WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF

DISCIPLINARY PROCEEDINGS AGAINST:

LISA M. LANGE, R.N.	FINAL DECISION AND ORDER
RESPONDENT	LS0101173NUR

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99 NUR 133; 00 NUR 069

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

Lisa M. Lange

219 W. Emmett Street

Portage, WI 53901

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. Lisa M. Lange (dob: 12/09/65) is and was at all times relevant to the facts set forth herein a registered nurse licensed in the State of Wisconsin pursuant to license # 100555. This license was first granted September 7, 1988.

2. Respondent has been treated for migraine headaches since at least 1993 with prescription medications, including hydrocodone, oxycodone, meperidine, Tylenol # 3 and Fiorinal.

3. Respondent has admitted that on an unspecified date in 1999 she obtained the prescription drug, nortryptyline hydrochloride from a family member for her own use. Respondent reported to work after taking the drug and became disoriented.

4. During March and April, 1999, while employed as a registered nurse at St. Mary’s Hospital, Madison, Respondent made the following medication administration errors:

a. signed out the following medications for patients who did not have a physician order for the medication:

- Patient 1 4/02/99 40 mg morphine sulfate,

- Patient 2 4/16/99 200 mcg fentanyl.

b. signed out the following medications but failed to document administration or waste:

- Patient 1 4/20/99 20 mg morphine sulfate,

- Patient 2 4/10/99 250 mg morphine drip & 20 mg morphine syringes,

- Patient 3 4/13/99 20 mg morphine sulfate,

- Patient 4 3/16/99 100 mg morphine drip & 20 mg morphine syringes,

- Patient 5 3/19/99 50 mg morphine sulfate,

- Patient 6 3/28/99 250 mg morphine drip,

- Patient 7 3/16/99 100 mg morphine drip.

5. On 2/16/00, while employed as a registered nurse at Divine Savior Healthcare in Portage, Respondent left her shift without completing the documentation of patient records, and without conducting a required end-of-shift inventory of medications. Respondent also took the narcotic keys home with her in violation of hospital policy.

6. Also on 2/16/00, Respondent received a telephone order for ICU patient B from a physician which she recorded as " morphine 2 mg IVP every hour prn, comfort." The controlled substance register indicates that Respondent signed out 10 mg morphine during each 2 hour period of her duty shift for patient B, instead of the ordered 2 mg per hour. When questioned Respondent stated that she interpreted the order to mean that Patient B could receive up to 2 mg morphine on each occasion of need at any time during the hour; therefore she administered 2 mg at the top of the hour and 1 mg each 15 minutes until the top of the next hour. Respondent’s documentation of administration of the drug does not support her explanation.

7. On 2/17/00, Respondent received an opiate based medication from a friend for her personal use. When she appeared for duty to complete her documentation from the previous day Respondent appeared to her supervisor to be impaired. An employer requested drug test proved positive for opiates.

8. An AODA evaluation of Respondent conducted October 21, 1999, by the Paquette Center resulted in no finding of drug abuse or dependence. A second AODA evaluation of Respondent conducted July 24, 2000, by Meriter Newstart resulted in an impression of "opioid abuse- rule out dependence" based upon a lack of objective information.

CONCLUSIONS OF LAW

9. The Wisconsin Board of Nursing has jurisdiction to act in this matter pursuant to §441.07(1)(b)(c) and (d) Wis. Stats. and is authorized to enter into the attached Stipulation pursuant to §227.44(5), Wis. Stats.

10. The conduct described in paragraphs 2 through 5, above, violated N 7.03(1)(a) and (b) and N 7.04(1), (2) and (15) Wis. Adm. Code. Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED, that the Respondent is REPRIMANDED for her unprofessional conduct.

IT IS FURTHER ORDERED, that the license to practice of respondent shall be LIMITED as follows:

TRAINING AND MONITORING

Training Required

1. Within 6 months of the date of this Order, Respondent shall certify to the Board the successful completion of an acceptable course of training in medication administration and documentation. Within 2 months of the date of this Order Respondent shall submit to the Board designee for approval a course outline 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 training requirement of this Order shall result in the immediate suspension of Respondent's license to practice as a nurse, without further notice or hearing, until such time as full compliance with the training provision of the Order has been attained.**

Department Monitor

2. The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including receiving and coordinating all reports and petitions, and requesting additional monitoring and surveillance. The Department Monitor may be reached as follows:

Department Monitor

Department of Regulation Division of Enforcement

P.O. Box 8935

Madison, WI 53708-8935

FAX (608) 266-2264

TEL. (608) 261-7938

Required Reporting

3. Respondent is responsible for compliance with all of the terms and conditions of this Final Decision and Order. It is the responsibility of Respondent to promptly notify the Department Monitor, of any suspected violations of any of the terms and conditions of this Order.

4. For a period of at least 2 years following the date of this Order, Respondent shall arrange for her employer to provide formal written reports to the Department Monitor in the Department of Regulation and Licensing, Division of Enforcement, P.O. Box 8935, Madison, Wisconsin 53708-8935 on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's work performance.

PRACTICE LIMITATIONS

Controlled Substance Access

5. Respondent shall refrain from access to or the administration of controlled substances in her work setting until such time as access or administration is approved by the Board.

6. Respondent shall practice only under the general supervision of a licensed professional nurse or other licensed health care professional approved by the Board or in a work setting pre-approved by the Board or its designated agent.

PETITIONS FOR MODIFICATION OF TERMS

7. Respondent may petition the Board for modification of the terms of this limited license. Any such petition shall be accompanied by a current AODA evaluation of Respondent by a licensed physician which provides proof to the satisfaction of the Board that Respondent does not have a chemical abuse or dependence condition, and proof satisfactory to the Board that Respondent can safely and reliably practice as a registered nurse without the limitations imposed in this Order. Denial of the petition in whole or in part shall not be considered a denial of a license within the meaning of Sec. 227.01(3)(a), Stats. and Respondent shall not have a right to any further hearings or proceedings on any denial in whole or in part of the petition for modification of the limited license.

Change in Address or Work Status

8. Respondent shall report to the Board any change of employment status, residence, address or telephone number within five (5) days of the date of a change.

9. Respondent shall furnish a copy of this Order to all present employers immediately upon issuance of this Order,

and to any prospective employer when respondent applies for employment as a health care provider.

Violation of any of the terms of this Order shall be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license; the Board in its discretion may in the alternative deny a stay of suspension of the license or impose additional conditions and limitations or other discipline.

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

WISCONSIN BOARD OF NURSING

By: Ann Brewer	5-3-01
Board Chair	Date