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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST:

THOMAS W. BURKE, RN,	FINAL DECISION AND ORDER
RESPONDENT	LS0106012NUR

Division of Enforcement Case No. 99 NUR 052; 99 NUR 373

The parties to this action for the purposes of section 227.53 of the Wisconsin statutes are:

Thomas W. Burke

17230 Lakeview Drive

Maribel, WI 54227

Board of Nursing

PO Box 8935

Madison, WI 53708-8935

Department of Regulation and Licensing

Division of Enforcement

PO 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. Thomas W. Burke (D.O.B. 08-09-50), the Respondent, is duly licensed as a registered nurse in the State of Wisconsin (Lic. # 98921). Respondent's license was first granted on April 1, 1988, has been renewed every biennium thereafter.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 17230 Lakeview Drive, Maribel, Wisconsin, 54227.

3. At all times relevant to this action, Respondent was working as a registered nurse at Brown County Mental Health Center in Green Bay, Wisconsin.

4. On February 12, 1999, Respondent was the registered nurse assigned to Unit 8 for the night shift. Respondent's shift began at approximately 10:00 p.m. and ended at approximately 6:20 a.m.

5. At approximately 6:15 a.m., Debra Moore, the Certified Nursing Assistant, brought a female patient to the nursing station and asked Respondent to assess the patient. The patient had a medical history of heart disease and a cardiac pacemaker.

6. Moore informed Respondent that the patient had indicated that she did not feel well, that her color was ashen, and that she was sweaty at the time that Moore went in to get the patient out of bed and dressed for the day.

7. Moore indicated that Respondent had asked her to get the patient's vitals and she responded that she would perform an oxygen saturation test. Moore reported that the patient's oxygen saturation was in the low 70's and that the patient had complained of chest and shoulder pain.

8. Respondent disputes that he requested the oxygen test or other vitals, but was informed that the patient's tympanic temperature was normal. Respondent did not check the patient's heartbeat with a stethoscope, monitor her respiration, or obtain her vital signs. Respondent did not question the patient about her complaint of "not feeling well." Respondent's nursing assessment of the patient was limited to a visual assessment.

9. Moore requested that Respondent stay to assist with the patient because the day shift RN would not be until 7:00 a.m. Respondent refused to stay because he did not feel that the patient was in acute distress. Respondent did not give any instructions to the nursing assistants or notify the other medical staff because he thought they knew what to do if the patient had a medical emergency. Respondent did not make an entry into the patient's chart concerning his assessment.

10. After Respondent left, Kay Webb, the RN House Manager was called to the nursing station. When Webb arrived she observed that the patient was in respiratory distress. Webb performed a complete nursing assessment, including listening to the patient's apical heart, performed an oxygen saturation test, and determined that the patient had the symptoms of a myocardial infarction.

11. Upon obtaining the information from the assessment, Webb contacted the patient's physician and received an order for oxygen and nitroglycerin. An EKG cardiac test was ordered for the patient. The EKG results were abnormal but did not indicate that the patient had suffered a myocardial infarction.

12. On November 7, 1998, Respondent was responsible for the care of a terminal cancer patient on Unit 8. The patient was designated as "no-code" and was to receive "comfort measures" only. The patient had stopped eating and drinking fluid and it was expected that his death was imminent.

13. During the course of the night shift, William Finger and John Begalke, the nursing assistants on duty, informed Respondent that the patient did not look good and asked him to check on the patient. Finger and Begalke last observed the patient at approximately 4:30 a.m.

14. Respondent performed his patient rounds at 11:00 p.m., 1:00 a.m., 3:00 a.m. and 5:00 a.m. Respondent indicated that he checked the patient at approximately 3:15 a.m. and observed that the patient was still alive. Respondent started his final rounds later than usual, at approximately 5:30 a.m. and did not re-check the patient before his shift ended at 6:20 a.m. Respondent did not feel it was critical to check on the patient because the day shift would arrive at 6:00 a.m. and check on all of the patients.

15. When the day shift RN, Deborah Miller, arrived at the facility, she was immediately notified by the nurse aides to go to the patient's room as it appeared that the patient had died. Miller found the patient dead when she checked him at approximately 6:40 a.m.

16. Miller noted that patient was lying on his right side with no radial pulse, his neck was hyper-extended, his right arm was at a 90-degree angle and his knees were bent. The patient's body was cold and stiff. The patient's bed sheets and mattress were soaked with dried blood and stool. The patient's room was of normal temperature and the windows were closed.

17. Miller checked the 24-hour review sheet and noted that the Respondent's entry stated that the patient had slept all night and looked fine. Miller prepared a lengthy written report describing the condition of the patient's body and difficulty for the staff in handling the body.

18. The medical examiner's report confirmed that the patient's body was in full rigor mortis.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter, pursuant to sec. 441.07, Stats.2.

2. The Wisconsin Board of Nursing is authorized to enter into the attached stipulation, pursuant to sec. 227.44(5), Stats.

3. The conduct described in paragraphs 4 through 6, above, violated §N 6.03(1)(a) and §N 6.03(3) (b); §N 7.03(1)(b); §N 7.03(1)(c); and §N 7.03(4) of the Wis. Adm. Code.

4. The Findings of Fact set forth above constitute an agency finding of neglect within the meaning of secs. 48.685 and 50.065, Stats. requiring a rehabilitation review by the Department of Health and Family Services.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the license of Thomas W. Burke to practice as a registered nurse in the State of Wisconsin (Lic.# 98921) is LIMITED as follows:

Practice restrictions

A. Until such time as Respondent successfully completes a rehabilitation review administered by the Wisconsin Department of Health and Family Services, Respondent shall REFRAIN from any nursing employment in any Wisconsin DHFS-licensed facility.

B. Until otherwise ordered by the Board:

i. Respondent shall practice only in settings where he works under the direct supervision of another registered nurse or other licensed health care professional for a period of one [1] year from the effective date of this Order. To be acceptable supervision, a description of the supervision plan must be submitted to and approved by the Nursing Board;

ii. Respondent shall refrain from nursing employment as a pool nurse, a visiting nurse or other home health care practitioner; and

iii. Respondent shall refrain from employment as a charge nurse.

Required reporting

C. For a period of one [1] year from the date of this Order, Respondent shall arrange for quarterly reports from his supervising nurse employer(s) reporting the terms and conditions of his employment and evaluating his work performance. These reports shall be submitted to the Department Monitor in the Department of Regulation and Licensing Division of Enforcement.

D. Respondent shall notify the Department Monitor of any change of employment during the time in which the Order is in effect. Notification shall occur within fifteen (15) days of a change of employment and shall include an explanation of the reasons for the change.

Continuing Education

E. Within one [1] year from the date of this Order, Respondent shall submit documentation of successful completion of at least three (3) credits in Ethics in Health Care and four (4) hours in Patient's Rights. To be acceptable, the educational courses shall be approved by a member or designated agent of the Board of Nursing. Acceptable documentation shall include certification from the sponsoring organization as well as a statement signed by Respondent verifying his attendance and completion of course and/or therapy requirements.

F. Respondent shall be responsible for all expenses incurred for training and other reporting as required by this order.

Counseling

G. Respondent shall arrange for and obtain psychological counseling for a period of one [1] year from the effective date of the Order. The counseling shall be provided by a licensed independent mental health professional, approved by the Board. The counseling sessions shall occur on a bi-monthly basis, consisting of not less than one-hour per session, and shall focus on the Respondent's interpersonal communication with patients and staff in a hospital setting. Respondent shall provide written reports verifying his participation and progress in counseling. These reports shall be prepared by the counselor and submitted to the Board on a quarterly basis. Respondent may petition the Board to modify the counseling requirement, based upon a submission of proof from his counselor that Respondent has progressed sufficiently to warrant such modification.

Department Monitor

H. The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including the receipt of supervisory reports and any other related notices, as well as coordinating all requests for approval of education or other petitions. The Department Monitor may be reached as follows:

Department Monitor

Division of Enforcement

PO Box 8935

Madison, WI 53708-8935

FAX (608) 266-2264

TEL. (608) 261-7938

Petition for Modification or Termination of Limitations

I. Respondent may at any time petition the Board 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. §§227.01(3) and 227.42.

Summary Suspension

J. In the event that Respondent fails to timely comply with the requirements set forth in the paragraphs above, his Wisconsin license to practice as a registered nurse shall be SUSPENDED, without further notice or hearing, until he has complied with the terms of this Order. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license pursuant to the procedures set forth in Wis. Admin. Code RL Ch. 6. The Board in its discretion may, in the alternative, impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order.

K. For purposes of the DHFS Rehabilitation review, the findings set forth herein shall become effective thirty [30] days from the date of its signing.

THE WISCONSIN BOARD OF NURSING

By: Ann Brewer	6-1-01
On behalf of the Board	Date