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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
THERESA GILLICH, L.P.N., RESPONDENT.	:	LS0401273NUR

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

Theresa Gillich
1540 Parknoll Lane
Port Washington, WI 53074

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

Wisconsin Board of Nursing
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

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. Theresa Gillich, L.P.N., Respondent, date of birth September 29, 1939, is licensed by the Wisconsin Board o Nursing as a licensed practical nurse in the state of Wisconsin pursuant to license number 4103, which was first grantec December 6, 1961.

2. Respondent's last address reported to the Department of Regulation and Licensing is 1540 Parknoll Lane, Por Washington, WI 53074.

3. From May 4, 1998 to June 7, 2001, Respondent was employed as a home health aide by a private home healtl care agency. In that employment during 2001, Respondent provided home health care services to Mr. A, who was 80 year old and resided at home with his 82-year-old wife in Grafton, Wisconsin. At that time, Mr. A qualified to have those service paid by Medicare. Mr. A was diagnosed with severe Parkinson's disease, dementia, chronic renal insufficiency, anemia, anc atherosclerotic heart disease.

4. After June 7, 2001, Mr. A was no longer eligible to receive Medicare compensation for home health care services from the agency which employed Respondent. At that time, Respondent resigned from that employment. Responden subsequently entered into an agreement with Mr. A and his family to provide private duty nursing services to Mr. A. This continued until the family terminated the agreement on September 18, 2002.

5. On September 1, 2002, Mr. A was taking the following medications which had been prescribed by his physicians:

Norvasc 5 mg daily [calcium channel blocker (CCB)- for blood pressure]
Effexor 75 mg daily [serotonin and norepinephrine reuptake inhibitor- for depression/anxiety]
Sinemet 25/100 two before breakfast, two at 11:00 a.m., one and ½ at 2:00 p.m. and one and ½ at 7:00 p.m. [Carbidopa-levodopa- for treatment of Parkinson's disease]
Seroquel 100 mg at bedtime [quetiapine fumarate-"atypical antipsychotic"- for treatment of dementia]
Aricept 25 mg at bedtime [donepezil hydrochloride- for treatment of dementia]
Lasix 40 mg in the morning and 80 mg at bedtime [furosemide- a diuretic]

6. On September 1, 2002, Mr. A was admitted to St. Mary's Hospital-Ozaukee because of increased dyspn (difficult breathing) and two pillow orthopnea (difficulty breathing when lying down) for the past week. He was diagnosed wi congestive heart failure in addition to the other existing conditions. Mr. A's physician met with the family on September 4 and was explained that his health was quite poor and was expected to become worse and that consideration should be given f hospice care in the near future if he continued to deteriorate at this rate. The family decided that Mr. A was a "No Code."

7. Mr. A was discharged to his home on September 6, 2002 with the following medications ordered by h physicians:

Norvasc 10 mg daily
Effexor XR 75 mg daily
Sinemet at the same dose as on admission
Seroquel 100 mg h.s.
Aricept 25 mg h.s.
Lasix 80 mg b.i.d.
Zaroxolyn 5 mg 30 minutes before Lasix [a diuretic]
Imdur 30 mg daily [Isosorbide mononitrate- a vasodilator]

8. Respondent provided care to Mr. A on September 9, 2002. She states that she "could not believe the increase of meds that [Mr. A] was on" following his hospitalization. Respondent noted her observations that Mr. A had: more severe tremors, spasms and leg cramps, poor appetite, increased confusion, legs with +3 pitting edema, hardness and shin appearance.

9. Respondent provided care to Mr. A again from September 13 to September 16, 2002. Respondent decided it was in Mr. A's best interest to return him to the medications and doses he was on prior to his September 1 through 6 hospitalization and provided him with those medications and doses rather than following the current medication orders. Respondent made the medication changes without authorization from any physician and without any consultation or notification.

10. On September 17, 2002, another person provided Mr. A's care and gave him medications as ordered by his physicians. On September 18, Respondent withheld the following ordered medications from Mr. A without physician authorization or notification:

Imdur 30 mg
Effexor 75 mg
Docusate 250 mg
Zaroxolyn 5 mg
Lasix 80 mg (morning dose)

11. Before leaving Mr. A's residence on September 18, 2002, Respondent left an order for the other people assisting with Mr. A's care that the medications should be changed back to what they were before the September hospitalization. This was an order by Respondent and was not by any physician. Respondent actually hid some of the medications she did not wan

Mr. A to have so they could not be given as ordered by his physician. Mr. A's family terminated her contract to provide services on September 18, 2002 when they discovered she had hidden Mr. A's medications.

12. On October 24, 2002, Mr. A fell at home, was transported by the Grafton Rescue Squad and hospitalized. He was diagnosed with end-stage renal disease, Parkinson's disease, dementia and atherosclerotic heart disease. Mr. A and his family decided on no further treatment and he was discharged to a nursing facility with hospice care where he died about a month later. Neither Mr. A's fall nor his death was the result of Respondent's actions.

13. By intentionally giving her patient medications other than as ordered, Respondent failed to execute a medical order. If Respondent believed that the medication orders were inappropriate, Respondent was obligated to notify an appropriate person, which Respondent did not do.

14. By deciding to change her patient's medications and leaving an "order" changing his medications for other providers to follow, Respondent practiced beyond the scope of her license.

15. Respondent has admitted this conduct. In responding to inquiries from the Division of Enforcement, Respondent has shown no understanding that she has done anything inappropriate. She contends that Mr. A's primary care physician, who ordered the medications on September 6, 2002, "is a doctor who hasn't kept up with the times." However, that physician is recently educated. He graduated from the University of Wisconsin Medical School in 1993, was first licensed to practice medicine in 1994 and subsequently completed a residency and became board certified in internal medicine before issuing those orders in 2002.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07 and has authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

2. By failing to execute a medical order, Respondent has committed negligence as defined by Wis. Adm. Code § N 7.03(1)(d) and is subject to discipline pursuant to Wis. Stat. § 441.07(1).

3. By practicing beyond the scope of her license, Respondent has committed misconduct as defined by Wis. Adm. Code § N 7.04(5) and is subject to discipline pursuant to Wis. Stat. § 441.07(1).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The SURRENDER by Theresa Gillich, L.P.N., of her license as a practical nurse in the state of Wisconsin is hereby ACCEPTED, effective immediately.

2. Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $650.00 pursuant to Wis. Stat. § 440.22(2).

3. Payment shall be mailed or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817

Jacqueline Johnsrud
A Member of the Board

1-27-05
Date