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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JODIE M. WARREN, RN	:	LS # 0507148NUR
RESPONDENT.	:	

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02 NUR 028

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

Jodie M. Warren, RN
829 4th Avenue North
Onalaska, WI 54650

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 & 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 Wisconsin Board of Nursing. The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Jodie M. Warren, RN (DOB 06/18/72), Respondent herein, is duly licensed as a registered nurse in the state of Wisconsin license #131826. This license was first granted on 03/19/99.

2. Respondent's address as of the date of this Final Decision and Order is 829 4th Avenue North, Onalaska, Wisconsin 54650.

3. At all times relevant to this action, Respondent was working as a registered nurse at the Tomah Health Care Center in Tomah, Wisconsin.

4. At all times relevant to this action, MDL, the patient herein, date of birth 3/27/13, was a resident at the Tomah Health Care Center and received nursing services from Respondent.

5. The patient's medical record indicated that she was allergic to morphine. She was a terminally ill patient with diagnoses of cecal adenocarcinoma with liver metastases, congestive heart failure, hypertension, and dementia. The patient at all times relevant to this matter was experiencing end stage liver cancer and was on comfort measures.

6. On 1/19/02 at 1300, the patient's physician gave a telephone order to Respondent for "12.5 – 25 mg Demerol IM q 4 hours prn; may give with Ativan; Update MD with info if no improvement". Respondent recorded this order on the "Telephone Orders" form and also on the "Physician's Orders" form. Respondent also communicated the telephone order from the patient's physician to the supervising charge nurse.

7. On 1/19/02, after receiving the order for Demerol from the patient's physician, Respondent and the supervising charge nurse went to the medication room at the Tomah Health Care Center to obtain the medication out of the emergency contingency medication supply box. The sealed emergency contingency medication supply box was opened by Respondent and the supervising charge nurse. Respondent removed from the emergency contingency medication supply box 5 pre-loaded multi-dose syringes which Respondent believed contained Demerol (meperidine). Respondent did not review the labels on the pre-loaded multi-dose syringes at the time she removed them from the emergency contingency medication supply box. In fact, each of these 5 multi-dose syringes contained 10 mg. of morphine, not Demerol (meperidine), and was correctly labeled as containing morphine. Syringes containing meperidine were also located in the emergency contingency medication supply box and were similar in physical appearance to the pre-loaded multi-dose syringes containing the morphine except that the syringes containing the meperidine were labeled as containing meperidine.

8. On 1/19/02 at 1310, Respondent administered to the patient what she believed was 13 mg of Demerol IM but which, in fact, was morphine.

9. On 1/19/02 at 1335, Respondent recorded that the patient was resting comfortably with a blood pressure of 110/85, a pulse of 176, respirations of 12 and an oxygen saturation of 89% on room air. At 1500, Respondent recorded the patient's blood pressure as 126/86, her pulse as 169 and her respirations as 10 with brief 8 – 10 second periods of apnea.

10. The nursing staff on the 1/19-20/02 night shift did not administer any additional narcotics to the patient. On 1/19/02 at 2200, the nurse noted that the patient's blood pressure was 112/79, her pulse was 128 and her respirations were 10 and shallow.

11. The Respondent assessed the patient at 0930 on 1/20/02 and noted that the patient's pupils were pinpoint and fixed. At 0945, the patient was very agitated and began striking out at staff. At approximately 1000, Respondent administered Ativan .05 mg and what she believed was 12.5 mg of Demerol IM but which, in fact, was morphine from the pre-loaded multi-dose syringes she had previously retrieved from the emergency contingency medication supply box on 1/19/02. At 1020, Respondent noted that the patient had not been responsive to the medications and administered what she believed was an additional 12.5 mg of Demerol IM but which, in fact, was morphine.

12. On 1/20/02 at 1300, Respondent recorded that the patient was resting comfortably with a blood pressure of

100/52, a pulse of 184, respirations of 10 with apnea and oxygen saturations of 88% on room air. At 1715, the Respondent recorded the patient's blood pressure as 86/40, her pulse as 180, her respirations as 10 with apnea and her oxygen saturations at 88% on room air.

13. On 1/18/02 at 1515, before the patient receiving any injections of morphine, the patient's records reflect that the patient had a blood pressure of 131/89, a pulse of 100, respirations of 18 and an oxygen saturation of 90% on room air.

14. On 1/21/02, the patient died. The death of this terminally ill patient was disease-related. The patient's death was not caused by the erroneous administration of the morphine.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter, pursuant to Wis. Stat. § 441.07,[smg1] and is authorized to enter into the attached Stipulation and Final Decision and Order, pursuant to Wis. Stat. § 227.44(5).

2. The conduct described in the Findings of Fact constitutes a violation of Wis. Admin. Code § N7.03(1)(b) in that (a) Respondent failed to verify that she was administering the drug that had been ordered for the patient prior to administering the drug to the patient, and (b) Respondent administered morphine to the patient on three separate occasions when, in fact, the patient's physician had ordered Demerol (meperidine) for the patient.

3. The Wisconsin Board of Nursing has the authority pursuant to Wis. Stat. sec. 440.22 to assess the costs of this proceeding against the Respondent.

4. This Final Decision and Order shall not be construed as a Board of Nursing finding of caregiver misconduct, abuse or neglect of a client, or misappropriation of the property of a client within the meaning of Wis. Stat. §§48.685 and 50.065.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. The license of Jodie M. Warren, RN, to practice as a registered nurse in the state of Wisconsin is hereby limited as follows:

a. Respondent will practice nursing only under the general supervision of the Supervising Nurse, as hereafter designated, or his or her designee and will practice nursing only in a setting approved by the Board of Nursing for the term of this limited license.

b. Respondent will not practice home health care nursing or practice nursing as an agency or pool nurse for the term of this limited license.

c. Respondent is currently employed as a registered nurse in the Gastroenterology Section of the Department of Internal Medicine at Gundersen Lutheran Medical Center, Inc. in LaCrosse, Wisconsin. Respondent has nominated her immediate supervisor, Diane Krueger, R.N., the Clinical Manager in the Gastroenterology Section, as the Supervising Nurse. The Board of Nursing hereby approves Diane Krueger, R.N. as the Supervising Nurse. The Board of Nursing retains the authority to appoint a replacement for the Supervising Nurse if he Supervising Nurse fails to fulfill his or her responsibilities under the terms of this Order or no longer supervises the Respondent in her employment or is otherwise unable or unwilling to continue to serve as the Supervising Nurse .

d. Respondent will provide a copy of this Final Decision and Order to the Supervising Nurse within 10 calendar days of the date of the Final Decision and Order or within 10 calendar days of the date on which the Board of Nursing appoints a replacement for the Supervising Nurse.

e. The Supervising Nurse will within 30 calendar days of the date of this Final Decision and Order file an initial report with the Board of Nursing assessing the Respondent's practice of nursing for the period from 1/1/05 to the date of this initial report including, but not limited to, the Supervising Nurse's evaluation of the Respondent's medication dispensing practices and her recordkeeping practices relating to the dispensing of medications. The Supervising Nurse will continue to submit reports to the Board of Nursing every 3 months for a period of 1 year from the date of this Final Decision and Order assessing the Respondent's practice of nursing over the preceding 3 months including, but not limited to, the Respondent's medication dispensing practices and her recordkeeping practices relating to the dispensing of medications.

f. If the Respondent changes her place of residence to a state other than Wisconsin and terminates her practice of nursing in the state of Wisconsin at any time within 1 year of the date of this Final Decision and Order, the Respondent will within 10 days of the occurrence of these events notify the Board of Nursing of her departure from the state of Wisconsin and of her termination of the practice of nursing in Wisconsin and advise the Board of Nursing of her new residence address and place of employment. The Supervising Nurse will file a final report with the Board of Nursing within 10 days of the date on which the Respondent gives the above-referenced notice to the Board of Nursing. The supervision and reporting requirements of this Final Decision and Order will be suspended effective on the date on which the Supervising Nurse submits her final report to the Board of Nursing.

g. If the Respondent gives the notice to the Board of Nursing as required by paragraph f, but returns to the practice of nursing in Wisconsin within 2 years of the date of this Final Decision and Order, the Respondent will advise the Board of Nursing of her return to the practice of nursing in Wisconsin and will again be subject to the supervision and reporting requirements as stated above until such time as the Respondent has completed 1 full year of supervision with the required reports from the Supervising Nurse. The 1 year of supervision with the required reports from the Supervising Nurse will be calculated by excluding the period of time for which the requirements of this Final Decision and Order were suspended pursuant to paragraph f.

h. The Respondent will be responsible for the timely filing of all reports and notices contemplated by the terms of this Final Decision and Order.

i. The Respondent will within 9 months of the date of this Final Decision and Order take and satisfactorily complete a minimum of 24 hours of coursework in pharmacology, a portion of which will include instruction on the administration of medications, including controlled and noncontrolled medications, and on the documentation of medications administered. This coursework will be pre-approved by the Board of Nursing.

j. The Respondent will provide evidence satisfactory to the Board of Nursing that she has attended each of the approved courses in its entirety. This evidence will include:

i. Certification of attendance from the sponsoring organization; and

ii. Respondent's affidavit given under oath that she has attended each of the approved courses in its entirety.

k. Respondent will pay all costs of attending the approved courses and of verifying attendance at the courses.

l. All reports, notices, requests for approval of courses, certifications of attendance, affidavits and other documents required to be filed with the Board of Nursing will be mailed, faxed or delivered to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817

Fax (608) 266-2264

m. The limited license will terminate and the Respondent's license will be restored to full and unrestricted active status if:

i. The Board of Nursing has determined from the reports that the Respondent has demonstrated the competence necessary to safely practice as a registered nurse including the competence to properly administered medications and document the medications administered; and

ii. All terms of this Final Decision and Order have been complied with.

IT IS FURTHER ORDERED that:

2. Respondent will, within 6 months from the date of this Final Decision and Order, pay costs of this proceeding in the amount of $2,975.14. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

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

3. Violation of any of the terms of this Final Decision and Order may be construed as conduct imperiling public health, safety and welfare and 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 Final Decision and Order. In the event Respondent fails to timely submit any payment of the costs as ordered or fails to comply with the ordered education the Respondent's license #131826 SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Final Decision and Order. [smg2]

4. This Final Decision and Order is effective on the date of its signing.

Wisconsin Board of Nursing

By: Jacqueline Johnsrud, RN
A Member of the Board

July 14, 2005
Date

[smg1] THis should be deleted/ changed to a blank

[smg2] This section should be the standard summary suspension provision: **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. 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.** Where the terms of discipline consist of a forfeiture, costs or continuing education, alternative "self-effectuating" language should be utilized. E.g.: **In the event Respondent fails to timely submit any payment of the forfeiture as set forth above, the Respondent's license(#1550) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.**