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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF
THE INVESTIGATION OF

DONNA J. KREYE, L.P.N.,

Licensee LS0003072LPN

MEMORANDUM AND ORDER ON SETTLEMENT CONFERENCE

TO: Donna M. Kreye, LPN
1144 North Oak Street
Lake City, MN 55041

Pamela M. Stach
Attorney at Law
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

An informal settlement conference was conducted by telephone in the above-captioned matter before an informal settlement conference of the Board of Nursing on January 6, 2000. The purpose of the conference was to provide interested parties with an opportunity to discuss allegations received pertaining to the practice of Ms. Kreye as a licensed practical nurse, and to attempt to reach a fair and consensual resolution of the matter.

Ms. Kreye appeared telephonically without legal counsel. The committee consisted of Ann Brewer, RN, and Ruth Lindgren, RN. Others present included Pamela M. Stach, attorney for the Department of Regulation & Licensing, Division of Enforcement, and Wayne Austin, the board's legal counsel.

The parties orally presented their respective positions regarding the matter to the committee, and the committee deliberated on a possible disposition of the matter. The committee thereafter presented a proposed Stipulation for Ms. Kreye's consideration, a copy of which is attached hereto and made a part hereof. The Stipulation was ultimately executed by Ms. Kreye, Ms. Stach, and Ann Brewer, board Chair.

Based upon the proceedings at the conference, and upon the Stipulation of the parties, the board enters the following order.

ORDER

NOW, THEREFORE, IT IS ORDERED that Within six months of the date of this Order, Ms. Kreye shall complete at least 6 hours of continuing education in the area of the management of the diabetic patient.

IT IS FURTHER ORDERED that within six months of the date of this Order, Ms. Kreye shall complete at least 6 hours of continuing education in the legal and ethical issues in the practice of nursing.

IT IS FURTHER ORDERED that for a period of one year following the date of this Order, Ms. Kreye shall arrange for quarterly work reports from her employer setting forth Ms. Kreye's activities and performance in her nursing practice.

Dated this 7th day of March, 2000.

STATE OF WISCONSIN
BOARD OF NURSING

by _____
Ann Brewer, R.N.
Chair

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF
THE INVESTIGATION OF

DONNA J. KREYE, L.P.N.,

Licensee

STIPULATION

Donna Kreye, L.P.N. (Ms. Kreye), and the Board of Nursing (board), having reached agreement on disposition of the informal complaint identified as 98 NUR 091, agree and stipulate as follows:

1. This Stipulation shall be made a part of a Memorandum and Order on Settlement Conference to be issued by the board, and all terms of the Stipulation shall be binding on Ms. Kreye as a part of the board's order.

2. This Stipulation and the board's order shall be placed in Ms. Kreye's permanent file, and may be used if there are further complaints against her.

3. Ms. Kreye is licensed to practice as a practical in Wisconsin by license #34486, issued on November 26, 1997 and her address of record is 1144 North Oak Street, Lake City, MN 55041.

4. Ms. Kreye was working at Pepin Manor (an extended care nursing facility) as a licensed practical nurse on January 2, 1998.

5. Ed Lyons was one of the patients for which Ms. Kreye was responsible on January 2, 1998. Mr. Lyons, an 84-year old male, suffered from poorly controlled diabetes. His treatment regiment for the diabetes included a specific amount of insulin administered every morning, and a sliding scale of insulin to be given in the afternoon, depending on the Accu-check reading. The sliding scale for the insulin was 8 units plus anywhere from 3-7 additional units depending on the elevation of the Accu-check reading, according to the MAR and the physician orders in the patient chart.

6. At 4:00 p.m. on January 2, Ms. Kreye took Mr. Lyon's Accu-check reading. It registered at 42, which is a low reading. Ms. Kreye gave the patient orange

juice with sugar. At 4:30, according to the medication administration records and Ms. Kreye's statement, Ms. Kreye gave the patient 8 units of 70/30 human insulin without checking the blood glucose level.

7. At 4:45 Ms. Kreye's notes in the patient record indicate she took another Accu-check reading at it was unreadably low. Ms. Kreye wrote in the patient record that the patient was 'semi-responsive' but had a blinking reflex. The respondent assisted the patient to a lying position and gave more orange juice with sugar. No physician contact was initiated at that time, according to the patient record. Ms. Kreye states that contact with the attending physician was not possible because he was "not available". There is no indication as to how the attending was unavailable or why an on-call physician was not contacted.

8. At 5:10 another Accu-check reading was made and his blood sugar level continued to be read as LO. At 5:15, Ms. Kreye attempted to administer Glutose 15 orally. The patient's notes written by Ms. Kreye indicate that she had a difficult time getting the patient to swallow the gel. The patient was non-responsive to verbal stimuli at this point, but according to the patient record had a blinking reflex. There is no indication that an attempt to reach the attending or the on-call physician was made at this time.

9. At 5:30 p.m., another Accu-check reading was taken, which continued to be LO. The patient remained unresponsive according to the patient record. Ms. Kreye's notes indicate she was going to attempt to administer another tube of Glutose 15. There is no indication in the patient record that an attempt to reach the attending or on-call physicians was made at this time.

10. Jodi Mueller, another LPN working at the facility that evening was contacted and states that the patient was not truly unresponsive when she observed him at approximately 5:45 p.m. Ms. Mueller stated that the patient was weak but conscious, and able to verbalize in words but not complete sentences. Ms. Mueller stated that at the time she saw Mr. Lyons he was unable to swallow. Ms. Mueller stated that she understood that the Glutose was to be put in Mr. Lyons mouth to be absorbed through the mucus membranes, and was not given to the patient with the intention that it be swallowed

11. At 5:45, the patient record indicates that Ms. Kreye contacted a family member to request permission to transport the resident to a hospital. Ms. Mueller stated in her interview that she 'took over' at this point to make sure that the appropriate contacts were being made. Ms. Kreye, in her initial rebuttal to the Board, indicated that she allowed Ms. Mueller to "assume a lot of the responsibility and leadership in this situation" due to her lack of experience with this type of situation. At 5:50 the physician was contacted and gave consent to transfer the patient; at 5:55 the ambulance

was called for transfer. The notes indicate that the physician OK'd the use of Glutose x2 and sugar in the mucosa of the mouth to raise the patient's blood sugar level. There is no indication in the patient record that this was done at this time.

12. There is no indication that the RN on call was notified of any of the events that transpired as they were occurring. Ms. Kreye states that she did contact a RN before transferring the patient to the hospital; though this contact is not reflected in the patient record. Ms. Kreye states that there was "never certainty as to who would be the RN to call if there was a problem."

13. Based on the statement made in the BQA survey report, the patient was given IM Glucagon upon admission to the ER and became alert within seconds.

14. The survey report from BQA also indicated that at the time of the incident, there was no care plan for this patient which addressed the appropriate nursing interventions in the case of a hypoglycemic episode. In addition, the BQA survey reported that the facility had no policies, procedures or protocols which addressed the consistent oral treatment of hypoglycemia, the use of gluctose and glocagon, or the parameters for when to notify physicians regarding abnormal blood sugar results. Facility staff was inserviced on general parameters for oral treatment of hypoglycemia and physician notification on January 6, 1998. However, a specific care plan for this patient addressing these issues was not developed until February 23, 1998.

15. The parties agree that Ms. Kreye's actions in this instance constituted an act or omission demonstrating a failure to maintain competency in practice and methods of nursing care, in violation of sec. N 7.03(1)(b), Code.

16. The parties agree that in resolution of this matter, Ms. Kreye's license shall be limited as follows:

a. Within six months of the date of the board's Order adopting the terms of this Stipulation, Ms. Kreye shall complete at least 6 hours of continuing education in the are of the management of the diabetic patient.

b. Within six months of the date of the board's Order adopting the terms of this Stipulation, Ms. Kreye shall complete at least 6 hours of continuing education in the legal and ethical issues in the practice of nursing.

c. For a period of one year following the date of the board's Order adopting this Stipulation, Ms. Kreye shall arrange for quarterly work reports from her employer setting forth Ms. Kreye's activities and performance in her nursing practice.

Dated this 10th day of January, 2000.

Donna J. Kreye, L.P.N.

Dated this _____ day of _____, 2000.

Pamela M. Stach
Attorney, Division of Enforcement

Dated this 2nd day of March, 2000.

STATE OF WISCONSIN
BOARD OF NURSING

by _____
Ann Brewer, R.N.
Chair

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