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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
ROBERT E. DIONNE, R.N., RESPONDENT.	:	LS0606087NUR

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

Robert E. Dionne, RN
2563 Rangeline Rd.
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. Robert Edward Dionne (D.O.B. 3/21/61) is duly licensed in the state of Wisconsin as a professional nurse (license #138504). This license was first granted on 8/2/01.

2. On 9/21/02, Respondent was the nurse in charge at Friendly Village, a nursing him in Rhinelander, Wisconsin; his shift lasted into the morning of 9/22/02. On 9/21/02, before Respondent started his 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. 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 as he was the RN in charge at the time.

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 another RN; 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. No further action was taken by the floor nurse who obtained these readings and administered the glucagon, whose shift ended at 22:30. The physician was

not notified.

4. Respondent began his shift at 22:00. At 23:30, the floor nurse, an LPN, noted that the patient's blood sugar was 40; Respondent was then notified of the patient's status, and went to the patient's room. Respondent assessed the patient, but the physician was not called at that time, nor was additional glucagon administered. In his assessment, Respondent noted that the added contents label on the patient's IV bag was illegible and that it was a normal saline base 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. He did not attempt to determine whether the bag previously hung had any other incorrect or missing ingredients which may have contributed to the patient's deteriorating condition. The physician was not notified at that time of the patient's condition.

5. At 02:45 on 9/22, the patient's blood sugar was noted to be 11 by the LPN providing direct care, and the patient vomited a small amount. The physician was notified at 2:50 AM by Respondent of the patient's condition and that the daughter was requesting that no heroic measures be taken; no new orders were given. No other measures were taken with respect to the patient's glucose level and the patient expired at approximately 4:55 that morning.

6. 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.

7. Following these events and the investigations by the nursing home and the DHFS Bureau of Quality Assurance, Respondent underwent training at the nursing home 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 his 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. Robert E. Dionne, RN, is REPRIMANDED for his unprofessional conduct in this matter.

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

WISCONSIN BOARD OF NURSING

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