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STATE OF WISCONSIN
BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	FINAL DECISION
	:	AND ORDER
JENNIFER J. SKIFTON, R.PH.	:	LS0410133PHM
RESPONDENT	:	

Division of Enforcement
02 PHM 099

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

Jennifer J. Skifton, R.Ph.
814 Aspen Valley Drive
Onalaska, WI 54650

Wisconsin Pharmacy Examining Board
1400 E. Washington Ave.
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 Pharmacy Examining Board received a Stipulation submitted by the parties to the above-captioned matter. The Stipulation, a copy of which is attached hereto, was executed by Jennifer J. Skifton, R.Ph., Respondent, and by her attorney, Thomas H. Taylor; and by Gilbert C. Lubcke, attorney for the Department of Regulation and Licensing, Division of Enforcement. Based upon the Stipulation of the parties, the Wisconsin Pharmacy Examining Board makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Jennifer J. Skifton, R.Ph., Respondent herein, 814 Aspen Valley Drive, Onalaska, Wisconsin, 54650, was born on 5/4/71 and is licensed and currently registered to practice pharmacy in the State of Wisconsin, license #13611, said license having been granted on 5/2/02.

2. Respondent, at all times relevant to this complaint, was employed as a pharmacist at the hospital pharmacy at Gundersen Lutheran Medical Center, Inc. in La Crosse, Wisconsin.

3. On 6/29/02, Thomas J. Schroeppel, M.D. entered an order for patient UK. for Colchicine 2 mg. IV administered over 2 to 5 minutes, then 0.5 mg. every 6 hours IV. The order did not include any stop order or other directions or criteria for termination of the administration of the Colchicine.

4. Colchicine is a drug used for the treatment of gout and has potentially serious side-effects including bone marrow suppression, multi-system failure and death. The maximum recommended cumulative dose of Colchicine is 4 mg.

5. Respondent received the order for Colchicine in the hospital pharmacy on 6/29/02 and transcribed the order into the hospital pharmacy order entry system as ordered by Dr. Schroeppel. The order for Colchicine as given by Dr. Schroeppel was deficient in that it failed to specify the criteria for termination of the administration of the drug. The criteria for termination of this drug include directions for termination of the drug upon satisfactory response of the patient's symptoms to

the administration of the drug, upon the development of adverse side-effects to the administration of the drug, by a specified end date and time, or upon administration of the maximum recommended cumulative dose of 4 mg., whichever event is the first to occur.

6. Respondent did not recognize the deficiencies in the order as given by Dr. Schroeppel and did not contact the physician to clarify the deficiencies in the order.

7. The patient, pursuant to the order for Colchicine as entered by Respondent in the hospital pharmacy order entry system on 6/29/02, was administered IV Colchicine as follows:

Date/ Time	Dosage Administered	Cumulative Dose (mg.)
6/29/02 @ 1100	2 mg over 2 - 5 minutes, IV	2.0
@ 1700	0.5 mg every 6 hours IV	2.5
@ 2330	0.5 mg every 6 hours IV	3.0
6/30/02 @ 0700	0.5 mg every 6 hours IV	3.5
@ 1245	0.5 mg every 6 hours IV	4.0
@ 1810	0.5 mg every 6 hours IV	4.5
@ 2400	0.5 mg every 6 hours IV	5.0
7/01/02 @ 0600	0.5 mg every 6 hours IV	5.5
@ 1800	(On Hold)	5.5
@ 2345	0.5 mg every 6 hours IV	6.0
7/02/02 @ 0530	0.5 mg every 6 hours IV	6.5
@ 1200	0.5 mg every 6 hours IV	7.0
@ 1850	(No IV)	7.0
@ 2400	0.5 mg every 6 hours IV	7.5
7/03/02 @ 0615	0.5 mg every 6 hours IV	8.0
@ 1140	0.5 mg every 6 hours IV	8.5
@ 1830	0.5 mg every 6 hours IV	9.0
@ 2345	(CME not here)	9.0
7/04/02 @ 0130	0.5 mg every 6 hours IV	9.5
@ 0630	(CME not here)	9.5
@ 0745	0.5 mg every 6 hours IV	10.0
@ 0830	0.5 mg every 6 hours IV	10.5
@ 1400	0.5 mg every 6 hours IV	11.0
@ 2000	0.5 mg every 6 hours IV	11.5
7/05/02 @ 0215	0.5 mg every 6 hours IV	12
@ 0850	0.5 mg every 6 hours IV	12.5
@ 1415	0.5 mg every 6 hours IV	13.0

8. The patient's condition deteriorated throughout the period of hospitalization.

9. On 7/5/02, an infectious disease consultant noted that the patient had leukopenia and thrombocytopenia and concluded that these conditions were most probably due to the amount of Colchicine that had been administered to the patient. The infectious disease consultant recommended that the administration of the Colchicine be terminated.

10. The administration of the Colchicine was terminated on 7/5/02 with the last dose administered at 1415.

11. The patient's condition continued to deteriorate with multi-system organ failure. The patient was placed on dialysis and required increased doses of pressors to support his blood pressure. The family made the decision to withdraw support and the patient died on 7/9/02.

12. Respondent's conduct as herein described departed from the standard of care ordinarily exercised by a pharmacist in the following respects:

a. Respondent failed to recognize that the order for Colchicine was deficient in that it failed to specify any criteria for termination of the administration of the drug.

b. Respondent failed to clarify the deficiencies in the order for the Colchicine by contacting the physician who had ordered the drug.

13. Respondent's conduct created the following unacceptable risks of harm to the health, welfare and safety of the patient:

a. The patient would be administered a cumulative dose of Colchicine, a drug with potentially serious side-effects, in excess of the amount necessary to resolve the patient's symptoms.

b. The patient would be administered a cumulative dose of Colchicine in excess of the maximum recommended cumulative dose thereby resulting in a Colchicine overdose with the accompanying unacceptable risks of bone marrow suppression, multi-system failure and death.

14. To avoid or minimize the unacceptable risks of harm to the patient, the Respondent should have:

a. Recognized that the order for Colchicine was deficient in that it failed to specify any criteria for termination of the administration of the drug.

b. Clarified the deficiencies in the order for the Colchicine by contacting the physician who had ordered the drug.

15. There were multiple other contributing causes for the patient's death including, without limitation:

a. The original order for IV Colchicine by a resident, Thomas Schroeppel, M.D. on June 29, 2002;

b. The failure of that resident and others involved in the patient's care to check the aggregate maximum dose of IV Colchicine and place a stop order on that medication;

c. The failure of that resident and others involved in the patient's care to order a consult with a Rheumatologist to oversee the administration of IV Colchicine;

d. The lack of adequate communication between different staff involved in the care and treatment of the patient;

e. The absence of a prompt in the hospital pharmacy's order entry system to identify and monitor the aggregate maximum dose of IV Colchicine; and

f. The absence of formal competency based orientation and assessment of staff in the hospital pharmacy.

CONCLUSIONS OF LAW

1. The Wisconsin Pharmacy Examining Board has jurisdiction in this proceeding pursuant to Wis. Stats. sec. 450.10.

2. The Wisconsin Pharmacy Examining Board has the authority to resolve this proceeding by Stipulation without an evidentiary hearing pursuant to Wis. Stats. sec. 227.44(5).

3. Respondent's conduct in failing to recognize and seek clarification of a deficient order was unprofessional conduct contrary to Wis. Stats. sec. 450.10(1)(b)(1) and Wis. Admin. Code sec. Phar 10.03(2) in that she engaged in conduct that departed from the standard of care that ordinarily should be exercised by a pharmacist which harmed a patient.

4. The Wisconsin Pharmacy Examining Board has the authority pursuant to Wis. Stats. sec. 440.22 to assess the

costs of this proceeding against Respondent.

ORDER

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

IT IS FURTHER ORDERED that Jennifer J. Skifton, R.Ph. is REPRIMANDED.

IT IS FURTHER ORDERED that Jennifer J. Skifton, R.Ph. will pay a forfeiture in the amount of $500.00 within thirty (30) days of the date of this Final Decision and Order.

IT IS FURTHER ORDERED that Jennifer J, Skifton, R.Ph. will pay costs in the amount of $848.11 within thirty (30) days of the date of this Final Decision and Order.

Payment of the forfeiture and of the costs will be made by certified checks or money orders, payable to the Wisconsin Department of Regulation and Licensing and mailed to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935

IT IS FURTHER ORDERED that violation of any term or condition of this Final Decision and Order may constitute grounds for further disciplinary action. If the Pharmacy Examining Board determines that there is probable cause to believe that Jennifer J. Skifton, R.Ph. has violated the terms of this Final Decision and Order and that the public health, safety or welfare imperatively requires emergency action, the Pharmacy Examining Board may summarily suspend the license of Jennifer J. Skifton, R,Ph. to practice pharmacy in the state of Wisconsin pending proceedings for revocation or other disciplinary action.

Dated at Madison, Wisconsin, this 13th day of October, 2004.

WISCONSIN PHARMACY EXAMINING BOARD

Michael Bettiga
A Member of the Board