history, Nurse Dittmann testified that she "had seen DW in a similar instance before, in his cell, in the same type of situation where he appeared the same way. And he was conscious at that time. Acting as if he was unconscious". When questioned by the Complainant, Nurse Dittmann admitted that on those occasions when DW had feigned unconsciousness she knew he was conscious because he "verbalized" with her. *Transcript, p. 136-138; 180-183; 187-189.*

HOLLY MEIER

The evidence presented establishes that, by failing to conduct a complete neurological assessment of DW, Nurse Meier engaged in conduct which fell below the minimum standards of the profession, in violation of ss. N 6.03 (1) and N 6.05, Code.

A. Factual Overview

Holly Meier is a registered nurse. She has been employed as a nurse clinician II at the Waupun Correctional Institution at least since May, 1988. In September 1990, Nurse Meier worked the 6:30 p.m., to 7:00 a.m., shift.

4. Did Lt. Westfield's statement to Nurse Dittmann that DW "has his eyes shut now. Do you want to check him again" constitute a request to her to check DW's medical condition? There is no evidence in the record indicating that there were concerns at that time relating to DW's restraints.

On September 8, 1990, at or around 6:30 p.m., Nurse Meier reported to work at the Institution. At some point in time, Nurse Dittmann informed her that DW had been placed in restraints; that the restraints had been checked and that DW had not responded to her.

At or around 2:00 a.m., on September 9, 1990, Nurse Meier went to the Adjustment Center to check DW's restraints. According to Nurse Meier, inmates who have been placed in restraints are checked by a nurse initially and every 8 hours thereafter. When she arrived at DW's cell, she observed that he was "laying quietly on his bed" on his back. His head was turned toward the light. His eyes were "half open". His mouth was "partially open, half open". There was no towel over his mouth. He was in full restraints. He had a strap across his chest, both wrists, both ankles and one across his thighs. She said that "he had a towel over his private area, otherwise he wasn't dressed".

Nurse Meier stated that she asked DW how he was, but she could not get any response. She further stated that:

> I checked his restraints and his wrists and ankles and I felt, pedal pulses, peripheral pulses. I checked his nails and it seemed to me that there was capillary refill and also his left hand was kind of rigid. I didn't know if he was you know, because a lot of the guys you know freeze themselves and stuff. His chest restraint was tight, I couldn't get a finger under it. They had to loosen that. *Exhibit #2, p. 3.*

In addition, Nurse Meier stated that DW's extremities felt warm; that she checked his breathing with a stethoscope and found his breathing to be adequate; that she did not see or feel his chest rising and falling; that she did not put her hand up to his nose or mouth area to feel if he was breathing and that she did not check his pupils. She also said that DW did not say anything and did not move. *Exhibits #2, p. 4; #6, p. 8, lines 6-7; p. 12-13.*

Nurse Meier stated that in her opinion DW did not appear to have any kind of medical problems. She said that she had been told that he had been quiet and not responding; that in the past he had a history of hysterical paralysis and that "he has had some psychiatric problems lately". *Exhibit #2, page 6.*

Nurse Meier further stated, in reference to observations made regarding DW's breathing, that she listened with the stethoscope because it seemed like it was very shallow and that she heard "faint breath sounds". She also said it seemed to her that he was in like a "catatonic state". She said "he was making himself rigid" and not responding to staff. She felt that he was inducing rigidness because he did not give any response, "there was no eye contact". *Ex. 2, p. 3.*

After checking DW's restraints, Nurse Meier asked Captain Feldman if he was going to remove DW's restraints because "the man had been down. He had been quiet. He should have been let up at that point". Captain Feldman said no. *Transcript, p.194-195; Exhibit #6, p. 8.*

Prior to returning to the hospital, Nurse Meier charted the following information:

> Restraints checked, CMST, which is circulation, motion to all extremities, peripheral pulses present. Capillary refill less than 3 seconds. Chest strap loosened one notch. And able to fit two fingers under strap easily. No verbal response to writer when asked if he had any complaints. Appears to be in catatonic state, head to left side and eyes partially open, not looking at staff members. *Ex. 2, p.9; 6, p.14;10.*

Nurse Meier said that when she returned to the Health Services Unit, she started thinking about DW's condition. Her concern related to the rigidity of his left hand. She said that she tried to look up some information on "catatonia", but could not find very much in her book. Then she called Sgt. Kuske to find out if he could see if DW's chest was rising and falling since the restraint had been loosened or if he had changed position. According to Nurse Meier, Sgt. Kuske told her that he could not see anything because the room was fairly dark, but that DW had not changed position since she checked his restraints. Between 3:00 and 3:15 a.m., she contacted Captain Feldman and told him that he needed to re-checked DW. She said that she "felt kind of uneasy".

At or about 3:33 a.m., on September 9, 1990, Nurse Meier went back to the Adjustment Center to recheck DW. She said that she took the emergency bag to see if he would respond. She took a penlight with her to check his pupils and some ammonia capsules to see if he would respond to that. She said that she first checked his pupils. His head was cold. His pupils were fixed and dilated. She immediately called for some oxygen and initiated CPR. She checked his pulses. He had none. She stated that in her professional opinion DW was dead. *Exhibit #6, p.6.*

More specifically, Nurse Meier stated that when she entered the cell she verbally tried to arouse DW and she tried to get pulses with a stethoscope without success. She said that he was cold to the touch, he was very rigid around the head, jaw and neck area and that his arms and legs were rigid compared to what they had been at 2:00 o'clock. Then she and an officer started CPR. Someone called an ambulance. She and the officer continued CPR for about 15 minutes each. Nurse Meier continued to check compressions until DW was placed into the ambulance. *Exhibit #2, p.8.* She charted the following information:

> Patient rechecked. Pupils fixed and dilated. Head cold and stiff, restraints removed. No chest movements noted. No pulse palpated. Attempted to insert airway and mouth rigid. CPR started. Ambulance called. No response to CPR noted upon transfer to Waupun Memorial Hospital, ER per ambulance." *Exhibits #2, p. 9; #6, p. 15; #10.*

Finally, Nurse Meier said that she did not have much experience in dealing with rigormortis and she felt that maybe she may have missed it at the 2:00 a.m., assessment. *Ex. #2, p. 11.*

B. Analysis

The evidence establishes that Nurse Meier did not perform a complete neurological assessment of DW at the time of her contact with him.

When Nurse Meier checked DW's restraints, around 2:00 a.m., she said that she did not get a response from him when she asked him how he was doing. He did not say anything and did not move. *Exhibit #2, p. 2; Exhibit 6, p. 12-13.*

Nurse Miller Lemke testified that Nurse Meier did an incomplete neurological assessment of DW at the time she checked his restraints. She said that Nurse Meier had documented that DW did not respond to her verbal stimulation; that he had some rigid posturing of his arm, and that she questioned his respirations. Nurse Miller Lemke further testified that Nurse Meier did not provide a minimally competent nursing assessment to DW because she only did verbal stimulation. According to Nurse Miller Lemke, a complete neurological assessment of a person who in unresponsive would start with verbal stimulation, then move on to the next level, which would be light pain and if the person still does not respond then move on to deep pain. Nurse Miller Lemke further stated that minimum standards of the profession require a registered nurse performing a neurological assessment to cover all these areas in order to fully assess a patient. *Transcript, p. 63-67; 70; 83-84; 98; 100-101; 103; Exhibit 2, p. 2,3, and 5; Exhibit #6, p. 12-13.*

In reference to verbal stimulation, the evidence establishes that Nurse Meier did attempt to talk to DW, but he did not respond. *Exhibit #2, p. 2; Exhibit #6, p. 21, lines 12-16.*

In reference to tactile stimulation, there is no evidence that Nurse Meier employed tactile stimulation to assess DW's neurological status. Nurse Miller Lemke testified that when a person does not respond to verbal stimulation, the next step is to give them light stimulation or tactile stimulation, shaking them, tapping their chest, giving them some type of light pain. *Tr. p.103; Exhibit #6, p. 21.*

In reference to painful stimulation, Nurse Meier testified that she did not use any painful or noxious stimuli. *Exhibit #6, p. 21, lines 20-25; p. 22, lines 1-3.*

As to why she did not use painful or noxious stimuli, Nurse Meier stated that she felt DW was sleeping, and maybe it was his coping mechanism to be quiet so he could get out of restraints. She said that she had not been told anything to think that he was in trouble. *Exhibit 6, p. 22.*

In reference to DW's history, Nurse Meier testified that he had a known history of hysterical paralysis. In the past when they had been called out in emergencies DW would not respond; however, Nurse Meier stated that "they knew, he would respond". *Exhibit 6, p.13.*

Nurse Miller Lemke testified that it is not acceptable practice to discontinue the assessment process before determining whether the patient's lack of response is voluntary, or to presume catatonic conditions without making a determination regarding a patient's level of function. *Transcript, p. 105; 117.*

II. Negligence

The Complainant alleges in its Complaint that Nurses Dittmann and Meier's conduct in providing professional nursing care to DW, including but not limited to, failure to intervene on behalf of DW to obtain medical attention for him in a timely manner, constitutes negligence under s. 441.07 (1) (c), Stats., and s. N 7.03 (1) (a) and (c), Code.

Based upon the evidence presented, it can be concluded that there is insufficient evidence in the record to establish by a preponderance of the evidence that the conduct of Nurse Dittmann and Nurse Meier in failing to conduct a complete neurological assessment of DW or to obtain medical attention for DW in a timely manner, constituted negligence, under s. 441.07 (1)(c), Stats., or s. N 7.03 (1), Code.

Section 441.07 (1) (c), Stats., states, in part, that the Board of Nursing may discipline a registered nurse if it finds that the nurse has committed: "Acts which show the registered nurse ... to be unfit or incompetent by reason of negligence ...."

Section N 7.03 (1), Code states, in part, that as used in s. 441.07 (1)(c), Stats., "negligence" means a substantial departure from the standard of care ordinarily exercised by a competent licensee. "Negligence" includes but is not limited to the following conduct:

> (a) Violating any of the standards of practice set forth in ch. N 6;
> (c) Failing to observe the conditions, signs and symptoms of a patient, record them, or report significant changes to the appropriate person;

In this case, Nurse Miller Lemke provided testimony regarding whether Nurse Dittmann and Nurse Meier's conduct fell below the minimum standard of the profession of professional nursing. However, Nurse Miller Lemke did not offer an expert opinion regarding whether Nurses Dittmann and Meier's conduct constituted negligence. There is no direct expert testimony in the record regarding the standard of care ordinarily exercised by a competent licensee or regarding whether respondents' conduct constituted a "substantial departure" from such standard. A finding of a violation of misconduct or unprofessional conduct does not constitute negligence per se.

Whether expert testimony is necessary to establish what constitutes ordinary care depends upon the type of care involved. If the patient requires professional nursing care then expert testimony as to the standard of that type of care is necessary. *Kujawski v. Arbor View Center*, 139 W. 2d 455, 463; 407 N.W. 2d 249 (1987).

DISCIPLINE

Having found that Nurses Dittmann and Meier violated statutes and regulations relating to the practice of professional nursing, a determination must be made regarding what type of discipline, if any, should be imposed.

The Board of Nursing is authorized under s. 441.07 (1), Stats., to reprimand a licensee or limit, suspend or revoke the license of any licensee if it finds that the licensee has engaged in conduct described under that section.

The purposes of discipline by occupational licensing boards are to protect the public, deter other licensees from engaging in similar misconduct and to promote the rehabilitation of the licensee. *State v. Aldrich*, 71 Wis. 2d 206, 237 N.W. 2d 689 (1976). Punishment of the licensee is not a proper consideration. *State v. McIntyre*, 41 Wis. 2d 481, 164 N.W. 2d 235 (1969).

The Complainant recommends that the licenses of Nurses Dittmann and Meier be suspended for a period of one year, and that they be required to complete a minimum of 16 hours in assessment practice and 16 hours in determining whether a patient needs help. *Tr. p. 234.*

Nurses Dittmann and Meier request that the matter be dismissed based upon the Complainant's failure to meet its burden of proof. If it is determined that violations have occurred, respondents recommend that no discipline be imposed. *Tr. p. 243.*

The Administrative Law Judge recommends that the licenses of Nurses Dittmann and Meier be suspended for a period of not less than 90 days, and that their licenses be limited for an indefinite period of time. This measure is designed to assure protection of the public, and to deter other licensees from engaging in similar misconduct.

At or around 6:00 p.m. on September 8, 1990, DW was placed in restraints. At 4:05 a.m., on September 9, 1990, DW was pronounced dead. The evidence presented does not establish when DW actually died or identify the individual (s) who contributed to his death. Complainant does not allege in its Complaint, and the evidence does not establish, that Nurses Dittmann and Meier caused DW's death. The Coroner who conducted DW's autopsy, included a comment in his report which reads as follows:

> Since the preliminary report, I have been informed that a towel was held over decedent's face. Plainly he was restrained. No adequate natural or drug cause of death appears Given the above facts, I must regretfully conclude for an asphyxial death. Further, the extensive preservation of neurons would argue that he died all at once.

The Complainant allege, and the evidence establishes, that Nurse Dittmann and Meier failed to conduct an adequate assessment of DW's physical condition to determine his medical status as required under ch. N 6, Code. Nurse Miller Lemke testified that Nurse Dittmann and Meier failed to conduct a complete neurological assessment to determine DW's neurological status. They employed verbal stimulation, but stopped short of employing tactile and/or painful stimulation, as required by the minimum standards of the profession. The evidence establishes that their conduct fell below the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient.

The assessment step of the nursing process is crucial. According to Nurse Miller Lemke, it is not possible to practice nursing in a competent manner without performing a competent nursing assessment of a patient. Thus, it is imperative that Nurses Dittmann and Meier possess the knowledge and skills needed to conduct nursing assessments in a competent manner.

In reference to protection of the public, Nurse Dittmann and Nurse Meier will be required to obtain a complete evaluation of their knowledge and skills in the area of nursing assessment during the proposed 90-day suspension period. If deficiencies are revealed during the evaluation process, they would be required to complete the appropriate training, as well as practice under the general supervision of a licensee approved by the Board. They would also be required to complete 30 hours of coursework in the areas of nursing assessment, planning, intervention and evaluation. They may petition the Board for return to full licensure upon a showing of complete, successful and continuous compliance for a period of one year with the specified limitations and conditions. Finally, the Order provides that the Board may grant such petition if it determines that respondents may safely and competently engage in practice as registered nurses.

In reference to deterrence, the proposed discipline is designed to send two messages to other licensees: 1) that registered nurses are required to perform nursing assessments in accordance with the standards established by the Board of Nursing, and 2) that "work rules" do not supersede the standards established by the Board. Registered nurses are required by law to comply with the standards of practice established by the Board.

There is considerable discussion in the record regarding the role of a registered nurse and the significance of compliance with work rules established by the employer. When asked why she was called to the Adjustment Center, Nurse Dittmann testified as follows (*Ex. #5, p.11*):

> Q. Why were you called to the Adjustment Center?
> A. My role in that function would be to assure that the restraints were not placed on the inmate too tight, therefore to cause a lack of circulation, for example, to an extremity. Or that it could result in an inmate perhaps losing some type of -- circulation or feeling in his arm or something like that. The purpose was to check the restraints. That they were adequately applied.

When asked why she denied in her Answer to the Complaint that she failed to obtain medical intervention in a timely manner, Nurse Dittmann stated:

> A. The role that we played was checking the restraints. I went over there and I checked the restraints and that was my function Checked the restraints. Check for the pulses, capillary refill, so on, and make sure the extremities are warm. Checked for breathing. Check for a pulse. That was the role of the nurse as I was directed to do for an assessment of an inmate in restraints. And I believe I carried out that role completely. I did follow through and I gave a report to my co-worker at the end of my shift. I documented what I had done. *Ex. #5, p. 29-30.*

Nurses Dittmann and Meier complied with the rules established by their employer. They checked DW's restraints and found, with minor exceptions, that the restraints were adequate. They did not comply with the standards of practice established by the Board of Nursing. In the end, the restraints were adequate. The patient was dead.

Based upon the record herein, the Administrative Law Judge recommends that the Board of Nursing adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein.

Dated at Madison, Wisconsin this 11th day of February 1997.

Respectfully submitted,

Ruby Jefferson-Moore

Ruby Jefferson-Moore
Administrative Law Judge

FILE COPY

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

BETH DITTMAN, R.N., &
HOLLY A. MEIER, R.N.

Respondents

ORDER DENYING PETITION

The Board of Nursing issued its Final Decision and Order in the captioned matter on May 9, 1997. In its Order, the board ordered that, pursuant to Wis. Stats. sec. 440.22, the costs of the proceeding be assessed against the respondents. On June 25, 1997, the board received the Affidavits of Cost from the Office of Board Legal Services and the Division of Enforcement, and respondents' objections to the imposition of costs was filed by letter from Attorney Helen Marks Dicks dated July 10, 1997. The objection first petitions the board to issue an order reducing the costs assessed against respondents by at least 50 percent, based upon the board's having failed to make a finding that respondents were negligent. The objection also petitions for a stay of the payment of costs pending the outcome of the judicial review of the matter.

Based upon respondents' petition, and upon other information of record herein, the board orders as follows:

ORDER

NOW, THEREFORE, IT IS ORDERED that the petition of respondents for a reduction in the amount of costs assessed against them in this matter, and for a stay of the payment of costs until the conclusion of the pending judicial review of this matter be, and hereby is denied.

DISCUSSION

In terms of respondents' request for a 50% reduction in the amount of costs assessed, the Final Decision and Order of the board sets forth as Conclusions of Law for both respondents that their respective failures to conduct a complete neurological assessment of DW was below the minimum standards of the profession of professional nursing; exposing DW to a risk of harm to which a minimally competent nurse would not expose a patient, and constituting practice which violated the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient, in violation of secs. N 6.03 (1) and N 6.05, Code. That the board

did not find that the violations found also constituted negligence may not be said to lead to the conclusion that respondents therefore somehow prevailed in some aspect of the case. Respondents were found to have violated the board's rules of conduct and were ordered disciplined, and they may not be said to have prevailed in any sense of the word. There is thus no basis for a reduction in the amount of the costs assessed against them.

Nor may the board grant respondents' second request that payment of costs be stayed. Sec. 440.22(3), Stats., states:

> **440.22 Assessment of costs.**
>
> * * * *
>
> **(3)** In addition to any other discipline imposed, if the department, examining board, affiliated credentialing board or board assesses costs of the proceeding to the holder of the credential under sub. (2), the department, examining board, affiliated credentialing board or board may not restore, renew or otherwise issue any credential to the holder until the holder has made payment to the department under sub. (2) in the full amount assessed.

Under the cited section, the board is statutorily prohibited from renewing respondents' credentials when they expire on March 1, 1998, though it is entirely possible that the judicial review will have been completed by that time.

Dated this 25th day of September, 1997.

STATE OF WISCONSIN
BOARD OF NURSING

by Timothy D. Burns CRNA
Timothy D. Burns, CRNA
Chairman

WRA:9709173.doc

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

AFFIDAVIT OF COSTS
LS9601182-NUR

BETH S. DITTMANN, R.N.,
HOLLY A. MEIER, R.N.,
RESPONDENTS.

STATE OF WISCONSIN)
) ss.
COUNTY OF DANE)

Ruby Jefferson-Moore, being first duly sworn on oath deposes and states:

1. That affiant is an attorney licensed to practice law in the State of Wisconsin, and is employed by the Wisconsin Department of Regulation and Licensing, Office of Board Legal Services.

2. That in the course of affiant's employment she was appointed administrative law judge in the above-captioned matter. That to the best of affiant's knowledge and belief, the costs for services provided by affiant are as follows:

ACTIVITY	DATE	TIME
Preparation/Conduct of Hearing	06/18/96	6 hrs/45 min.
Review record/draft decision	12/17/96	2 hrs.
Review record/draft decision	12/18/96	2 hrs.
Review record/draft decision	01/15/97	2 hrs.
Review record/draft decision	01/16/97	2 hrs/15 min.
Review record/draft decision	01/17/97	45 min.
Review record/draft decision	01/21/97	2 hrs.
Review record/draft decision	01/22/97	2 hrs/30 min.
Review record/draft decision	01/23/97	2 hrs.
Review record/draft decision	01/24/97	3 hrs/45 min.
Review record/draft decision	02/06/97	3 hrs/30 min.
Review record/draft decision	02/11/97	6 hrs/30 min.

Total Time: 36 hours.

Total costs for Administrative Law Judge: $ 977.40.

3. That upon information and belief, the total costs for court reporting services provided by Magne-Script are as follows: $953.30.

4. That upon information and belief, the total costs for Office of Board Legal Services are as follows : $ 1,930.70.

Ruby Jefferson-Moore
Administrative Law Judge

Sworn to and subscribed to before me
this 21st day of May, 1997

Notary Public
My Commission: is permanent

State of Wisconsin
Before the Board of Nursing

In the Matter of the Disciplinary Proceedings Against

Beth S. Dittmann
Holly Meier
Respondents.

Case No. LS 9601182 NUR

Affidavit of Costs, Division of Enforcement

State of Wisconsin
County of Dane, ss:

James E. Polewski, being duly sworn on oath, deposes and says:

1. He is an attorney licensed to practice law in Wisconsin, and employed by the Division of Enforcement, Department of Regulation and Licensing.

2. In the course of that employment, he was assigned to prosecute the above captioned case, and in the course of that assignment he expended the following time and committed the Division to the payment of the following costs:

Date	Activity	Time
8/10/95	File review	1.5
8/10/95	Telephone conference, Board Advisor	.25
8/11/95	Research, nursing examination/assessment	.5
8/22/995	File review, prepare for expert	1.5
9/29/95	Prepare and send packet to expert	1.5
11/22/95	Confer, Lemke	5.0
12/11/95	Draft complaint	.75
12/11/95	Letter, JEP to Board Advisor re: complaint	.25
1/2/96	Locate Helen Morris Bell	.25
1/26/96	Telephone conference, DOC/HMD	.25
1/26/96	Letter, JEP to HMD, extension for answer	.2
2/1/96	Compile records for HMD	1.5
2/2/96	Letter, JEP to HMD re: records, no attorney relationship	.2
2/12/96	Analysis of answer	1.5
2/12/96	Letter, JEP to HMD, with records	.2
2/14/96	Motion to strike affirmative defenses	3.0
2/16/96	Draft Request for Admissions	.75
2/16/96	Letter, JEP to Lemke	.25

2/21/96	Prehearing conference	.25
3/5/96	Telephone conference, JEP/Lemke	.25
3/5/96	Letter, JEP/Lemke	.1
3/13/96	Telephone conference, JEP/Lemke	.25
3/14/96	Reply brief on motion in limine, motion on affirmative defenses	8.0
3/15/96	Letter, JEP/ALJ with briefs	.1
3/19/96	Notice of deposition, Dittmann and Meier	.5
3/19/96	Letter, JEP/HMD with notices of deposition	.1
3/29/96	Letter, JEP/HMD requesting Respondent Witness List	.2
4/3/96	Prepare for depositions	1.0
4/4/96	Depositions, Dittmann and Meier	2.5
4/4/96	Letter, JEP/HMD; deposition of Lemke	.25
4/19/96	Letter, JEP/Lemke	.25
5/8/96	Conference, JEP/Lemke	4.5
5/9/96	Deposition, Lemke	4.5
5/21/96	TC, JEP/HMD; settlement	.25
5/24/96	Review training records for Respondents from HMD	.3
5/24/96	Letter, JEP/HMD; request detail on Respondents' training	.25
5/29/96	TC. JEP/HMD; settlement, witness list	.25
6/3/96	File final witness list	.50
6/4/96	Subpoena Poliak, Thorpe for deposition	.75
6/7/96	Depose Poliak, Thorpe	3.0
6/10/96	Review motion to exclude Lemke	1.0
6/11/96	Response to motion to exclude Lemke	2.0
6/13/96	Review order denying motion to exclude Lemke	.2
6/14/96	Prepare for hearing	8.0
6/17/96	Prepare for hearing	5.0
6/18/96	Hearing	8.5
7/2/96	Draft brief on motion to dismiss	1.5
7/9/96	Brief	1.0
7/16/96	Brief	1.5
7/19/96	Brief	.5
7/25/96	Brief	3.0
7/26/96	Brief	4.0
7/29/96	Review Respondents' Brief to Dismiss	1.5
8/1/96	Reply Brief to Respondents' Brief to Dismiss	5.0
8/5/96	Review Respondents' reply	.5
2/12/97	Review Proposed Decision	3.0
2/14/97	Draft Objections	2.5
2/15/96	Draft Objections	3.0
2/18/96	Draft Objections	2.5
2/24/96	Finish and File Objections	2.0

2/26/97	Review Respondents' Objections	2.0
3/4/96	Response to Respondents' Objections	6.0
3/6/97	Review Respondents' Reply to Division's Objections	.5

Total Attorney Time this case, 1995 through Final Decision and Order: 112.1 hours

Chargeable attorney expense: 111.8 hours @ $42.00: $4708.20

DISBURSEMENTS

May 13, 1991	Records from Department of Corrections	24.75
May 9, 1996	Transcript of Lemke Deposition	110.00
June 17, 1996	Transcript of Poliak, Thorpe Depositions	282.60
August 2, 1996	Expert witness fees	1256.10
	TOTAL Disbursements	1673.45

Total Assessable Costs, Division of Enforcement: $6381.65

James E. Polewski

Sworn to and Subscribed before me this 24th day of June, 1997.

Notary Public
My Commission is Permanent

State of Wisconsin \ DEPARTMENT OF REGULATION & LICENSING

Tommy G Thompson
Governor

Marlene A. Cummings
Secretary

1400 E WASHINGTON AVENUE
P O BOX 8935
MADISON, WISCONSIN 53708-8935
(608) 266-2112

June 25, 1997

HELEN MARKS DICKS, ATTORNEY
BOUSHEA, SEGALL & JOANIS
124 W BROADWAY, SUITE 100
MONONA WI 53716-0079

RE: In The Matter of Disciplinary Proceedings Against Beth Dittmann, R.N. and Holly A. Meier, R.N., Respondents, LS9601182NUR, Assessment of Costs

Dear Ms. Marks Dicks:

On May 9, 1997, the Board of Nursing issued an order involving the licenses to practice nursing of Beth S. Dittmann, R.N. and Holly A. Meier, R.N. The order requires payment of the costs of the proceedings.

Enclosed please find the Affidavits of Costs of the Office of Legal Services and the Division of Enforcement in the above captioned matter. The total amount of the costs of the proceedings is $8,312.35.

Under sec. RL 2.18, Wis. Adm. Code, objections to the affidavits of costs shall be filed in writing. Your objections must be received at the office of the Board of Nursing, Room 174, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, on or before July 10, 1997. After reviewing the objections, if any, the Board of Nursing will issue an Order Fixing Costs. Under sec. 440.23, Wis. Stats., the board may not restore or renew a credential until the holder has made payment to the department in the full amount assessed.

Thank you.

Sincerely,

Pamela A Haack

Pamela A. Haack
Administrative Assistant
Office of Legal Services

Enclosures

cc: Board of Nursing
Department Monitor

STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING
BEFORE THE BOARD OF NURSING

In the Matter of Disciplinary Proceedings Against

Beth Dittman, R.N., &
Holly A. Meier, R.N.,

AFFIDAVIT OF MAILING

Respondents.

STATE OF WISCONSIN)
)
COUNTY OF DANE)

I, Kate Rotenberg, having been duly sworn on oath, state the following to be true and correct based on my personal knowledge:

1. I am employed by the Wisconsin Department of Regulation and Licensing.

2. On October 7, 1997, I served the Order Denying Petition dated September 25, 1997 upon the Respondents Beth Dittman & Holly A. Meier's attorney by enclosing a true and accurate copy of the above-described document in an envelope properly stamped and addressed to the above-named Respondents' attorney and placing the envelope in the State of Wisconsin mail system to be mailed by the United States Post Office by certified mail. The certified mail receipt number on the envelope is P 221 158 220.

Helen Marks Dicks, Attorney
124 W. Broadway
Monona WI 53713

Kate Rotenberg
Kate Rotenberg
Department of Regulation and Licensing
Office of Legal Counsel

Subscribed and sworn to before me
this 7th day of October, 1997.

Notary Public, State of Wisconsin
My commission is permanent.

NOTICE OF APPEAL INFORMATION

Notice Of Rights For Rehearing Or Judicial Review. The Times Allowed For Each. And The Identification Of The Party To Be Named As Respondent.

Serve Petition for Rehearing or Judicial Review on:

STATE OF WISCONSIN BOARD OF NURSING
1400 East Washington Avenue
P.O. Box 8935
Madison. WI 53708.

The Date of Mailing this Decision is:

October 7, 1997

1. REHEARING

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

A petition for rehearing should name as respondent and be filed with the party identified in the box above.

A petition for rehearing is not a prerequisite for appeal or review.

2. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in sec. 227.53, *Wisconsin Statutes* a copy of which is reprinted on side two of this sheet. By law, a petition for review must be filed in circuit court and should name as the respondent the party listed in the box above. A copy of the petition for judicial review should be served upon the party listed in the box above.

A petition must be filed within 30 days after service of this decision if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30-day period for serving and filing a petition commences on the day after personal service or mailing of the decision by the agency, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing this decision is shown above.)

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

BETH DITTMAN, R.N., and
HOLLY A. MEIER, R.N.

Respondents

ORDER DENYING PETITION FOR REHEARING

The Board of Nursing issued its Final Decision and Order in this matter on May 9, 1997. The board found that respondents had engaged in practice which violated the minimum standards of the profession, ordered that their licenses be suspended for 30 days, limited their licenses to require an evaluation of their knowledge and skills in the area of nursing assessment, and required them to complete any remedial training recommended by the evaluator. Respondents were also required within six months of the board's Order to successfully complete 30 hours of professional nursing education in the areas of nursing assessment, planning, intervention and evaluation.

On May 14, 1997, James E. Polewski, attorney for complainant, filed his Petition for Rehearing. Attorney Helen Marks Dicks filed a responsive letter on or about May 28, 1997, by which she requested that if Mr. Polewski's petition were to be granted, then the rehearing should be opened on all grounds. Mr. Polewski filed a rebuttal letter on May 29, 1997.

Complainant's Petition for Rehearing in this matter alleges a material error of law based upon alleged inconsistencies between the Board's Conclusions of Law numbers 2 and 3, and Conclusion of Law number 4. Those Conclusions state as follows:

> 2. Nurse Beth Dittmann's failure to conduct a complete neurological assessment of DW as described in Findings of Fact 6-10 and 16 herein, was below the minimum standards of the profession of a professional nursing; exposed DW to a risk of harm to which a minimally competent nurse would not expose a patient, and constituted practice which violated the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient, in violation of s. N 6.03 (1) and N 6.05, Code.
>
> 3. Nurse Holly Meier's failure to conduct a complete neurological assessment of DW as described in Findings of Fact 11-16 herein, was below the minimum standards of the profession of professional nursing; exposed DW to a risk of harm to which a minimally

competent nurse would not expose a patient, and constituted practice which violated the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient, in violation of s. N 6.03 (1) and N 6.05, Code.

4. There is insufficient evidence in the record to establish by a preponderance of the evidence that the conduct of Nurse Dittmann and Nurse Meier in failing to conduct a complete neurological assessment of DW or to obtain medical attention for DW in a timely manner, constituted negligence, under s. 441.07 (1)(c), Stats., or s. N 7.03 (1), Code.

In her Opinion accompanying the Proposed decision, the Administrative Law Judge commented on her proposed conclusion that there was insufficient evidence to find negligence as follows:

Based upon the evidence presented, it can be concluded that there is insufficient evidence in the record to establish by a preponderance of the evidence that the conduct of Nurse Dittmann and Nurse Meier in failing to conduct a complete neurological assessment of DW or to obtain medical attention for DW in a timely manner, constituted negligence, under s. 441.07 (1)(c), Stats., or s. N 7.03 (1), Code.

Section 441.07 (1) (c), Stats., states, in part, that the Board of Nursing may discipline a registered nurse if it finds that the nurse has committed: "Acts which show the registered nurse ... to be unfit or incompetent by reason of negligence ...."

Section N 7.03 (1), Code states, in part, that as used in s. 441.07 (1)(c), Stats., "negligence" means a substantial departure from the standard of care ordinarily exercised by a competent licensee. "Negligence" includes but is not limited to the following conduct:

(a) Violating any of the standards of practice set forth in ch. N 6;
(c) Failing to observe the conditions, signs and symptoms of a patient, record them, or report significant changes to the appropriate person;

In this case, Nurse Miller Lemke provided testimony regarding whether Nurse Dittmann and Nurse Meier's conduct fell below the minimum standard of the profession of professional nursing. However, Nurse Miller Lemke did not offer an expert opinion regarding whether Nurses Dittmann and Meier's conduct constituted negligence. There is no direct expert testimony in the record regarding the standard of care ordinarily exercised by a competent licensee or regarding whether respondents' conduct constituted a "substantial departure" from such standard. A finding of a violation of misconduct or unprofessional conduct does not constitute negligence per se.

Whether expert testimony is necessary to establish what constitutes ordinary care depends upon the type of care involved. If the patient requires professional nursing care then expert testimony as to the standard of that type of care is necessary. *Kujawski v. Arbor View Center*, 139 W. 2d 455, 463; 407 N.W. 2d 249 (1987).

Complainant argues, however, that Conclusions of Law 2 and 3, finding that respondents' failure to conduct a complete neurological assessment was below the minimum standards of the profession necessary for the protection of the health welfare and safety of a patient, do in fact lead unalterably to the conclusion that they were also guilty of negligence.

> Conclusion of Law Number 4 states that there is insufficient evidence in the record to establish by a preponderance of the evidence that the conduct of Nurse Dittmann and Nurse Meier in failing to conduct a complete neurological assessment of DW or to obtain medical attention for DW in a timely manner constituted negligence, under s. 441.07(1)(c), Stats., or s. N 7.03(1), Code. This Conclusion contradicts Conclusions 2 and 3, which say that the failure of Nurse Dittmann and Nurse Meier to conduct a complete neurological assessment of DW was below the minimum standards of the profession, and was below the minimum standards of the profession necessary for the protection of the health, welfare or safety of a patient. Further, Conclusion of Law Number 4 disregards s. N 7.03(1), Wis. Admin. Code, which defines "negligence" to mean a violation of any of the standards of practice of professional nursing in ch. N 6, Wis. Admin. Code. Section N 6.03(1)(a), Wis. Admin. Code, states that it is a standard of practice for registered nurses to use the nursing process, specifically assessment of a patient's condition.

Where, as here, violations of ch. N 6, Code, have been found, and where the board's own rule defines negligence as violation of the standards of practice set forth at ch N 6, the question whether expert testimony specifically addressing the question of negligence is necessary is certainly a debatable issue. It is not, however, as clear as complainant paints it. The problem is that while the board's rule would define "negligence" as any violation of the standards of practice set forth in ch. N 6, that definition must be read in the context of the statutory definition at sec. 441.07(1)(c), Code, which authorizes the board to take disciplinary action against a nurse if the board finds that the nurse committed "acts which show the registered nurse, nurse-midwife or licensed practical nurse to be unfit or incompetent by reason of negligence, abuse of alcohol or other drugs or mental incompetency." A requirement that the extent of the nurse's negligence must render him or her "unfit or incompetent" to practice puts a considerable gloss on the usual definition of negligence as "the omission to do something which a reasonable man, guided by those ordinary considerations which ordinarily regulate human affairs, would do, or the doing of something which a reasonable and prudent man would not do."[1] It is thus certainly not unreasonable to require expert testimony to the effect that the acts complained of in this case demonstrate that respondents are unfit or incompetent to practice professional nursing.

But even assuming, *arguendo*, that the better Conclusion of Law would have been that respondents were negligent within the meaning of sec. N7.03(1), Code, there remains the question whether failure to so find constitutes a "material error of law." Materiality, in the evidentiary sense, is not what is intended here. Rather it is used in much the same sense as the term "material fact," which is a "fact upon which outcome of litigation depends." The question here is not whether failure to find negligence was error, it is whether that error, if error it be, is or

[1] Black's Law Dictionary, Fifth Edition, West Publishing Company, 1979.

was important to the outcome of the case; that is, whether it could be deemed a *material* error. The board accepted the ALJ's recommended Conclusion of Law number 4 because it was a reasonable conclusion by an experienced administrative law judge. But whether the board made that conclusion or some other was not and is not determinative of the result of this case. The board found that respondent's conduct fell below the minimum standards of the profession, and that conclusion was fully justified by the evidence. Having so found, the board fashioned discipline deemed by the board to effectuate the disciplinary objective of protecting the public by deterring other licensees from engaging in similar misconduct and by promoting the rehabilitation of these licensees. The long and the short of it is that these respondents were found to have violated the standards of practice for nurses and were disciplined for those violations. There is nothing accomplished by attempting to now increase the number of code violations found to have been violated except to further delay closure of a case that should have been closed a long time ago.

Dated this 14th day of June, 1997.

STATE OF WISCONSIN
BOARD OF NURSING

by _____
Timothy D. Burns, R.N.
Chairman

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STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING
BEFORE THE BOARD OF NURSING

In the Matter of the Disciplinary Proceedings Against

Beth Dittman, R.N., and
olly A. Meier , R.N.,

AFFIDAVIT OF MAILING

Respondents.

STATE OF WISCONSIN)
)
COUNTY OF DANE)

I, Kate Rotenberg, having been duly sworn on oath, state the following to be true and correct based on my personal knowledge:

1. I am employed by the Wisconsin Department of Regulation and Licensing.

2. On June 18, 1997, I served the Order Denying Petition for Rehearing dated June 14, 1997 upon the Respondents Beth Dittman and Holly A. Meier 's attorney by enclosing a true and accurate copy of the above-described document in an envelope properly stamped and addressed to the above-named Respondents' attorney and placing the envelope in the State of Wisconsin mail system to be mailed by the United States Post Office by certified mail. The certified mail receipt number on the envelope is P 221 157 580.

Helen Marks Dicks, Attorney
124 W. Broadway Suite 100
Monona WI 53716-0079

Kate Rotenberg
Kate Rotenberg
Department of Regulation and Licensing
Office of Legal Counsel

Subscribed and sworn to before me
this 18th day of June, 1997.

Notary Public, State of Wisconsin
My commission is permanent.

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

BETH DITTMAN, R.N., and
HOLLY A. MEIER, R.N.

Respondents

ORDER DENYING PETITION AND APPROVING PROGRAM

The Board of Nursing issued its Final Decision and Order in this matter on May 9, 1997. The board found that respondents had engaged in practice which violated the minimum standards of the profession, ordered that their licenses be suspended for 30 days, limited their licenses to require an evaluation of their knowledge and skills in the area of nursing assessment, and required them to complete any remedial training recommended by the evaluator. Respondents were also required within six months of the board's Order to successfully complete 30 hours of professional nursing education in the areas of nursing assessment, planning, intervention and evaluation.

By letter dated July 3, 1997, respondents, by Attorney Karl L. Kliminski, petitioned the board to accept coursework completed by them from July, 1987 through April, 1997. Alternatively, respondents requested that the board approve an educational program entitled "Correctional Health Services Physical Assessment Series," offered in October, 1997. The board considered the matter at its meeting of July 11, 1997, and orders as follows:

ORDER

NOW, THEREFORE, IT IS ORDERED that the petition of Beth S. Dittmann, RN, and Holly A. Meier, RN, that the board accept continuing education previously acquired by them in satisfaction of the continuing education requirement set forth in the board's Final Decision and Order in this matter be, and hereby is, denied.

IT IS FURTHER ORDERED that the continuing education program entitled "Correctional Health Services Physical Assessment Series," to be offered in October, 1997, be, and hereby is, accepted in satisfaction of the continuing education requirement set forth in the board's Final Decision and Order in this matter.

DISCUSSION

The board's Order in this matter states as to the required continuing education: "Within six (6) months of the effective date of this Order, each respondent shall certify to the Board the successful completion of 30 hours of professional nursing education in the areas of nursing assessment, planning, intervention and evaluation, which shall be pre-approved by the Board." Continuing education taken prior to the filing of the board's Order and not approved by the board obviously does not fulfill the requirements of the Order. More important, the course submitted for approval by respondents appears to be exactly and specifically what was intended by the board, and would seem to be precisely tailored to address the educational remediation suggested as necessary by the findings in this case. Accordingly, the petition for substitution of previous continuing education must be denied, and the course submitted for approval is so approved.

Dated this 22ND day of July, 1997.

STATE OF WISCONSIN
BOARD OF NURSING

by Timothy D. Burns CRNA
Timothy D. Burns, R.N.
Chairman

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STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING
BEFORE THE BOARD OF NURSING

In the Matter of the Disciplinary Proceedings Against

Beth Dittman, R.N., and
Holly A. Meier , R.N.,

Respondents.

AFFIDAVIT OF MAILING

STATE OF WISCONSIN)
)
COUNTY OF DANE)

I, Kate Rotenberg, having been duly sworn on oath, state the following to be true and correct based on my personal knowledge:

1. I am employed by the Wisconsin Department of Regulation and Licensing.

2. On July 24, 1997, I served the Order Denying Petition and Approving Program dated July 22, 1997 upon the Respondents Beth Dittman and Holly A. Meier's attorney by enclosing a true and accurate copy of the above-described document in an envelope properly stamped and addressed to the above-named Respondents' attorney and placing the envelope in the State of Wisconsin mail system to be mailed by the United States Post Office by certified mail. The certified mail receipt number on the envelope is P 221 157 380.

Karl L. Kliminski, Attorney
124 W. Broadway, Suite 100
Monona WI 53716-3902

Kate Rotenberg
Department of Regulation and Licensing
Office of Legal Counsel

Subscribed and sworn to before me
this 24th day of July, 1997.

Notary Public, State of Wisconsin
My commission is permanent.

NOTICE OF APPEAL INFORMATION

Notice Of Rights For Rehearing Or Judicial Review, The Times Allowed For Each, And The Identification Of The Party To Be Named As Respondent.

Serve Petition for Rehearing or Judicial Review on:

STATE OF WISCONSIN BOARD OF NURSING

1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708.

The Date of Mailing this Decision is:

July 24, 1997

1. REHEARING

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

A petition for rehearing should name as respondent and be filed with the party identified in the box above.

A petition for rehearing is not a prerequisite for appeal or review.

2. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in sec. 227.53, *Wisconsin Statutes* a copy of which is reprinted on side two of this sheet. By law, a petition for review must be filed in circuit court and should name as the respondent the party listed in the box above. A copy of the petition for judicial review should be served upon the party listed in the box above.

A petition must be filed within 30 days after service of this decision if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30-day period for serving and filing a petition commences on the day after personal service or mailing of the decision by the agency, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing this decision is shown above.)

STATE OF WISCONSIN CIRCUIT COURT BRANCH II DODGE COUNTY

HOLLY A. MEIER, R.N., and,
BETH S. DITTMANN, R.N.,

Petitioners,

Case No. 97 CV 338

v.

STATE OF WISCONSIN BOARD OF NURSING,

Respondent.

MEMORANDUM DECISION & ORDER

Holly A. Meier and Beth S. Dittmann are licensed to practice as registered nurses in the State of Wisconsin. On May 9, 1997, the State of Wisconsin Board of Nursing ("Board") issued a Final Decision and Order which suspended the licenses of Meier and Dittmann for a period of not less than thirty days. The Board's Final Decision and Order also imposed a detailed series of limitations and conditions upon the licenses of Meier and Dittmann and assessed them with the costs of their respective disciplinary proceedings.

Meier and Dittmann petitioned the Board for rehearing shortly after the adverse decision was handed down. However, the Board denied the Petition for Rehearing on June 14, 1997. Consequently, Meier and Dittmann sought judicial review[1] of the adverse decision in the Circuit Court of their respective counties of residence: Meier in Dodge County, Dittmann in Fond du Lac County. By agreement of the parties, the two actions were ultimately consolidated into a single action in this Court.

[1] *See*, §§ 227.52 and 227.53, Wis. Stats.

back on a bed, and an officer was kneeling at Woods' head, holding a towel across Woods' mouth. Dittmann checked Woods' restraints and spoke to him, but Woods did not respond.

During this initial contact, Dittmann determined that Woods' hands, feet, chest, and neck were warm to the touch. She felt Woods' chest rise and fall. She found his pulse was palpable. She observed that Woods' eyes were partially open, but he did not move, except to breathe. Dittmann did not observe anything "out of the normal," such as bruising or cuts, while checking on Woods at this time.

At some point during her initial contact with Woods, Dittmann determined that one of the restraints was too loose and informed the security officers. One of the security officers re-adjusted this restraint and Dittmann checked it again, determined it was adequate and exited Woods' cell to chart her findings at a workstation which was located in the adjustment center.

While Dittmann was charting her findings, a security supervisor in the Adjustment Center informed Dittmann that Woods' eyes had closed. In light of this occurrence, the security supervisor asked Dittmann whether she wanted to re-check Woods.

Dittmann returned to Woods' cell. She placed her hand on his chest and called him by name. Woods did not provide a verbal response, but Dittmann determined that Woods' had a "nice strong carotid pulse," and that his chest was rising and falling. She left the cell and returned to her workstation at the Health Services Unit.

When Dittmann returned to the Health Services Unit, she informed the relief nurse, Meier, that she had checked Woods' restraints and that he did not respond to her verbally. At approximately 6:30 PM on September 8, 1990, Dittmann left the institution.

capsules at approximately 3:33 AM to assess Woods' medical condition. At this time, Meier's examination of Woods revealed that his head was cold and stiff, his pupils were fixed and dilated, and he did not have a pulse. She commenced CPR with a security officer and she continued to check compressions until Woods was placed in an ambulance. Woods was pronounced dead shortly thereafter.

Significantly, the administrative law judge concluded her findings of fact as follows:

> "16. It is below the standards of the profession for a registered nurse to fail to conduct a complete neurological assessment of a patient who is non-responsive to verbal stimulation, and in failing to do so, Nurses Dittmann and Meier exposed DW [Woods] to a risk of harm to which a minimally competent nurse would not expose a patient, including, if unconscious, the possibility of DW [Woods] causing harm to himself, and the possibility of DW being deprived of prompt medical attention."

The aforementioned findings of fact, of course, form the backdrop of Meier and Dittmann's appeal.

Meier and Dittmann have preserved six issues for judicial review: (1) whether the administrative law judge should have dismissed these disciplinary actions in accordance with the doctrine of laches; (2) whether the administrative law judge should have excluded the testimony of an expert witness named Denise Miller Lemke because she was inexperienced in the "field" of "correctional nursing;" (3) whether the testimony of Ms. Miller Lemke should now be stricken from the record; (4) whether the record supports a finding that the conduct of Meier and Dittmann fell below the standards of care of the profession; (5) whether the level of discipline which the Board imposed was excessive and punitive; (6) whether the costs of the disciplinary process are properly assessed against Meier and Dittmann. The Court addresses, in turn, each of these issues in the pages which follow.

reasonable minds acting as such could reach the decision which was reached by the agency. *See*, Samens, 117 Wis. 2d at 660. If so, the court cannot disturb the agency's findings. *See*, Id.

Legal conclusions drawn by an administrative agency are also subject to judicial review. *See*, § 227.57 (5) and (10). Although an agency's resolution of questions of law does not bind a reviewing court, some level of deference is often appropriate due to the agency's expertise. The Wisconsin Supreme Court has recently clarified both when to defer to an agency's legal conclusion, and how much deference the courts should give. UFE, Inc. v. LIRC, 201 Wis.2d 274, 284, 548 N.W.2d 57, 61 (1996) (citations omitted). The three levels of deference described by the *UFE Court* are "great weight" deference, "due weight" deference and *de novo* review.

An agency's interpretation or application of a statute may be accorded "great weight" deference when all four of the following requirements are met:

> (1) the agency was charged by the legislature with the duty of administering the statute; (2) the interpretation of the agency is one of long-standing; (3) the agency employed its expertise or specialized knowledge in forming the interpretation; and (4) the agency's interpretation will provide uniformity and consistency in the application of the statute. Id. (citing Harnischfeger Corp. v. LIRC, 196 Wis.2d 650, 660, 539 N.W.2d 98, 102 (1995)).

Moreover, under the "great weight" standard, "a court will uphold an agency's reasonable interpretation that is not contrary to the clear meaning of the statute, even if the court feels that an alternative interpretation is more reasonable." UFE, 201 Wis.2d at 287, 548 N.W.2d at 62.

"Due weight" deference is accorded when "the agency has some experience in an area, but has not developed the expertise which necessarily places it in a better position to

II. LACHES.

As previously stated, the first issue which Dittmann and Meier have preserved for judicial review is whether the administrative law judge [or the Board] should have dismissed these disciplinary actions under the doctrine of laches. As set forth in the Court's recitation of facts, the incident which gave rise to these disciplinary proceedings occurred in September, 1990. However, the Department of Regulation and Licensing's Division of Enforcement ("Division") did not file a complaint with the Board until January, 1996, almost five and one-half years after the incident.

Dittmann and Meier filed a Motion to Dismiss at the agency level, arguing that the Division's failure to pursue diligently the prosecution of these matters and the doctrine of laches barred prosecution. The motion was denied. Dittmann and Meier have renewed their laches objection and supporting arguments in this Court.

Laches is an equitable doctrine developed to prevent injustice from resulting in situations where a party unreasonably delays asserting his or her rights and in so doing causes the other party to be disadvantaged in asserting a defense. Smart v. Dane County Bd. of Adjustments, 177 Wis.2d 445, 458, 501 N.W.2d 782, 787 (1993). Stated another way, the concept of laches is that a party is to be forgiven his or her unreasonable delay, provided it has had no prejudicial consequences. *See* Baird v. Bellotti, 724 F.2d 1032, 1033-34 (1st Cir. 1984). The rule was developed by chancellors in equity to prevent the assertion of stale claims and to remedy injustices that might arise from the fact that statutes of limitation ordinarily applicable to the assertion of legal rights did not apply in equitable actions. *See* Knox v. Milwaukee County Bd. of Elections Comm'rs, 581 F. Supp. 399, 402 (E.D. Wis.

Professional Responsibility from bringing a disciplinary action against him, the *Eisenberg Court* stated as follows:

> "[W]e are not persuaded that the doctrine of laches does or should bar a proceeding the issue of which is an attorney's fitness to practice law as demonstrated by his professional conduct. However, a substantial lapse of time between professional misconduct and the initiation of disciplinary proceedings based thereon is a factor to be considered in the determination of appropriate discipline to be imposed, as it may affect the ends lawyer discipline is to achieve: protection of the public, the courts and the legal profession, rehabilitation of the attorney and deterrence of like misconduct by others." Eisenberg, 144 Wis.2d at 294.

Thus, in accordance with *Eisenberg*, the passage of a significant amount of time between an incident of professional misconduct and the commencement of a disciplinary proceeding which is based upon that misconduct does not determine whether a particular licensing body has lost competency to enforce the standards of its profession. Rather, the passage of time is a factor which goes to the issue of the appropriate level of discipline to be imposed. Objectively speaking, the Board heeded these principles: it reduced the period of Dittmann and Meier's suspension from 90 to 30 days, commenting, "Based upon the accepted disciplinary considerations of rehabilitation, deterrence, and public protection, *and in light of the fact that seven years have passed since the conduct in question without apparent incident*, an extended suspension of the licenses is deemed by the board to be inappropriate." (*emphasis added*).

For the purposes of this review the Court will assume that the doctrine of laches applies, notwithstanding what has been set forth above in the preceding paragraph. However, even assuming, *arguendo*, that the doctrine of laches applies to this case, the Court is unpersuaded that each of the three elements of laches are satisfied. Most notably, the

Ultimately, however, this notion proved to be incorrect: the Division's expert witness, Denise Miller Lemke, was permitted to rely upon the correctional officers' reports and written recorded statements in rendering her damning opinions even though the Division did not call a single officer to testify personally at the disciplinary hearing to attest to the authenticity or veracity of their respective statements and/or reports[10].

In essence, Dittmann and Meier claim that they were duped by the Division. They contend that the Division's tactic of getting the statements of the correctional officers into evidence through the testimony of Denise Miller Lemke circumvented the administrative law judge's initial ruling which declared that such statements were inadmissible[11]. They further contend that this tactic nullified their right under §§ 227.44 (3) and 227.45 (6), Stats., to cross-examine the correctional officer witnesses and show the inaccuracies and inconsistencies of their statements[12]. "As such," Meier and Dittmann argue, "the delay substantially prejudiced [our] ability to establish a defense[13]." This Court disagrees.

The prejudice which Dittmann and Meier have claimed is not a function of the five and one-half year delay in the commencement of the prosecution of this matter. There is nothing in this record which shows that the five and one-half year delay caused evidence to go stale or memories to fade. There is nothing in this record to show that the five and one-half year delay made witnesses unavailable or otherwise prevented Meier and Dittmann from

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[10] *Brief of Dittmann and Meier*, filed with the Court on 10/2/97, p. 8.

[11] *Ibid.*

[12] *Ibid.*

[13] *Ibid.*

officers] who were under investigation at the time they made their reports. The administrative law judge denied the motion, reasoning in pertinent part as follows:

> "Section 907.02, Stats., states that: 'If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise'. . . In essence, the respondents argue that the standard of nursing care provided to an individual confined to a correctional facility differs from that provided to individuals in other settings.. [Dittmann and Meier's] argument lacks merit and is not supported by law . . . [Dittmann and Meier also] contend that the testimony which Ms. Miller Lemke will provide will not assist the trier of fact because any opinion which she might offer is based solely on the reports of lay people who were under investigation at the time they made the reports . . . [this argument] goes to the weight, not the admissibility of [Ms. Miller Lemke's] testimony . . . Finally, contrary to [Dittmann and Meier's] contention, the inclusion of [Ms. Miller Lemke's] testimony in the record regarding the standard of care of professional nursing will assist the trier of fact in making a determination in this matter[14]."

Dittmann and Meier contend that the administrative law judge abused her discretion by denying their motion in limine and allowing Denise Miller Lemke to testify on behalf of the Division at the hearing. In support of their contention, they essentially restate the arguments which they had made to the administrative law judge concerning the issue of Denise Miller Lemke's qualifications to testify as an expert in this case[15]. Notwithstanding Dittmann and Meier's arguments to the contrary, this Court believes that the administrative law judge's decision to allow Ms. Miller Lemke to testify at the hearing was a sound decision. Accordingly, the Court refuses to disturb that decision.

Regardless of which standard of review is applied to the administrative law judge's decision to deny Meier and Dittmann's motion to exclude the testimony of Denise Miller

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[14] *See*, Interim Decision and Order of Administrative Law Judge, dated 6/13/96.

[15] *Brief of Dittmann and Meier*, filed with the Court on 10/2/97, pp. 8-12.

It follows that because the Court believes that it was proper for the administrative law judge to have allowed Denise Miller Lemke to testify at the disciplinary hearing of Dittmann and Meier, it is proper not to strike Denise Miller Lemke's testimony from the record. Dittmann and Meier have cited a number of reasons why they believe Denise Miller Lemke's opinions are unreliable and flawed[17]. However, even accepting as true every alleged flaw in the opinion testimony of Denise Miller Lemke, the Court is not led to concur with Dittmann and Meier that the testimony must be stricken from the record altogether. The flaws which Dittmann and Meier claim are a factor in weighing Miller Lemke's testimony with the testimony of the other witnesses who testified at the hearing, not an outright bar to admissibility.

IV. THE VIOLATION OF THE NURSING STANDARD OF CARE.

The fourth issue which Dittmann and Meier have preserved for judicial review is whether the record supports a finding that their conduct fell below the standards of care of the nursing profession. Dittmann and Meier contend that the record does not support such a finding. The Court disagrees.

Dittmann and Meier invite this Court to weigh the evidence anew to determine whether the Division met its burden of proof as to whether a standard of care was violated. The Court must decline the invitation. Rather than weigh the evidence anew, this Court must merely determine whether reasonable minds could have reached the same conclusion that was reached by the agency concerning the standard of care issue. Because reasonable

[17] *Brief of Dittmann and Meier*, filed with the Court on 10/2/97, pp. 11-12.

V. LEVEL OF DISCIPLINE.

The fifth issue which Dittmann and Meier have preserved for judicial review is whether the level of discipline which the Board imposed in their case was excessive and punitive. The Court notes at the outset that the Board is the sole entity responsible for disciplining registered nurses by taking action against their licenses[19]. Accordingly, the decision of whether to take action against a particular nurse's license is a decision which rests in the sound discretion of the Board. The same is ostensibly true of the decision regarding the level of discipline to impose against a given licensee. *See*, Galang v. Medical Examining Bd., 168 Wis. 2d 695, 699 484 N.W.2d 375 (Ct. App. 1992). It is well settled that a court may not exercise discretion committed to an administrative agency. *See*, § 227.57 (8), Stats.; *See also*, Kammes v. Mining Investment & Local Impact Bd., 115 Wis. 2d 144, 157, 340 N.W.2d 206, 213 (Ct. App. 1983). By statute, the Court may only reverse an agency's discretionary decision if it finds that "the agency's exercise of discretion is outside the range of discretion delegated to the agency by law; is inconsistent with an agency rule . . . stated policy or . . . prior agency practice . . . or is otherwise in violation of a constitutional or statutory provision . . ." § 227.57 (8), Stats.

This Court cannot find that the Board's decision to suspended the licenses of Meier and Dittmann for a period of not less than thirty days and impose a detailed series of training requirements and other limitations and conditions upon their licenses was outside the range of discretion delegated to the Board by law. The purposes of discipline by occupational licensing boards are to protect the public, deter other licensees from engaging in similar

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[19] *See generally*, §§ 441.01 and 441.07 (1), Stats.

ORDERED:

The Final Decision & Order of the State of Wisconsin Board of Nursing which was rendered on May 9, 1997, In the Matter of Disciplinary Proceedings against Registered Nurses Holly A. Meier and Beth S. Dittmann is hereby **AFFIRMED** and Holly A. Meier and Beth S. Dittmann's petition for judicial review of that decision is hereby **DISMISSED.**

Dated this 30th day of December, 1997.

BY THE COURT:

John R. Storck
Circuit Court Judge

copies: Attorney Helen Marks Dicks
Attorney Wayne Austin