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State Of Wisconsin

Before The Wisconsin Board Of Nursing

In The Matter Of Disciplinary :

Proceedings Against : FINAL DECISION AND ORDER

: LS0208092NUR

HENRY J MASLACH, RN, :

Respondent :

Division of Enforcement Case #00 NUR 49

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

Henry J. Maslach, R.N.

5250 Brindisi Court, Apt. 8

Middleton, WI 53562

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 Wisconsin Board of Nursing has received a Stipulation submitted by the parties to the above-captioned matter. The Stipulation, a copy of which is attached hereto, was executed by Henry J. Maslach, R.N., personally and by his attorney, Kathleen E. Bonville, and by Claudia Berry Miran, attorney for the Department of Regulation and Licensing, Division of Enforcement. Based upon the Stipulation of the parties, the Wisconsin Board of Nursing makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Henry J. Maslach, R.N., was born November 5, 1953. Mr. Maslach's latest address on file with the Department of Regulation and Licensing is 5250 Brindisi Court, Apt. 8, Middleton, WI 53562.

2. Mr. Maslach is licensed to practice in the state of Wisconsin as a registered nurse pursuant to license #129100, which was first granted on March 25, 1998.

3. On December 15, 1999, Mr. Maslach was an employee of Advantage Health Care, a temporary staffing agency. He was assigned to University of Wisconsin Hospital and reported for duty at 11:00 p.m. The Nursing Administration office instructed him to report to F4/5, to a step-down medical cardiac unit where he had not worked before.

4. Mr. Maslach received report upon arriving at F4/5. After report, Nurse KH, the charge nurse for the shift, asked Mr. Maslach about his familiarity with the unit. Mr. Maslach told her he had been oriented on D4/5, a unit in proximity to F4/5 but not having the same resources.

5. Nurse CP showed Mr. Maslach the medication room, and told him he could use her and Nurse KH as resources if he had questions. He was issued a temporary number to access the Accudose machine and was assigned to care for four patients, three of whom were already on the floor. The fourth patient, MG, was being transferred to the floor by the emergency room.

6. Mr. Maslach set up a room for MG's arrival. He conferred by telephone with an emergency room nurse, who told him that MG had a IV heparin drip running at 30 cc's per hour and .9 NS IV running at 120 cc's per hour. MG arrived on the unit shortly before midnight; he was accompanied by Dr. PR, a third-year resident, and Dr. SL, a first-year resident.

7. At approximately 12:40 a.m. on December 16, Mr. Maslach and Dr. RL were conducting an admission assessment of MG when Dr. PR entered the room. MG had become tachycardic, and Drs. PR and RL believed that he was dehydrated. Dr. PR orally ordered that the fluids be increased to 125 cc's per hour. Neither she nor anyone else entered the order in the patient's chart at that time.

8. Mr. Maslach went to the left side of MG's bed, where a single IV AC pump was standing and increased the rate from 30 cc's per hour to 125 cc's per hour. He did not look to see whether the heparin or the NS was infusing through the pump. He then left the room to assess the other three patients he was caring for.

9. About 1:30 a.m., Mr. Maslach drew blood from MG for labs, which included a PTT. He then left the room to send the blood sample to the laboratory via the tube system. About 1:50 a.m., Nurse CP went to MG's room to remind Mr. Maslach to draw MG's labs, if he had not done so already. When she entered MG's room, Mr. Maslach was not there. She noted, however, that the heparin was being infused at a higher than usual rate.

10. Nurse CP then found Mr. Maslach and inquired whether the heparin drip for MG should be running at 125 cc's per hour. Mr. Maslach looked in MG's chart and could find nothing in writing to reflect the oral order that Dr. PR gave earlier. He and Nurse CP went to MG's room and stopped the heparin drip. Upon further examination, they found that the .9 NS had not been connected properly in the emergency room and had not been infusing.

11. Nurse CP located a second IVAC pump. About 2:05 Mr. Maslach connected the IV solutions to the pumps and restarted the solutions through the pumps.

12. About 2:20 a.m., Mr. Maslach observed that MG had developed a left facial droop, weakness in the left upper extremity, decrease in alertness, and increased difficulty in following conversation. He shut off the heparin drip, notified Nurses CP and KH, and contacted the resident.

13. MG's neurological symptoms worsened, and a CT scan showed a large evolving hemorrhage in the right frontal area. The patient had emergency surgery to remove the clot, but remained unresponsive postoperatively. Medical support and medications were withdrawn on January 6, 2000, and MG died later that day.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to § 441.07 (1), Stats.

2. The Board of Nursing has the authority to resolve this disciplinary proceeding by Stipulation without an evidentiary hearing pursuant to § 227.44 (5), Stats.

3. Wis. Adm. Code § N 7.03 (intro.) states that negligence means a substantial departure from the standard of care ordinarily exercised by a competent licensee.

4. A competent licensee would know that an oral order to increase the IV rate to 125 cc's per hour applied to the base iv, not to heparin.

5. Mr. Maslach was negligent when he increased the rate on the pump with the heparin without checking to see what fluid was being controlled through the pump.

ORDER

NOW, THEREFORE, IT IS ORDERED that the stipulation of the parties is approved.

IT IS FURTHER ORDERED that:

1. The license of Henry J. Maslach is hereby SUSPENDED for one year from the effective date of this order.

2. Upon completion of the continuing education specified in paragraph 8 below, Mr. Maslach may apply at any time to the Board for a stay of suspension for a period of three months, conditioned upon compliance with the conditions and limitations outlined below.

3. Mr. Maslach may apply for consecutive three (3) month extensions of the stay of suspension, which shall be granted upon acceptable demonstration of compliance with the conditions and limitations imposed on him for practice during the prior three (3) month period.

4. The Board may without hearing deny an application for extension of the stay, or commence other appropriate action, upon receipt of information that Mr. Maslach has violated any of the terms or conditions of this Order. If the Board denies the petition by Mr. Maslach for an extension, the Board shall afford an opportunity for hearing in accordance with the procedures set forth in chapter RL 1, Wis. Adm. Code, upon timely receipt of a request for hearing.

5. Mr. Maslach may petition the Board for modification of the terms of this limited license. Denial of the petition in whole or in part shall not be considered a denial of a license within the meaning of § 227.01(3)(a), Stats., and Mr. Maslach 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.

6. Mr. Maslach shall, not later than sixty (60) days following the effective date of this order, pay to the Department $200 toward the costs of the investigation, pursuant to § 440.22, Stats.

7. Mr. Maslach shall, within twelve (12) months of the date of this order, submit documentation acceptable to the Board showing successful completion of continuing education in the following areas:

a. IV Therapy, 20 hours (including 4 hours in anticoagulant therapy); and

b. Nursing Ethics, 6 hours.

8. The following courses shall meet the continuing education objectives stated in paragraph 7 above:

a. CRN21507, Meds for Nurses, Waukesha County Technical College;

b. 2002 Wisconsin Nursing Law, Southwest Seminars; and

c. CRN5108, IV Therapy and Insertion.

9. If a designated course is cancelled by the sponsor, Mr. Maslach shall obtain pre-approval of a replacement course from the Board or its designated agent before she takes the course(s) in fulfillment of this requirement.

10. The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including pre-approval of continuing education and receipt of all reports. The Department Monitor may be reached as follows:

Department Monitor

Division of Enforcement

Department of Regulation and Licensing

P. O. Box 8935

Madison, WI 53708-8935

FAX (608) 266-2264

TEL. (608) 267-3817

11. Mr. Maslach shall be responsible for all costs and expenses incurred in conjunction with supervision, education and any other expenses associated with compliance with the terms of this Order.

12. Mr. Maslach shall arrange for his 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 for two years after the effective date of this order, as directed by the Department Monitor. These reports shall assess Mr. Maslach's work performance.

13. Mr. Maslach 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.

14. Mr. Maslach shall furnish a copy of this Order to all present employers immediately upon issuance of this Order, and to any prospective employer when he accepts employment as a health care provider.

15. IT IS FURTHER ORDERED that if Mr. Maslach does not comply with all terms (including the time period for completion of continuing education) of this Final Decision and Order of the Wisconsin Board of Nursing, the Board may take further legal action pursuant to Wis. Stats. § 441.07 or in other legal proceedings to enforce remedies available to the Board of Nursing.

The rights of a party aggrieved by this Final Decision and Order to petition the Wisconsin Board of Nursing for rehearing and to petition for judicial review are set forth in the attached "Notice of Appeal Information."

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

By: Linda M. Sanner 08-09-02

A Member of the Board Date