WISCONSIN DEPARTMENT OF REGULATION & LICENSING

Wisconsin Department of Regulation & Licensing
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Regulation & Licensing website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Regulation and Licensing from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Regulation and Licensing data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Regulation and Licensing, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Regulation and Licensing is shown on the Department's Web Site under "License Lookup." The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DRL website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST :	FINAL DECISION AND ORDER
PATRICIA A. BAUER, R.N	LS9903052NUR
RESPONDENT.	

:

: ., : :

---

96 NUR 203

The parties to this action for the purposes of Wis. Stats. sec. 227.53 are:

Patricia A. Bauer
5544 South 113th Street
Hales Corners, WI 53130

Wisconsin 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

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Patricia A. Bauer (D.O.B. 3/01/47) is duly licensed in the state of Wisconsin as a registered nurse (license # 85258). This license was first granted on September 1, 1983.

2. Respondent’s latest address on file with the Department of Regulation and Licensing is 5544 South 113th Street, Hales Corners, WI 53130.

3. At all times relevant to this action Respondent was employed as a registered nurse in the cardiac unit of St. Josephs Hospital, Milwaukee, Wisconsin.

4. On August 16, 1994, a 77 year old female patient, GS , was admitted to the hospital with a diagnosis of

congestive heart failure, massive edema and severe coronary heart disease. The patient's prognosis was poor. During her hospital stay the patient's potassium level fluctuated widely. On September 13 the treating physician issued a standing nurses order for "KCL 20 MEQ W 50mg Lidocaine, IV Solucet. Repeat to keep K greater than 3.8" In addition there was a daily order for a KCL extended release tablet. On September 17 it was noted that the patient was very ill, had a fever and was perspiring. Blood cultures revealed gram-positive cocci and treatment with Vancomycin was started.

5. Respondent was assigned to care for patient GS on September 17 from 7:30 A.M. to 7:00 P.M. In conjunction with her mid-morning assessment of the patient Respondent reviewed the computerized patient chart including lab reports of the morning's blood draw. The computer terminal was located at the nurse's station. By touching the screen Respondent was able to access a particular patient record and could switch from the general patient record to the lab reports. However, the lab reports could be scrolled from patient to patient . Respondent believes that she inadvertantly touched the screen and accessed the wrong patient's lab report so that she actually read the potassium level of someone other than patient GS. Respondent was aware of the computer screen sensitivity, but did not check or see the patient name that was displayed in the upper corner of the computer screen. She read a potassium level of 3.2 (slightly low).

Respondent proceeded to administer scheduled medications including a potassium chloride tablet. However, the patient vomited after receiving her medications. At 15:30 Respondent telephoned the doctor on call to report that GS was nauseous and that her potassium was low. Respondent reported her intent to administer the standing order potassium, and following the telephone conference she did so.

At 18:00 Respondent completed her charting and shift report at the nurse's station. As a matter of routine she re-checked the computer charts and then discovered that the potassium level of GS from the morning blood draw was 5.7 and not 3.2. Respondent telephoned the doctor on call to report the error and that the Solucet had been administered. A stat potassium level test was ordered and the result was a level of 8.2. Respondent was referred to the cardiologist and then to the nephrology unit. Kayexalate enemas were initiated and the Code team was alerted due to widening heart rhythms. The patient went to VT tach and then asystole at 19:27. The patient was not responsive to chemical intervention and was pronounced dead at 19:51.

6. In addition to the above, the patient record of patient GS reflects that Respondent charted a 9:00 assessment at 11:30, "back- timed" a 15:30 Solucet administration to 15:00, did not record the time of a physician order for dopamine drip and did not record the name of the physician who ordered IV Lasix. It is Respondent's position that the conduct of "back-timing" entries is not in violation of the policies and procedures of St. Joseph's Hospital.

CONCLUSIONS OF LAW

By the conduct described above, Patricia A. Bauer is subject to disciplinary action against her license to practice as a registered nurse in the state of Wisconsin, pursuant to Wis. Stats. sec. 441.07(1)(b), (c) and (d), and Wis. Adm. Code sec. N 7.03(1)(a), (b), (c) and (e) and N 7.04(15).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that :

1. Patricia A. Bauer is REPRIMANDED.

2. The license of Respondent to practice as a nurse in the state of Wisconsin is LIMITED as follows:

a. Respondent shall certify to the Board the successful completion of an approved course of training in medication administration and documentation to include training in the use of computer based patient record data entry and interpretation, within 9 months of the date of this order. Within 2 months of the date of this Order, Respondent shall submit to the Board designee an outline of the required training for approval, which shall contain the name of the institution providing the instruction, the name of the instructor, and the course content.

Failure by Respondent to fully and timely comply with the requirements of this Order shall result in the suspension of Respondent's license to practice as a nurse without further notice or hearing, until such time as full compliance with the provisions of this Order has been attained.

b. Respondent shall provide her nursing employers with a copy of this Order before engaging in any nursing employment.

3. The rights of a party aggrieved by this Decision to petition the Board for rehearing and to petition for judicial review are set forth on the attached "Notice of Appeal Information".

4. This Order shall become effective upon the date of its signing.

WISCONSIN BOARD OF NURSING

By: Timothy D. Burns CRNA	Date
A Member of the Board	March 5, 1999