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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF	:	
DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
IRIS M. DENNARD, L.P.N.,	:	LS0409163NUR
RESPONDENT.	:	

Division of Enforcement Case # 03 NUR 253

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

Iris M. Dennard
2138 N. 29th St.
Milwaukee, WI 53208

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 of Nursing. 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. Iris M. Dennard (D.O.B. 08-01-1955) is duly licensed as a licensed practical nurse in the state of Wisconsin (license # 301923). This license was first granted on January 8, 1999.

2. Respondent's most recent address on file with the Department of Regulation and Licensing is 2138 N. 29th St., Milwaukee, WI 53208.

3. At all relevant times, Respondent worked as a pool nurse for Trinity Staffing in Milwaukee.

4. On September 1 8, 2003, Trinity placed the Respondent to work at Honey Creek Health and Rehabilitation Center in Milwaukee Wisconsin.

5. While working at Honey Creek Health and Rehabilitation Center, Respondent administered medications to patient A.C. that were ordered for another patient, R.J. The medications included sixteen hundred (1600) units of HR Insulin, seven (7) units of Regular Insulin, Ibuprofen 600 mg, MS Contin 15 mg, Pindolol 10 mg, Vitamin C, Zinc 220, and Clonidine HCL 0.1 mg. A.C. was hospitalized, but suffered no long term effects.

6. At approximately 1600 hours, another LPN approached A.C. to administer her medication. Respondent told the other LPN that she had already given A.C. her medication. Respondent stated that she had called the patient's name, and A.C. answered her. However, at first Respondent admitted only that she had given patient A.C. the Vitamin C and Zinc.

Only after the second LPN stated that she was going to take A.C.'s blood sugar reading, Respondent admitted that she had already taken the blood sugar reading and that she had given Insulin. Because she believed that A.C. had received only one more unit of insulin than she should have received, the other LPN decided to watch A.C. but not to report the error until shift change unless there was a problem.

7. At approximately 1830 hours, A.C. had an emesis, looked gray in color, and did not feel well. The second L.P.N. told Respondent that she was going to call the RN supervisor. Respondent responded, "I should never have told you." While the second LPN was attempting to reach the RN supervisor, Respondent checked on patient A.C. then approached the second LPN and stated, "She said she is fine, there is nothing wrong with her."

8. The RN Supervisor questioned Respondent about the incident. Respondent admitted that she had given the medications listed in paragraph 5 above, at approximately 1600 hours. Respondent stated that she had noticed the error right after giving A.C. the wrong medication. However, she delayed informing her supervisor, and was reluctant to admit the extent of the error, to the patient's possible detriment.

9. Respondent states that her current practice is to check all wrist bands to identify residents prior to giving medications.

10. Respondent consents to the issuance of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

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

2. The conduct described above constitutes negligence pursuant to Wis. Admin. Code § N 7.03(1) and Respondent is therefore subject to discipline pursuant to § 441.07(1)(c) Wis. Stats.

ORDER

IT IS HEREBY ORDERED, effective the date of this Order:

1. The stipulation of the parties is approved.

2. Respondent is hereby **REPRIMANDED.**

3. Within ninety (90) days from the date of this order, Respondent shall submit acceptable documentation of successful completion of at least 6 hours of **Continuing Nursing Education**, pre-approved by the Board, in the subject areas of ethics. Acceptable documentation may include:

(a) Certification from the sponsoring organization;

(b) A statement signed by Respondent verifying her attendance at and completion of course requirements, as well as (if required by the Board) a statement signed by a proctor approved by the Board verifying Respondent's attendance and completion of course requirements; and

(c) If requested by the Department Monitor, proof of successful completion of a post-test acceptable to the Board and/ or submission of other documentation of course content comprehension acceptable to the Board.

4. Respondent shall be responsible for all expenses incurred for training as required by this order.

Department Monitor

5. The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with

the terms of this Order, including 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

Costs

6. Within six (6) months days from the date of this Order, Respondent shall pay to the Department of Regulation and Licensing COSTS of the investigation and prosecution of this action in the sum of Nine Hundred dollars ($900.00). Payment shall be made by certified check or money order, made payable to the Wisconsin Department of Regulation and Licensing and submitted to the Department Monitor.

Deferred Caregiver Finding

7. If Respondent fails to fully and completely comply with all terms and conditions set forth above, or if the Department receives a subsequent credible allegation against Respondent of abuse, neglect or misappropriation, the Department Monitor shall without further notice or hearing notify the Wisconsin Department of Health and Family Services that the findings set forth in this Order shall thereafter constitute an agency finding of neglect for the purposes of § 50.065, Wis. Stats. Respondent shall then REFRAIN from any nursing employment in any facility licensed by the Wisconsin Department of Health and Family Services until such time as Respondent successfully completes a rehabilitation review administered by DHFS.

Violations of this Order

8. Violation of any of the terms of this Order, including the terms relating to the payment of costs, may result in a summary suspension of Respondent's license. 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.

Dated at Madison, Wisconsin this 16th day of September, 2004.

Jacqueline A. Johnsrud, R.N.
Chair, Board of Nursing