WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JULIE THAO, R.N., RESPONDENT.	:	LS0612145NUR

[Division of Enforcement Case No. 06NUR247]

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

Julie Thao, R.N.
227 N. Park Street
Belleville, WI 53508

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. Julie Thao, R.N., Respondent, date of birth December 14, 1964, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 105580, which was first granted September 9, 1990.

2. Respondent's last address reported to the Department of Regulation and Licensing is 227 N. Park Street, Belleville, WI 53508.

3. Following her licensure in 1990, Respondent has always worked as a labor and delivery nurse. From 1993 through July 5, 2006, she worked on the labor and delivery unit (Birthing Unit) at St. Mary's Hospital in Madison.

4. On July 4, 2006, Respondent worked two consecutive 8 hour shifts and the second shift ended at midnight. Respondent had volunteered for the shifts some time prior to coming to work on July 4 and had arranged to sleep at the hospital following the shifts because she began another scheduled 8 hour shift on the Birthing Unit, at 7:00 a.m. on July 5.

5. On July 5, Respondent was assigned as the primary nurse to provide care to two patients on the Birthing Unit. The first patient, who was at 19 weeks gestation, had been admitted at 3:30 a.m. because her membranes had ruptured. Respondent first saw that patient at 8:41 a.m. Respondent anticipated the need for further contact with this patient after the expected arrival of the patient's husband and the attending physician to determine the course of action to be followed in the care of this patient. Respondent's last documented contact with the patient was at 8:47 a.m.

6. Respondent's other patient on July 5 was Ms. A, who had just turned 16 years old. Because Ms. A was past her due date of June 29, she had been scheduled to be admitted to the Birthing Unit for induction of labor on July 5. Prior to July 5:

a. Ms. A's prenatal care coordination was done by an RN with the Dane County Division of Public Health. On May 2, the public health nurse noted that Ms. A's birth plan was to try to have a natural birth and if she needed help with pain management, she would try a pain pill or IV pain medication and she did not want an epidural. [During childbirth, epidural anesthesia is injected into the mother's spine in the lower back and numbs the mother from the waist down. The mother remains awake and aware of her baby's birth and may still feel some pain and contractions.]

b. Ms. A had a vaginal culture performed by her obstetrician on June 1 which showed she was positive for beta streptococcus, group B. [The positive culture resulted in a prophylaxis order of IV penicillin during labor.]

7. Ms. A went to St. Mary's the morning of July 5 with her mother, aunt and brother. Because her admission had been scheduled, Ms. A's admission intake was done at the nursing station on the Birthing Unit at 9:25 a.m. by the unit secretary. At that time, the admission record was printed and Ms. A's medical chart was assembled by the unit secretary. According to the unit secretary, Ms. A looked frightened.

8. The unit secretary also printed Ms. A's patient identification wrist band and placed it in a pocket in her medical chart, which was taken to Ms. A's birthing room. Wrist bands are to be fastened to the patient's wrist as soon as possible. Prior to performing any treatment or providing any medication, a nurse is to check the wrist band to make certain it is the correct patient. It was Respondent's responsibility to fasten the wrist band on Ms. A's wrist, but the wrist band was never placed on Ms. A.

9. Ms. A and her family were taken to Ms. A's birthing room, which is a large room with the patient's delivery bed and an area for visitors. There is also a separate anteroom which contains supplies and is used by the nurse to prepare treatments.

10. Respondent met with Ms. A and her family in Ms. A's birthing room and spent almost an hour explaining the process and answering questions. This was Ms. A's first pregnancy and she was anxious about delivering. Respondent says that much of her focus was on alleviating Ms. A's anxiety. At 10:49 a.m., Respondent performed an examination and determined that Ms. A's cervix was dilated 2 cm and effaced 80%. They had a discussion about the possibility of Ms. A receiving an epidural. Ms. A's mother recalls saying that Ms. A wanted an epidural only as a last resort. Respondent recalls that Ms. A and her mother seemed interested in her having an epidural as early as possible. Respondent said that no epidural would be given until Ms. A was dilated 3-5 centimeters.

11. At 11:00 a.m., the obstetrics resident physician signed the order for the initiation of the initial prophylaxis dose of: "Penicillin G, 5 million units IV, may add 1ml Lidocaine 1% PRN." Respondent ordered the penicillin from the pharmacy, which is located in a different part of the hospital.

12. At 11:15 a.m., the resident signed the labor admission orders, which included: starting a one liter IV bag of lactated ringers to provide water and electrolytes, oxytocin (brand name Pitocin) to be used during labor to initiate or improve contractions and oral and IV analgesics for pain as needed.

13. Around 11:30 a.m., the obstetrician ruptured Ms. A's membranes to begin labor. The obstetrician did not order an epidural at that time. His practice was to wait and see if it was needed and then order it if it was required.

14. Respondent went across the hall on the Birthing Unit to the medication room where the Pyxis station was located which contained many of the medications used on the Birthing Unit. At 11:36 a.m., she entered Ms. A's identification into the Pyxis machine and gained access to and removed the bag of IV fluid (lactated ringers) and several other medications which had been ordered, which might be needed for the mother or the newborn. At the same time, because she believed it likely that an epidural would be ordered for Ms. A, she removed the epidural medications (a combination of bupivacaine and fentanyl), which had not been ordered. She took all of the medications back across the hall and placed them on the counter in the anteroom to Ms. A's birthing room.

15. At about that same time, the penicillin was delivered to the Birthing Unit from the pharmacy and another nurse brought it to the anteroom to Ms. A's birthing room, placed it on the counter and told Respondent it was there.

16. The penicillin was in 250 cc of liquid in a clear plastic mini-bag. The epidural was also in 250 cc of liquid in a clear plastic mini-bag the same size and shape as the penicillin mini-bag. The penicillin mini-bag is to be administered intravenously and the epidural mini-bag is to be administered into the patient's spine, but the outlets and connections were the same. However, there were visible differences between the appearances of the two mini-bags:

a. The name of the drug contained in the liquid was printed on each mini-bag.

b. The front of the epidural bag had a bright pink label approximately three inches square which said "Epidural Medication" and the back had a smaller bright pink label which said "Epidural Medication." The penicillin bag did not have any colored labels.

c. Each bag had a portal adjacent to its outlet with the spike. The portal on the epidural bag had a large dark cap, which cannot be removed and does not allow any additional medications to be inserted in the bag. The portal on the penicillin bag had a smaller light colored removable cap, which would allow medications to be inserted.

17. Each bed on the Birthing Unit has a computer terminal with a monitor, keyboard and scanner which nurses and other providers use to make entries into the patient's electronic record. In addition, the terminal had Bridge Medical MedPoint point-of-care patient safety software which uses bar-code scanning to help nurses intercept potential clinical errors at the patient bedside.

a. St. Mary's had been integrating the Bridge Medical system into its units over a period of time and began using it on the Birthing Unit three weeks before July 5, 2006, after training was provided to the unit's staff.

b. Using that system, before giving any medication to a patient, the nurse scans the bar codes on: 1) the patient's wrist band to confirm the patient, 2) the nurse's ID card to identify who was administering the medication, and 3) the medication container to verify the medication, dose, route of administration and time of administration.

c. A screen then appears on the monitor which verifies that the drug, patient, dose, time and route of administration all match the medication order before the drug is administered. If the medication has not been ordered for the patient, the nurse must check a box on the screen to override the lack of an order.

18. Shortly before noon, Respondent hung the IV bag of lactated ringers, inserted the needle into a vein in Ms. A's arm and began the flow of the IV fluid through the line into Ms. A's vein. Respondent then began the process of adding to the IV line the mini-bag of penicillin, which had been ordered. Respondent took what she thought was the mini-bag containing the penicillin and spiked it into the IV line into Ms. A's arm. However, it was actually the mini-bag containing the unordered epidural medication which is to be administered into a patient's spine and not intravenously.

19. Prior to starting the mini-bag to administer the medication to Patient A, Respondent did not scan the barcodes on the patient's wrist band, her own ID card or the mini-bag. Had Respondent scanned the barcodes, the computer monitor screen would have shown her that this was epidural medication and that there was no order for the patient.

20. Prior to starting the mini-bag to administer the medication to Patient A, Respondent did not follow basic nursing standards and read the label on the mini-bag to verify that she was giving the right medication to the right patient in the right dose at the right time by the right route of administration.

21. The order for the penicillin did not specify the rate at which it was to be infused. However, the hospital's pharmacy recommends 180 ml per hour as the rate of infusion. That recommendation is printed on the mini-bag containing the penicillin. Respondent infused what she thought to be the penicillin at a rate of 250 ml per hour. Infusion of the penicillin can sting the patient and Respondent usually infuses it at the faster rate so the stinging ends sooner. However, the order allowed for the addition of lidocaine to the solution and the appropriate way to lessen the stinging is by the use of lidocaine, not by increasing the rate of infusion.

22. Almost immediately upon the epidural entering Ms. A's veins, she began having a severe adverse reaction and appeared to be seizuring. Respondent assumed she was having a reaction to what Respondent thought to be penicillin and pulled the medication tube out of the IV line. A Code Blue was called and advanced cardiopulmonary life support was performed unsuccessfully on Ms. A. An emergency cesarean section was done and the baby was delivered at 12:20 p.m.

23. Respondent violated the minimum standards of the nursing profession necessary for the protection of the safety of the patient by:

a. Failing to place the wrist band on Patient A's wrist.

b. Failing to scan the barcodes and use the Bridge Medical, which would have alerted her that she was about to administer the wrong medication.

c. Failing to read the label on the mini-bag containing the epidural medication, which would have alerted her that she was about to administer the wrong medication.

24. Respondent has voluntarily not worked as a registered nurse since July 5, 2006, while the investigation of this matter could be completed.

25. As a result of the above events, Respondent was charged in Dane County Wisconsin Circuit Court case number 2006CF002512 with one count of Neglect of a Patient Causing Great Bodily Harm, a Class H Felony, in violation of Wis. Stat. § 940.295(3)(a)(3) and (3)(b)(3). That proceeding was still pending at the time the attached Stipulation was signed.

CONCLUSIONS OF LAW

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

2. The conduct described above constitutes a violation of Wis. Admin. Code § N 7.04 (Intro.) and is unprofessional conduct which subjects Respondent to discipline pursuant to Wis. Stat. § 441.07(1)(d).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The license of Julie Thao, R.N., as a registered nurse authorized to practice professional nursing in the State of Wisconsin is hereby SUSPENDED for a period of 9 months. The commencement of the 9-month suspension is retroactive to July 6, 2006.

2. Upon the end of the suspension of Respondent's license, Respondent's license shall then be LIMITED, as follows:

a. Practice Limitations for two years following the end of the suspension:

1) Respondent shall work no more than 12 hours in any 24 consecutive hours and shall work no more than 60 hours in any 7 consecutive days.

2) Respondent shall provide a copy of this Final Decision and Order and all other subsequent orders immediately to supervisory personnel at all settings where Respondent works as a nurse or caregiver or provides health care, during the two year period.

3) It is Respondent's responsibility to arrange for written reports from supervisors to be provided to the Department Monitor on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's work performance, and shall say whether Respondent's work hours have complied with the above limitations.

4) Respondent shall report to the Department Monitor any change of employment status, residence, address or telephone number within ten (10) days of the date of a change.

b. Education to be completed within one year of the date of this Order:

1) Respondent shall complete an approved educational program or programs, which total 54 hours (equivalent to 3 academic credits), and which address the roles of individuals and systems in preventing medication and health care errors.

2) Prior to commencing any program, Respondent shall request and have received approval from the Board, or its designee, that the program sufficiently addresses the required topic. Respondent shall provide the Department Monitor proof of completion of each approved program, within 30 days of its completion.

c. Presentations to Nursing Community to be completed during the 90 days immediately following completion of the 54 hours of education ordered above:

1) Respondent shall make 3 presentations to groups of nurses or nursing students on the topic of the roles of individuals and systems in preventing medication and health care errors. Each presentation shall be at least one hour in length.

2) Prior to giving any of the presentations, Respondent shall request and have received approval from the Board, or its designee, to make a presentation to the group. Respondent shall provide the Department Monitor proof of completion of each approved presentation, within 30 days of its completion.

3. Respondent's alleged conduct, which is the basis for the criminal charge against Respondent in Dane County Wisconsin Circuit Court case number 2006CF002512, has been considered in the discipline ordered in this matter. The resolution of the criminal charge, whatever it may be, shall not be the basis for either the imposition of any additional discipline or the modification of the discipline ordered.

4. Respondent shall, within 120 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $2,500 pursuant to Wis. Stat. § 440.22(2).

5. Payment, requests, and required proofs shall be mailed or delivered to:

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

6. 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. In the event Respondent fails to timely pay costs as ordered or fails to comply with the ordered continuing education, Respondent's license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

7. This Order is effective on the date of its signing.

Board of Nursing

By: Marilyn Kaufmann 12/14/2006
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
JULIE THAO, R.N., RESPONDENT.	:	LS _____ NUR

[Division of Enforcement Case # 06 NUR 247]

It is hereby stipulated and agreed, by and between Julie Thao, R.N., Respondent; John A. Nelson of von Briesen & Roper, S.C., attorneys for Respondent; and John R. Zwieg, attorney for the Complainant, Department of Regulation and Licensing, Division of Enforcement, as follows:

1. This Stipulation is entered into as a result of a pending investigation of Respondent's licensure by the Division of Enforcement (file 06 NUR 247). Respondent consents to the resolution of this investigation by stipulation and without the issuance of a formal complaint.

2. Respondent understands that by signing this Stipulation, she voluntarily and knowingly waives her rights, including the right to a hearing on the allegations against her, at which time the state has the burden of proving those allegations by a preponderance of the evidence; the right to confront and cross-examine the witnesses against her; the right to call witnesses on her behalf and to compel their attendance by subpoena; the right to testify herself; the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition for rehearing; and all other applicable rights afforded to her under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and any other provisions of state or federal law.

3. Respondent has obtained advice of legal counsel prior to signing this Stipulation.

4. Respondent neither admits nor denies the allegations in this matter but agrees to the adoption of the attached Final Decision and Order by the Board. The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's Order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall be returned to the Division of Enforcement for further proceedings. In the event that this Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. Attached to this Stipulation are Respondent's current wall and wallet registration certificates. If the Board accepts the Stipulation, Respondent's license shall be reissued at the time the suspension is terminated in accordance with the terms of the attached Final Decision and Order. If the Board does not accept this Stipulation, Respondent's certificates shall be returned to Respondent with a notice of the Board's decision not to accept the Stipulation.

7. The parties to this Stipulation agree that the attorney or other agent for the Division of Enforcement and any member of the Board ever assigned as a case advisor in this investigation may appear before the Board in open or closed session, without the presence of the Respondent or her attorney, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with the Board's deliberations on the Stipulation. Additionally, any such case advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

8. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

9. The Division of Enforcement joins Respondent in recommending that the Board adopt this Stipulation and issue the attached Final Decision and Order.

Julie Thao, R.N.
Respondent
227 N. Park Street
Belleville, WI 53508

Date

John A. Nelson
von Briesen & Roper, S.C.
Attorneys for Respondent
411 E. Wisconsin Avenue, Suite 700
P.O. Box 3262
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Date

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Date