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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF

DISCIPLINARY PROCEEDINGS AGAINST

STACY L. NELDAUGHTER. R.N. LS9712191NUR

Respondent

FINAL DECISION AND ORDER

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

Stacie L. Neldaughter, R.N.
3271 Annrae Street
San Diego, CA 92123

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

Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

This proceeding was commenced by the filing of a Notice of Hearing and Complaint on December 19, 1997**.** A hearing was held in this matter on July 28, 29 and 31, 1998. Attorney John Zwieg appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Attorney Virginia L. Lynns, Lynns Law Office, appeared on behalf of the Respondent at hearing; Attorney Christopher henry appeared for Respondent during the post-hearing phase of the proceedings. The hearing transcript of the proceeding was filed on or about August 27, 1998; and Closing Arguments were filed by the parties on or before August 31, 1998.

the administrative law judge filed her proposed decision in the matter on march 10, 1999. both parties filed written objections to the Proposed decision, and the parties appeared before the board on May 13, 1999, for oral arguments in support of their objections. The board considered the matter on that date.

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

FINDINGS OF FACT

1. Stacie L. Neldaughter (d.o.b. 04/13/63) is licensed by the Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 96959, which was first granted on August 27, 1987.

2. Neldaughter's latest address on file with the Department of Regulation and Licensing is 3271 Annrae Street, San Diego, California 92123.

3. Neldaughter was employed as a registered nurse on the psychiatric unit at St. Marys Hospital Medical Center in Madison, Wisconsin at least from 1989 to January or February 1994. She provided psychiatric nursing services to patients.

4. In January or February 1994, Neldaughter transferred to a position as a registered nurse on a medical surgical

unit at the hospital. Because of a lack of recent training or experience, Neldaughter was not comfortable functioning as a registered nurse on a medical surgical unit.

5. In April 1994, Neldaughter commenced employment as a laboratory customer service assistant at the hospital laboratory. An individual employed as a laboratory customer service assistant is not required to be licensed as a registered nurse.

6. While employed in the psychiatric unit between 1989 and January or February 1994, Neldaughter intermittently provided nursing services to a patient named T.H..

7. T. H. was an inpatient on the psychiatric unit at the hospital from July 24, 1994 through September 26,1994. Her admitting diagnosis on July 24, 1994 was major depression.

Her discharge diagnoses on September 26, 1994 were as follow: Principal diagnosis - Axis I: Major depression, recurrent, unspecified. Secondary diagnoses included, but are not limited to: multiple personality disorder, improved; prolonged post traumatic stress disorder; histrionic personality disorder, unspecified, and borderline personality.

8. On September 16,1994, T.H. was leaving the hospital on a pass when she encountered Neldaughter. Neldaughter was leaving work for the day. Both were going to the parking ramp across the street from the hospital at the time of the encounter. They recognized each other from the time Neldaughter provided psychiatric nursing services to T.H. at the hospital. They greeted each other. T.H. asked Neldaughter why she was not working on the psychiatric unit anymore. Neldaughter told T.H. that she was not working on the psychiatric unit because she had been fired for blowing the whistle on abuses and that she was unable to tolerate working on the unit as a nurse.

9. During the encounter between Neldaughter and T.H. on September 16, 1994, they discussed:

a. The electroconvulsive therapy treatment ("ECT") given to patients at the hospital.

b. That the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission") was conducting a survey at the hospital.

c. That they would get together again sometime in the near future.

10. During the encounter between Neldaughter and T.H. on September 16, 1994, T.H.:

a. Told Neldaughter that at some point in time in the past she had fallen down in the lobby of the hospital.

b. Told Neldaughter that her ex-roommate had ECT and that the ex-roommate told her she did not want ECT anymore.

11. During the encounter between Neldaughter and T.H. on September 16, 1994, Neldaughter:

a. Told T.H. that she met with the Joint Commission that day relating to informed consent ECT violations at the hospital.

b. In response to the question asked by T.H., "is there anything you want to say to anybody?" (on the unit) , told T.H. "yeah, tell Joan Hoyer to fuck herself" and said "fuck Jackie and fuck Claudette".

12. On Saturday, September 17, 1994, Neldaughter received a telephone call from a nursing assistant working at the hospital about ECT given to a patient who was screaming not to have it.

13. On Saturday, September 17, 1994, around 3:00 p.m., Neldaughter called T.H. on the psychiatric unit. They agreed to meet in the hospital cafeteria later that day for dinner. When Neldaughter arrived at the hospital she proceeded to go up to the psychiatric unit to see

T.H.. They went to the hospital cafeteria for dinner.

14. While in the hospital cafeteria on September 17, Neldaughter:

a. Told T.H. that patients on the psychiatric unit at the hospital were being given ECT without their consent.

b. Asked T.H. whether she heard screaming on the unit by patients who did not want ECT.

c. Handed T.H. a flyer (patient information sheet) relating to ECT informed consent and asked her to show it to patients on the unit who were receiving ECT.

d. Told T.H. that Claudette, T.H.'s therapist, said things about her to other staff people, such as "T.H. thinks she

is so important, she doesn't care about anybody".

e. Showed T.H. a picture of a plaque that a doctor had given to the nursing staff to compliment the care that the staff had given to a patient and explained to T.H. what the picture represented. The plaque, which was hung in the nurses' lounge, had a garden glove on it and underneath it read something to the effect: "The Adeline - In the face of overwhelming obstacles, for excellence in nursing care". The nurses wore garden gloves to protect themselves from being scratched by the patient. She told T.H. that the plaque represented a disrespectful attitude and that it was a violation of the dignity of the patient.

f. Told T.H. that the nurses listened to patients in their rooms over the intercom system.

g. Asked T.H. to talk with surveyors from the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission") and tell them about ECT issues.

h. Asked T.H. to go with her to a rally in front of the hospital on Monday, September 19 where she would be speaking about informed consent violations.

15. T.H. has never had ECT treatments.

16. Neldaughter's agenda included assuring patient input and participation in the informed consent ECT debate at St. Marys.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to s. 441.07 Wis. Stats., and ch. N 7, Wis. Adm. Code.

2. Respondent's conduct as described in Findings of Fact (11) (b), (14) (a) and (14) (c) through (h) herein, constitutes misconduct and unprofessional conduct in violation of s. 441.07 (1) (d), Stats., and s. N 7.04, Code.

3. For purposes of interpreting s. N7.04 (4), Code, T.H. is not a patient, as the term patient is defined in s. N 7.02 (5), Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Stacie L. Neldaughter to practice as a professional nurse in Wisconsin be, and hereby is, suspended for not less than one year.

IT IS FURTHER ORDERED that at any time after one year, Ms. Neldaughter may apply for reinstatement of her license. Prior to reinstatement of the license, Ms. Neldaughter shall submit to a psychological evaluation by a psychiatrist or psychologist, who shall be approved in advance by the board, to determine whether, in the opinion of the psychiatrist or psychologist, Ms. Neldaughter may safely and competently resume the practice of professional nursing in Wisconsin.

IT IS FURTHER ORDERED that should the psychologist or psychiatrist who conducts the evaluation of Ms. Neldaughter recommend that limitations be placed on her license to practice professional nursing in order to ensure that she is able to safely and competently practice, the board may impose such limitations as a condition of reinstating the license.

IT IS FURTHER ORDERED that Respondent's Motion to Dismiss the charges in Count II of the Complaint relating to the alleged violations of s. N 7.04 (4), Wis. Adm. Code is granted.

IT IS FURTHER ORDERED that, Pursuant to s. 440.22 Wis. Stats., the cost of this proceeding shall be assessed against Respondent, and shall be payable to the Department of Regulation and Licensing.

EXPLANATION OF VARIANCE

The Board of Nursing has accepted the Findings of Fact and Conclusions of Law of the Administrative Law Judge in their entirety. The board has also accepted that portion of the recommended Order by which Count II of the Complaint is dismissed, and by which the costs of the proceeding are assessed against the respondent. The board has not, however, accepted that portion of the recommended Order by which Ms. Neldaughter would be reprimanded, and has instead ordered that her license be suspended for at least one year, and that she submit to a psychological evaluation prior to reinstatement of her license to establish that she may safely and competently return to practice. Should the evaluation recommend that limitations be placed on her license to ensure her safe practice, the Order provides that the board may impose such limitations.

It is well established that the purposes of discipline is the protection of the public by promoting the rehabilitation of the licensee and by deterring other licensees from engaging in similar misconduct. *State v. Aldrich,* 71 Wis. 2d 206 (1976). Punishment of the licensee is not an appropriate consideration. *State v. McIntyre*, 41 Wis. 2d 481

(1968). The board concludes that these disciplinary objectives would not be adequately served by a simple reprimand.

The patient in this case, T.H., has a history of severe psychological difficulties and many inpatient hospitalizations. The hearing record documents T.H.'s vulnerability and lack of trust in her relationships with others. Respondent, a trained psychiatric nurse who had had previous professional contact with T.H., and who was aware that T.H. had had frequent inpatient treatment, acted with apparent indifference to the possible adverse impact that her interaction with the patient might have. In attempting to recruit T.H. as an active participant in her attempts to reform the hospital's policies and procedures relating to the administration of ECT, Ms. Neldaughter made numerous representations to T.H. that she knew or should have known would expose T.H. to the risk of harm. These included telling T.H. that patients on her hospital unit were receiving ECT without their consent, that staff on the unit were talking about and making fun of the patients, that the T.H.'s own therapist had said negative things about her, and that staff secretly listened to patients over the intercom system. Her attempts to recruit T.H. to her cause included asking that T.H. show an anti-ECT flyer to patients on her floor, and that she attend an anti-ECT rally to be held in front of the hospital.

That these actions by Ms. Neldaughter did in fact have an harmful impact on T.H. is shown in the medical records maintained at the time of T.H.'s meetings with Ms. Neldaughter. These records describe a patient steadily progressing toward discharge on September 16, 1994, but who then regressed to a state where she was fearful to leave the hospital on an overnight pass by September 21, 1994.

Just as alarming as Ms. Neldaughter's inappropriate conduct in this case is the fact that as late as the time of the hearing in this matter, she continued to maintain that she had done nothing wrong in her interactions with T.H.. Such inability to recognize the seriousness of her misconduct establishes that assuming that rehabilitation is possible, it has yet to occur.

Based upon the seriousness of Ms. Neldaughter's conduct, the board deems a one year suspension of her license to be the minimum discipline necessary to meet the disciplinary objectives of protecting the public and deterring other licensees from engaging in the same or similar misconduct. Because of the board's concern with Ms. Neldaughter's apparent inability to

recognize the potential and demonstrated patient harm arising from her actions, the board also orders that prior to returning to practice in Wisconsin, she submit to an evaluation of her ability to practice professional nursing with minimum skill and reasonable safety to her patients.

Dated this 21stday of May, 1999.

STATE OF WISCONSIN

BOARD OF NURSING

by_____

Timothy D. Burns, CRNA

Chairman