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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST:

CAROL NICKELL, RN	**FINAL DECISION AND ORDER**
RESPONDENT	LS00110311NUR

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

Carol Nickell

N253 Old Hwy 63

Barronett, WI 65064

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. Carol Nickell (D.O.B. 7/14/53) is duly licensed in the state of Wisconsin as a registered nurse (license # 65063). This license was first granted on 9/17/76.

2. On 7/31/96, respondent was employed as a floor nurse at Lakeview Medical Center, Rice Lake. Respondent had, at that time, worked exclusively as a hospital nurse on a floor for adult and pediatric surgical patients for many years, and had never personally cared for an infant or neonate surgical patient.

3. At the start of her 3 PM to 3 AM shift that day, respondent was assigned to the care of two adults and to KC, a 25 day old, 9 lbs. 15 oz., baby who was recovering from a pyloromyotomy performed earlier that afternoon. Respondent received an IV bag of morphine solution from the pharmacy, which was compounded by the pharmacy pursuant to the physician's order for morphine 0.5 to 1 mg/hr, IV continuous drip.

4. At the time, respondent did not have either experience or education to know whether this was an appropriate dose for a patient of this age, and did not consult either a reference work or an appropriate colleague, although there was a maternity ward in the same hospital with nurses experienced in working with neonates, and respondent did check with a nurse on that ward regarding normal respiration rate for a baby. In fact, this was a substantial overdose for a neonate, as standard reference works recommend a dosage of one-tenth the amount administered to this patient, when given by continuous IV.

5. Respondent did not at any time use pulse oximetry for this patient, nor was she asked or required to do so by the physician or hospital policy. She did have discretionary authority to do so, if she thought it appropriate.

6. Respondent began the IV at 4:30 PM at the 0.5 mg/hr rate. The patient was checked more often than the times dictated by hospital policy for post surgical patients (which policy was @15 min x4, @30 min x4, hourly x4, @4 hrs for 24 hrs). By the time respondent took over the care of the patient from the previous shift, the patient had already been checked through the first hour, the patient having come out of surgery at about 2:30, and transferred to the floor at 3:25. The following vital signs were taken by respondent (or, at 9:00, another nurse):

Time	Respirations	Blood Pressure	Pulse
3:55p	nr	113/64	166
4:30	44	104/44	186
5:05	22	81/33	170
6:00	24	84/30	140
7:00	24	73/28	135
8:00	24	76/29	142
9:00	28	58/20	114
10:00	24	80/40	nr

At 10:15 PM, the physician called to check on the condition of the patient. Following their conversation (during which respondent expressed her concern about the decreased respiration rate), respondent requested that the amount of morphine be decreased, and the physician authorized a reduction to 0.2 mg/hr. Respondent then reduced the flow to that amount; there are no recorded vital signs at that time. Following this change, the following respiration rates were noted:

12:00m	24	nr	nr
12:45a	24	nr	nr

At 1:55 AM, the patient was discovered to be not breathing and pulseless. A code was called, but the patient could not be revived. Life support was discontinued and the patient declared dead at 3:04 AM. The cause of death was subsequently determined to be morphine overdose

CONCLUSIONS OF LAW

By the conduct described above, respondent is subject to disciplinary action against her license to practice as a registered nurse in the state of Wisconsin, pursuant to Wis. Stats. §441.07(1)(b) and (d), and Wis. Adm. Code §§ N 6.03(1)(a) and (d), and (2)(b) and (c), 7.03(1)(a), (b), (c), (e), and (f), and N 7.04(15).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that :

1. Carol Nickell, RN, is REPRIMANDED for her unprofessional conduct in this matter.

2. The license of Carol Nickell, RN, to practice as a nurse in the state of Wisconsin is LIMITED as follows:

a. Respondent shall not provide nursing services to any pediatric, infant, or neonate.

b. Respondent may petition the Board at any time to have this limitation removed, in whole or in part, following her having taken a suitable course of instruction in administration of medications to neonate, infant, and pediatric patients.

c. Respondent shall provide her current and future nursing employers with a copy of this Order before engaging in or continuing any nursing employment.

WISCONSIN BOARD OF NURSING

By: Ann Brewer	11-03-00
A Member of the Board	Date