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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY

PROCEEDINGS AGAINST:

SANDY GARRAND, R.N.,	FINAL DECISION AND ORDER
RESPONDENT	LS0009063NUR

The State of Wisconsin, Board of Nursing, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Board of Nursing.

The Division of Enforcement and Administrative Law Judge are hereby directed to file their affidavits of costs with the Department General Counsel within 15 days of this decision. The Department General Counsel shall mail a copy thereof to respondent or his or her representative.

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

Dated this 4th day of January, 2001.

Ann Brewer

A Member of the Board

STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST

SANDY GARRAND, R.N.,	**PROPOSED DECISION**
RESPONDENT	**LS0009063NUR**

PARTIES

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

Sandy Garrand

360 South 200 West Palladio, D-509

Salt Lake City, Utah 84101

Board of Nursing

P.O. Box 8935

Madison, WI 53708-8935

Department of Regulation & Licensing

Division of Enforcement

P.O. Box 8935

Madison, Wisconsin 53708

This matter was commenced by the filing of a Notice of Hearing and Complaint on September 6, 2000. A hearing was held in the above-captioned matter on November 1, 2000. Atty. James W. Harris appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. The respondent, Sandy Garrand, did not file an Answer to the Complaint and did not appear at the hearing held in this matter.

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. Sandy Garrand (d.o.b., 07/27/49), is licensed as a registered nurse in the state of Wisconsin. This license, #99519, was first granted on June 3, 1988.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 11862 County H, Marshfield, Wisconsin 54449. Respondent's current address is 360 South 200 West Palladio, D-509, Salt Lake City, Utah 84101.

3. Ms. Garrand was employed as a registered nurse at St. Joseph's Hospital in Marshfield, WI, from December 1988 to February 2000. She initially worked as the nurse manager of the Neonatal Intensive Care Unit, then transferred to the Palliative Care Unit in approximately 1990. She was employed as a staff nurse on the Palliative Care Unit from 1990 to February 2000.

4. On February 10, 2000, while working as a registered nurse on the Palliative Care Unit at St. Joseph's Hospital, Ms. Garrand failed to change the concentration of a pain medication, Hydromorphone, on Patient EW's PCA (Patient Controlled Analgesia) pump from 5 mg/ml to 2 mg/ml, as ordered by the patient's physician. This resulted in the patient receiving less opioid than ordered by her physician to control her pain.

5. On February 10, 2000, while working as a registered nurse on the Palliative Care Unit at St. Joseph's Hospital, Ms. Garrand made a medication error involving a different patient in that she set the patient's pain medication rate, at 3.5 mg per hour instead of 3.0 mg per hour as ordered by the patient's physician. As a result, the patient received more Hydromorphone than the physician had ordered. Hydromorphone is a fairly potent pain medication. If a patient receives too much Hydromorphone, the patient could suffer respiratory depression and even death.

6. On February 17, 2000, while working as a registered nurse on the Palliative Care Unit at St. Joseph's Hospital, Ms. Garrand increased the bolus dose of Patient EM's pain medication from 2 mg to 3 mg, as ordered by the patient's physician. At the time Ms. Garrand made the adjustment to EM's pain medication pump, she also stopped the basal (continuous) dose of the patient's pain medication. Ms. Garrand did not have a physician's order to stop the basal (continuous) dose of the patient's pain medication. Setting the bolus dose should not have effected the basal dose. The risk to the patient was that he would experience uncontrolled pain and suffer as a result of it.

7. On February 18, 2000, at or around 7:30 a.m., while working as a registered nurse on the Palliative Care Unit at St. Joseph's Hospital, Ms. Garrand performed a routine pain assessment of Patient D, then recorded her findings in the patient's medication flow sheet. Hydromorphone was being given to the patient at the time Ms.

Garrand performed her assessment. Ms. Garrand wrote down on the medication flow sheet that the Patient D was receiving Morphine instead of Hydromorphone. Dr. Claessens, the Medical Director, noted that Ms. Garrand had recorded an incorrect narcotic name on the patient's pain flow sheet. Nurse Lennet Radke, Ms. Garrand's supervisor, handed the pain flow sheet to Ms. Garrand and pointed out the error to her and asked her to correct it right away. Ms. Garrand never corrected the error on the pain flow sheet.

8. On February 18, 2000, at or around 1:00 p.m., while working as a registered nurse on the Palliative Care Unit at St. Joseph's Hospital, Ms. Garrand removed a Morphine bag instead of a Hydromorphone bag, from the narcotic drawer and then hung the wrong medication on Patient D. Ms. Garrand did not check the Medication Administration Guide or the Hydromorphone bag that was in the PCA pump prior to hanging the next infusion. From 1:00 p.m., until 4:00 p.m., Patient D received substantially less pain medication than she should have received.

9. On February 18, 2000, while working as a registered nurse on the Palliative Care Unit at St. Joseph's Hospital, Ms. Garrand signed off on orders for Patient D that she never sent to the pharmacy, did not process and did not pass along in a report.

10. On February 18, 2000, while working as a registered nurse on the Palliative Care Unit at St. Joseph's Hospital, Ms. Garrand failed to post a sign in Patient AB's room stating that a fluid restriction order had been written for AB by her physician. AB was allowed to receive orally a certain number of cc of fluid each day (usually in order to control congestive heart failure, renal failure or some other condition). Depending on the patient's diagnosis, the risk to the patient was that she could have had a flare of her congestive heart failure or if she had been experiencing either congestive heart failure or renal failure, she could have gone into fluid overload if left unchecked long enough.

11. On June 6, 2000, following two evaluations performed by Dr. Stuart Waltonen, a licensed psychologist, Ms. Garrand was diagnosed as having cognitive dysfunction. There were secondary diagnoses relating to her alcohol and substance abuse. In addition, a diagnosis of bipolar disorder, depressed type, was referenced from her previous medical care.

12. Respondent did not file an Answer to the Complaint filed in this matter and did not appear at the hearing held in this matter.

CONCLUSIONS OF LAW

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

2. By having engaged in conduct as described in Findings of Fact 4-10 herein, respondent violated s. 441.07 (1) (b) and (d), Stats., and s. N 7.03 (1) (a) and (b), N 7.03 (2) and (3), and N 7.04 (2) and (15),Wis. Adm. Code.

3. By failing to file an Answer to the Complaint and failing to appear at the hearing held in this matter, respondent is in default under s. RL 2.14 Wis. Adm. Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license (#99519) of Sandy Garrand to practice as a registered nurse in the state of Wisconsin be, and hereby is, SUSPENDED FOR AN INDEFINITE PERIOD OF TIME.

IT IS FURTHER ORDERED that:

(1) Petition for Stay. Ms. Garrand may petition the Board at any time for a stay of the suspension of her license. In conjunction with such petition, Ms. Garrand shall submit documentation of an evaluation performed by one or more health care providers acceptable to the Board of her fitness to safely and competently resume practice as a registered nurse including, but not limited to: 1) an assessment of her current use and/or dependence on alcohol and controlled substances and 2) a re-evaluation of her cognitive and neuropsychologic status. The assessor (s) shall submit a written report of his or her findings directly to the Board, including: 1) any diagnosis; 2) recommendations (if any) for treatment; 3) an evaluation of Ms. Garrand's level of cooperation in the assessment process; 4) work restriction recommendations, and 4) Ms. Garrand's prognosis. The report (s) shall include a certification stating that Ms. Garrand is fit to safely and competently return to the active practice of nursing. The assessment (s) shall occur within thirty (30) days prior to the date of submission and reflect the fact that the person (s) performing the assessment (s) received a copy of this Order.

(2) Board Action. (a) Upon its determination that Ms. Garrand can safely and competently return to the active

practice of nursing, the Board may stay the suspension for a period of three (3) months, conditioned upon compliance with the conditions and limitations set forth in paragraph (3).

(b) Respondent may apply for consecutive three (3) months extensions of the stay of suspension, which shall be granted upon acceptable demonstration of compliance with the conditions and limitations imposed upon respondent's practice during the prior three (3) month period.

(c) Upon a showing by respondent of complete, successful and continuous compliance for a period of five (5) years with the terms of paragraph (3), below, the Board may grant a petition by respondent for return of full licensure if it determines that respondent may safely and competently engage in practice as a registered nurse.

(3) Conditions of Stay

(a) If the assessment report (s) referred to in paragraph (1) above recommends continued therapy, respondent shall maintain successful participation in a program of treatment at a health care facility acceptable to the Board. As a part of treatment, respondent must attend therapy on a schedule as recommended by her therapist; the Board may, however, in its discretion establish a minimum number of therapy sessions per month.

(b) If continued therapy is required under the stay Order, respondent shall arrange for submission of quarterly reports to the Board from her therapist evaluating her attendance and progress in therapy. If the assessment recommends work restrictions, respondent shall comply with all restrictions recommended.

(c) Respondent shall not engage in medication administration except under the direct supervision of another registered nurse.

(d) Respondent shall provide the Board with current releases complying with state and federal laws, authorizing release and access to the records of the health care provider(s) performing her assessment.

(e) Respondent shall be responsible for all costs associated with the assessment referred to in paragraph (1) above, and for all treatment and reporting required under the terms of the stay Order.

(f) Respondent shall provide all current and prospective nursing employers with a copy of this Final Decision and Order and any subsequent stay Orders; arrange for submission of quarterly reports to the Board of Nursing from her nursing employer(s) reporting the terms and conditions of her employment and evaluating her work performance, and report to the Board any change in her employment status within five (5) days of such change.

(4) Petition for Modification of Terms

Respondent may petition the Board in conjunction with any application for an additional stay to revise or eliminate any 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 within the meaning of Wis. Stats. s. 227.01 (3) and 227.42.

(5) Motion for Default. Complainant's Motion for Default is granted.

(6) Costs. 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.

This order is effective on the date on which a representative of the Board signs it.

OPINION

The complainant alleges in its Complaint that, by engaging in the conduct described therein, Ms. Garrand violated numerous provisions set forth in ch. 441, Stats., and ch. N 7, Wis. Adm. Code. The evidence presented establishes that the violations occurred.

I. Background

Ms. Sandy Garrand is licensed as a registered nurse in the state of Wisconsin. She was granted a license to practice professional nursing on June 3, 1988. She was employed as a registered nurse at St. Joseph's Hospital in Marshfield, WI, from December 1988 to February 2000. She initially worked as the nurse manager of the Neonatal Intensive Care Unit, then transferred to the Palliative Care Unit in 1990. She was employed as a staff nurse on the Palliative Care Unit from 1990 to February 2000.

Ms. Lennet Radke testified at the request of the Division of Enforcement. Her testimony was given at a deposition held on October 6, 2000. Ms. Radke is licensed as a registered nurse and nurse practitioner in the

state of Wisconsin. She is employed at St. Joseph's Hospital in Marshfield as program manager and nurse consultant for the Palliative Care Unit. Prior to holding that position, Ms. Radke was employed as nurse manager of the Oncology Program at St. Joseph's for about 13 years. She was Ms. Garrand's supervisor when Ms. Garrand worked on the Palliative Care Unit. Ms. Radke testified that Ms. Garrand was a staff nurse on the Unit and that Ms. Garrand's duties included providing direct patient care and supervision of non-licensed staff. She said that the general population of the Palliative Care Unit consists of patients who are at end stages of life as well as patients who have advance disease and are having trouble with symptoms such as pain or shortness of breath. *Exhibit 1, p. 3-4.*

Dr. Stuart Waltonen testified at the request of the Division of Enforcement. Dr. Waltonen is a licensed psychologist in the state of Wisconsin. He practices neuropsychology.

II. Evidence Presented

By failing to file an Answer to the Complaint and failing to appear at the hearing held in this matter, Ms. Garrand is in default under s. RL 2.14, Code. Therefore, the Board of Nursing may make findings and enter an order on the basis of the Complaint and other evidence.

The evidence presented at the hearing included the deposition testimony of Lennet Radke and the hearing testimony of Dr. Stuart J. Waltonen, Ph.D.

A. Deposition Testimony of Nurse Radke

1. Respondent's Nursing Practices - in General

Ms. Radke testified that in early 2000 she was made aware of concerns from the Unit staff about Ms. Garrand's nursing practice. She also had some concerns of her own. She said that in February 2000, she began receiving feedback from Ms. Garrand's peers on the Unit that Ms. Garrand's thought processes seemed distracted and that she lacked focus or attention. She said that the objective means that the staff used to described Ms. Garrand included "vague and insufficient reports, lack of knowledge about patient condition and planned care, and just inconsistencies in her practice, little things that they noticed that didn't seem to be quite right."

One example of Ms. Garrand's conduct that Ms. Radke expressed concern about related to taped reports that "off-going" nurses prepare for "on-coming" nurses. The nurses give each other a taped report at shift change, and they are able to ask questions of one another after that report. She said that if a nurse prepares a vague or insufficient report, the risk is that important information in that person's care could be missed and either symptoms would be poorly controlled or care is just not at top-notch quality. She said that in Ms. Garrand's reports, she did not seem familiar enough with the patients' care as the staff thought she should have been.

2. Respondent's conduct on February 10, 2000

Ms. Radke testified that on February 10, 2000, Ms. Garrand made two medication errors that the staff became aware of on February 11, 2000. One error involved failing to change the concentration of a pain medication, Hydromorphone, on Patient EW's PCA (Patient Controlled Analgesia) pump from 5 mg/ml to 2 mg/ml. This resulted in the patient receiving less opioid than ordered by her physician to control her pain. Ms. Radke said that a nurse with Ms. Garrand's level of experience would have known to go through every setting of the pump to make sure that it was correct. So, in essence, what Ms. Garrand failed to do in that situation was to verify what she was giving by looking at the bag and to verify the correct pump setting. *Exhibit 1, p. 9; Exhibit 2, p. 2.*

The second medication error made by Ms. Garrand involved a different patient. Ms. Garrand set the patient's pain medication rate at 3.5 mg. per hour instead of 3.0 mg. per hour as ordered by the physician. As a result, the patient received more Hydromorphone than the physician had ordered. Ms. Radke said that Hydromorphone is a fairly potent pain medication. If a patient receives too much of it, the patient could suffer respiratory depression and even death. When asked if there is a method that a registered nurse practicing up to standard would follow to ensure that she is administering the correct dosage, Ms. Radke testified as follows:

> A. Yes, in this situation it is the principal of the right patient, the right medication, at the right dose, at the right interval, that the nurse should check through each one of those items to assure that the patient is receiving the accurate medication at the accurate dose.
>
> Q. And that's a basic concept of nursing that nurses learn in nursing school and are reminded of throughout their years?
>
> A. Absolutely. Correct.

3. Respondent's conduct on February 17, 2000

a. Patient EW

Ms. Radke further testified that on February 17, 2000, two incidents occurred relating to Ms. Garrand's practice. First, Ms. Radke received a complaint from Patient EW's family about Ms. Garrand. The family members asked that Ms. Garrand not care for their mother again. They said that Ms. Garrand wasn't in the room, her interactions were extremely brief and that they did not see anything that Ms. Garrand did to aid their mother that day.

b. Patient EM

The second incident that Ms. Radke noted was that Ms. Garrand received an order from a physician to increase the bolus dose of Patient EM's pain medication to 3 mg from 2 mg. Ms. Garrand did make the adjustment to the patient's pump; however, at the same time she stopped his basal (continuous) dose of pain medication, which according to Ms. Radke, was a "completely unexplainable error at that point". She said that there was no order for that and the setting on the pump should not have even been effected by what she needed to do to increase the bolus dose. Ms. Radke said that she couldn't explain why Ms. Garrand did that. There would be no mechanics of the pump that one would have interfered with the other. They are completely separate functions. So setting the bolus dose should not have effected the basal (continuous) rate. Ms. Radke said that the risk to the patient was that the patient would experience uncontrolled pain and suffer as a result of it. *Exhibit 1, p. 12-13; Exhibit 2, p. 2.*

4. Respondent's conduct on February 18, 2000

a. Patient D

In a report dated February 21, 2000, Ms. Radke wrote that Ms. Garrand displayed very troubling behaviors and actions on February 18, 2000, throughout the entire day. She said that Ms. Garrand was the charge nurse that day and that she was required to be available to manage the staffing and admissions. According to Ms. Radke, despite the fact that she was the charge nurse that day, Ms. Garrand "knowingly did not wear the charge nurse pager". *Exhibit 2, p. 2.*

In addition, Ms. Radke testified at a deposition that on the morning of February 18, 2000, at or about 7:30 a.m., Ms. Garrand went into a patient's room and did a routine pain assessment of the patient, then recorded her findings in the medication flow sheet. According to Ms. Radke, when nurses do pain assessments they record certain information on the medication flow sheet. For example, the medication the patient is receiving, at what rate, and the pain rating of the patient at that point. Ms. Radke said that for an unknown reason, Ms. Garrand wrote down on the medication flow sheet that the patient was receiving Morphine instead of Hydromorphone which was actually running. Dr. Claessens, the Medical Director, noted that Ms. Garrand had recorded an incorrect narcotic name on the patient's Pain Flow Sheet. Ms. Radke said that she handed the flow sheet to Ms. Garrand and pointed out the error to her and asked her to correct it right away.

Ms. Radke further testified that later, around 12:15, she went back into the patient's room because the patient's pain pump was alarming and discovered that the patient's Hydromorphone infusion had run out. She paged Ms. Garrand to notify her that a new bag was needed. Later, Ms. Radke discovered that Ms. Garrand was not wearing a pager and that Ms. Garrand had not received her previous message. About 45 minutes after Ms. Radke notified Ms. Garrand that a new bag was needed for the patient, Ms. Garrand went to the narcotic drawer and removed a Morphine bag, instead of a Hydromorphone bag, and then hung the wrong medication on the patient. According to Ms. Radke, Ms. Garrand neglected to correct the 0730 error on the pain flow sheet and she failed to check the Medication Administration Guide and the bag that was in the PCA pump prior to hanging the next infusion. Ms. Radke said that Morphine is five times weaker than Hydromorphone. So the patient, from 1:00 in the afternoon until 4:00 in the afternoon had been receiving substantially less pain medication than she should have received. Ms. Radke testified that "the patient developed severe pain and was in a pain crisis at 4:00" and that it took them several hours "to overcome that pain". *Exhibit 1, p. 16-20; Exhibit 2, p. 2.*

Finally, Ms. Radke indicated in a report, dated February 21, 2000, that Ms. Garrand signed off on orders for Patient D that she never sent to pharmacy, did not process and did not pass along in a report. *Exhibit 2, p. 3.*

b. Patient AB

Ms. Radke also testified regarding another patient that Ms. Garrand admitted to the Unit on February 18, 2000. She said that Ms. Garrand made the statement that she couldn't understand why the new patient's medications had not yet arrived from the pharmacy. Ms. Garrand made several calls to the pharmacy asking where the medications were and also made a copy of the physician's original order and sent it down to the pharmacy. According to Ms. Radke, an admitting nurse needs to go through the admission orders and check to see what treatments, medications, tests, or procedures that need to be done immediately. She said that one of the first things that they do is to send down a carbon copy of the medication prescription for the patient who is being admitted. Ms. Radke said that they realized upon looking into the matter a little further that Ms. Garrand never sent the carbon down to the pharmacy on admission and that she did not even realize that she had not sent it

down. She said that Ms. Garrand seemed confused about the fact that she had not done that and was further confused by the fact that the pharmacy had not sent the medication.

Ms. Radke said that taking it one step further, Ms. Garrand then signed off the patient's orders, including medications, before pharmacy entered the orders. She said that it is the hospital's policy that nurses check off medication orders against the computerized report that comes up on all patient medications that are delivered by pharmacy. She said that verification by a nurse who signs off on the orders indicate that the pharmacy has correctly entered the medications for the patient into the computer system not that the medications are present on the unit. Ms. Garrand signed off on the orders before the pharmacy issued its report. *Exhibit 1 p. 23-24; Exhibit 2, p. 2.*

Ms. Radke further testified, in reference to Patient AB, that the patient had a fluid restriction order, meaning, that the patient was allowed a certain number of cc of fluid each day in order to control usually congestive heart failure, renal failure or things of that nature. Ms. Garrand signed off the orders without fulfilling the responsibilities of posting the fluid restrictions in the patient's room. In reference to the risk to the patient, Ms. Radke testified as follows:

> Q. What risk would there be of not placing the same?
>
> A. If a patient were supposed to have a fluid restrictions and that sign was not up there, they could receive more fluid in the form of water -- this is usually fluid that is taken orally just to clarify that -- the patient could receive more fluids and have, you know, depending on the patient's diagnosis they could have a flare of their congestive heart failure and if they are either in congestive heart failure or renal failure they could go into fluid overload if it was left unchecked long enough.

Finally, Ms. Radke testified that in her opinion the behavior and errors that she observed from Ms. Garrand fell below the level of minimal acceptable standards of practice for a registered nurse in an acute care setting. She also said that Ms. Garrand's conduct was a departure from her performance prior to that time. *Exhibit 1, p. 25-26; Exhibit 2, p. 3.*

B. <u>Testimony of Dr. Stuart Waltonen, Ph.D.</u>

Dr. Stuart Waltonen testified at the request of the Division of Enforcement. Dr. Waltonen is a licensed psychologist in the state of Wisconsin. He practices neuropsychology.

Dr. Waltonen testified that he performed evaluations of Ms. Garrand in February 2000, and May 2000. He said that he initially saw Sandra Garrand on February 25, 2000. She was referred by her internist, Dr. Gordon Hamilton, who works as a consultant in the alcohol and drug inpatient unit at St. Joseph's Hospital in Marshfield. Dr. Hamilton referred Ms. Garrand to him for evaluation because she had been admitted for detoxification and alcohol and Ativan abuse. At that time, she had been working on the hospice unit at St. Joseph's and apparently there had been a number of practice-related errors that had raised concerns. He said that it was his understanding that Ms. Garrand had been discharged from her position at St. Joseph's because of that. *Transcript, p. 5-6.*

Dr. Waltonen said that at the time that he saw Ms. Garrand, she "denied any significant difficulties with her mentation". She had a history in the past of depression and apparently there was some question that she may have had a bipolar disorder as well. She had undergone a course of electroconvulsive therapy back in 1989, for her depression. He said that he examined her neuropsychologically to determine whether or not there was any evidence of impairment in her cognitive functioning so that he could inform Dr. Hamilton about her current status in general. The evaluation that he did at that time did show evidence of impaired cognition, particularly with significant declines in her performance intelligence, her sustained attention, her ability to sequence rapidly, her problem-solving and reasoning as well as her verbal and visual memory. Her visual memory was far poorer than her verbal memory, but the verbal performances were also lower than one would have anticipated given her age, education and profession. He said that the other areas that he looked at, language, visual, spatial, etcetera, were probably within reasonable limits at that time. His impression was that Ms. Garrand was experiencing an encephalopathy at that time likely because of the poly-substance abuse. *Transcript, p. 6-7.*

In reference to Ms. Garrand's follow-up visit on May 9, 2000, Dr. Waltonen testified that he saw Ms. Garrand for the purpose of determining whether or not there had been any improvement in her cognitive functioning. He said that at the time he saw her, she reported to him that she had not been using any substances since her discharge from the AODA unit. She indicated to him at that time that she was not going to return to nursing and that she wanted to pursue a career in television broadcasting. She apparently had some kind of television spot, when she had lived in Salt Lake City, for health-related news and wanted to do something of that nature.

Transcript, p. 7-8.

Dr. Waltonen further testified that, at the time of Ms. Garrand's follow-up visit on May 9, 2000, he did a repeat examination of Ms. Garrand focusing upon areas where she had shown some deficits in the past. She did show some improvements. She was still showing a fairly significant impairment of her performance intelligence. That really had not improved all that much. She was still really down in the borderline range with regard to that. Her immediate attention was still impaired. She did show some improvement in her sequencing and sustained attention. There were continued deficits in her reasoning and problem solving. She was sluggish in terms of figuring out solutions. She was just very inefficient. Her verbal memory had improved to a reasonable degree and was now up close and generally in the average range. Her visual memory was still really quite impaired and she was having a significant problem with recalling information that she would see. He said that it was his impression at that point in time that she was continuing to show evidence of deficits in her neuropsychologic functioning and her performance intelligence. Immediate attention, reasoning, problem solving and visual memory as being the primary areas. It appeared to him that these deficits were lateralizing to the right hemisphere of the brain and more into the right temporal, right frontal regions. He said that he again had concerns about her returning to nursing at that point in time because of the memory and reasoning problems in particular. He said that she had not recovered sufficiently to return to nursing. He recommended that she return for a re-evaluation in four to six months, if she was still going to be pursuing or intending to return to nursing. At the time she saw him, she indicated that she was planning on leaving Marshfield and did not intend to return to nursing so they did not schedule any follow-up contacts or examinations after that point in time. He said that was the last time that he had contact with her. *Transcript, p. 8-10.*

In his report, signed June 6, 2000, Dr. Waltonen diagnosed Ms. Garrand as having cognitive dysfunction. There were secondary diagnoses relating to her alcohol and substance abuse and also bipolar disorder, depressed type, which was not one that he had given, but was really just a diagnosis that was referenced from her previous medical care. *Transcript, p. 10.*

In reference to treatment, Dr. Waltonen testified that the cognitive difficulties that Ms. Garrand sustained are "going to just go along their natural course". There's going to be a period of time when there will be recovery of function. He said that it gets to be increasingly unlikely as we get older, but at her age one would expect that there would still be a chance, maybe perhaps up to a year or more, that she could show some improvements. He said that whether or not she would ever improve to her baseline state or to a sufficient level that she could be kind of back to average range, it's difficult to know. It's just a very hard thing to predict with great certainty because of the fact that she has not just used alcohol, but she's had alcohol in combination with a variety of different medications. He said that many times in situations like this, you just have to watch and wait and see what happens. He said that in his opinion, prior to returning to nursing, Ms. Garrand would need to have a re-evaluation of her cognitive and neuropsychologic status and an updated substance abuse assessment to make sure that difficulty is not continuing. *Transcript p. 12-13.*

In reference to recovery, Dr. Waltonen testified that given Ms. Garrand's age, she would have a pretty good chance of showing a reasonable recovery. He estimated about four to six weeks would probably be the minimum for seeing her back. He said that he recommended at that time to Dr. Hamilton that Ms. Garrand not practice as a registered nurse because of the extent of the cognitive impairment, the chances of her committing errors of judgment were fairly substantial. He said that he shared those findings with Ms. Garrand at that time. *Transcript, p. 7*.

III. Discipline

Having found that Ms. Garrand violated laws governing the practice of professional nursing in Wisconsin, a determination must be made regarding whether discipline should be imposed, and if so, what discipline is appropriate.

The Board of Nursing is authorized under s. 441.07 (1), Stats., to reprimand registered nurses or limit, suspend or revoke the licenses of registered nurses if it finds that the licensees have violated ch. 441, Stats., or any rule adopted by the Board under the statutes.

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 (1976). Punishment of the licensee is not a proper consideration. *State v. McIntyre*, 41 Wis. 2d 481 (1969).

The Complainant recommends that Ms. Garrand's license be suspended for an indefinite period of time and that she be required to satisfy certain conditions in order continue practicing professional nursing. The Administrative Law Judge also recommends that Ms. Garrand's license be suspended for an indefinite period of time, subject to compliance with the conditions and limitations set forth in the proposed order. This measure is designed to provide protection to the public and, at the same time, promote Ms. Garrand's rehabilitation. In the future, the Board may permit Ms. Garrand to resume practice as a registered nurse; provided, she submits evidence satisfactory to the Board that she is capable of practicing in a manner that safeguards the interest of the public.

Based upon the record herein, the Administrative Law Judge recommends that the Wisconsin 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 30th day of November 2000.

Respectfully submitted,

Ruby Jefferson-Moore

Administrative Law Judge