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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
LAURIE E. PAUGEL, R.N., RESPONDENT.	:	LS06060811NUR

03 NUR 108

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

Laurie E. Paugel, RN
4746 E. Balsam Ln.
Rhinelander, WI 54501

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

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. 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. Laurie Ellen Paugel (D.O.B. 6/15/64) is duly licensed in the state of Wisconsin as a professional nurse (license #112743). This license was first granted on 3/24/93.

2. On 9/21/02, Respondent was a nurse at Friendly Village, a nursing him in Rhinelander, Wisconsin; her shift lasted until 10:30 PM that night. On 9/21/02, before Respondent started her shift, patient RS, an 84 year old woman with diabetes mellitus, grand mal seizures, and other medical problems, was sent to the hospital ER with a blood sugar level of 35. The patient was returned to the facility before Respondent's shift started with a blood sugar level of 129 and potassium of 3.2, with physician orders that her blood sugar be checked with a blood testing device every two hours twice, then every four hours twice, then every shift, if normal; and to call the internist "on call" if there were any further problems. An IV setup was ordered with D5/½NS with 20 meg/liter K+C, run for 1 day at 65 drops/min; Respondent prepared and hung this IV and connected it to an IV port which had been started at the hospital and then capped. This patient had a health care power of attorney appointing her daughter and the POA had been activated; the patient also had a no-CPR order, and was returned to the nursing home at about 16:30. At the time of the events described below, the patient's direct care was being given by an LPN, with Respondent's involvement being limited to the actions noted below.

3. The patient's chart shows no reading of her blood sugar until 22:00, when her blood sugar was 26 and one ampoule of glucagon was injected by Respondent; it was 24 some ten minutes later. At 22:15, it was 41. The patient's daughter were noted to be present and to request no "heroic" measures or further hospitalization.

4. Respondent did not call the physician at that time, nor was additional glucagon administered before she left the facility at approximately 10:30 PM. The nurse in charge noted later that the added contents label on the patient's IV bag was illegible and that it was normal saline instead of ½ normal saline as ordered; he replaced the bag with a new bag which he mixed himself, in compliance with the physician's order. No attempt was made to determine whether the bag previously hung had any other incorrect or missing ingredients which may have contributed to the patient's deteriorating condition.

5. The Board finds that the administration of glucagon is not an heroic measure and that the patient's no-CPR order and the family's request of "no heroic measures" or further hospitalization should not have precluded administration of additional glucagon, nor is there any legitimate reason for the staff to have delayed contacting the physician until several hours after the dangerously low blood sugar was detected and glucagon had been found to be ineffective at the dosage administered. The Board further finds that Respondent failed to effectively employ standard labeling and double-checking procedures for nurses, in selecting, labeling, and administering the IV solution ordered by the physician.

6. Following these events and the investigations by the nursing home and the DHFS Bureau of Quality Assurance, Respondent was suspended without pay for 5 days by her employer, and underwent training at the Friendly Village nursing home on ethics and boundary issues for nurses. Additionally, all nursing staff received training on diabetic procedures for insulin reaction, diabetic patient monitoring, physician notification, and recognizing possible medication errors.

CONCLUSION OF LAW

By the conduct described above, respondent is subject to disciplinary action against her license to practice as a registered nurse in the state of Wisconsin, pursuant to Wis. Stat. § 441.07(1)(b), (c) and (d), and Wis. Adm. Code §§ N 7.03(1)(a), (b), (c), (e), and N 7.04(1) and (15).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the attached Stipulation is accepted, and:

1. Laurie E. Paugel, RN, is REPRIMANDED for her unprofessional conduct in this matter.

2. Respondent shall pay the Costs of investigating and prosecuting this matter, in the amount of $800, before her license is next renewed.

WISCONSIN BOARD OF NURSING

By: Marilyn Kaufmann 6/8/06
A Member of the Board Date