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	:	AMENDED
	:	FINAL DECISION AND ORDER
BOBBIE J. COTTRELL, L.P.N., RESPONDENT.	:	LS 0708302 NUR

[Division of Enforcement Case # 06 NUR 446]

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

Bobbie J. Cottrell, L.P.N.
2768 N. 50th Street
Milwaukee, WI 53210

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

On August 30, 2007, the Board adopted a Stipulation of the parties in this matter and issued a Final Decision and Order. Because of subsequent events, the parties have agreed to the terms and conditions of the attached Amended Stipulation as an amended final decision of this matter, subject to the approval of the Board of Nursing. The Board has reviewed this Amended Stipulation and considers it acceptable.

Accordingly, the Board adopts the attached Amended Stipulation and makes the following:

FINDINGS OF FACT

1. Bobbie J. Cottrell, L.P.N., Respondent, date of birth November 20, 1959, is licensed by the Wisconsin Board of Nursing as a licensed practical nurse in the state of Wisconsin pursuant to license number 30947, which was first granted November 22, 1991.

2. Respondent's last address reported to the Department of Regulation and Licensing is 2768 N. 50th Street, Milwaukee, WI 53210.

3. Beginning March 1993, Respondent was employed as a licensed practical nurse in the Rehabilitation, Extended and Community Care Division at the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin. Respondent resigned from that employment on June 10, 2005 after being notified the VA intended to terminate her employment based upon her conduct set out below.

COUNT I

4. Respondent usually worked the third shift (midnight to 8:00 a.m.) on the Palliative Care Unit (8AS) at the Zablocki Center. Respondent's job duties included administering prn medications to the patients on the unit.

a. Prn pain medications are ordered to be given to a patient when in the nurse's judgment they are needed

to relieve breakthrough pain that is not relieved by the patient's regularly scheduled medications.

b. The nurse's decision to administer prn pain medication is based on verbal or non-verbal indicators from the patient.

c. The nurse must note in the patient's record the basis for administering the prn pain medication and the patient's stated level of pain on a 0 to 10 scale both before the medication is given and after it has taken effect.

d. Typically, patients on the unit required most prn pain medication during the first and second shifts due to increased activity levels that cause increased breakthrough pain.

5. During January and until February 5, 2005, Respondent administered prn pain medications, which were schedule II controlled substances, to patients on the unit, as follows:

a. Patient A was admitted to 8AS on January 14, with diagnoses of head and neck cancer, diabetes and neoplasm of the skin and ear external auditory canal. Patient A was confused, had decreased vision, and required total assistance with Activities of Daily Living (ADLs). Patient A was initially on an IV morphine drip to control pain.

1) On January 26, Patient A was taken off the IV morphine drip and an order was given for morphine sulfate solution, three 10 mg cups, prn.

2) From January 27 through January 30, Respondent administered two prn doses of 30 mg morphine sulfate solution to Patient A on each shift that she worked.

3) From January 30 through February 4, Respondent administered one prn dose of 30 mg morphine sulfate solution to Patient A on each shift that she worked.

4) No other third shift employee on the unit ever administered prn pain medication to Patient A during this time period. Respondent administered 70% of the prn pain medication given to Patient A on all three shifts during this time period.

5) From February 5 until February 12, when Respondent was not on duty, Patient A required no prn pain medication on the third shift.

6) Respondent entered few nursing notes in patient A's medical records of the patient's stated level of pain or why the prn pain medication was needed. Respondent did enter notes such as "no complaints," "appear comfortable," or "appear to be sleeping."

b. Patient B was admitted to 8AS on November 1, 2004 with diagnoses of lung cancer and intracranial hemorrhage. Patient B was aphasic, was alert with periods of confusion, and required total assistance with ADLs. An order for oxycodone, two 5 mg tablets prn, was in place for Patient B.

1) Respondent worked the third shift on 23 days during January 5 through February 5, 2005. On 13 of those 23 days, Respondent administered one dose of prn pain medication to Patient B. On 6 of the days, Respondent administered two doses of prn pain medication to Patient B.

2) On 11 of the 19 days, Respondent administered prn pain medication to Patient B on the third shift. Patient B received no other prn pain medication the entire day.

3) From February 5 through February 28, when Respondent was not on duty, Patient B required no prn pain medication on the third shift.

4) Respondent entered few nursing notes in patient B's medical records of the patient's stated level of pain or why the prn pain medication was needed. Respondent did enter notes such as "no complaints," "appear comfortable," or "appear to be sleeping."

c. Patient C was admitted to 8AS on December 28, 2004 with a diagnosis of lung cancer. Patient C was alert and oriented, but needed assistance with ADLs. An order for Percocet (oxycodone with acetaminophen), two tablets prn, was in place for Patient C.

1) Respondent worked third shift on 23 days from January 5 through February 4, 2005. On 7 of the 23 days, Respondent administered one dose of prn pain medication to Patient C. On 11 of the days, Respondent administered two doses of prn pain medication to Patient C.

2) During the 8 days that Respondent was not on duty from January 5 through February 4, Patient C required prn pain medication on the third shift on only one occasion.

3) From February 5 through February 28, when Respondent was not on duty, Patient C required

prn pain medication on the third shift on only one occasion.

4) Respondent entered few nursing notes in patient C's medical records of the patient's stated level of pain or why the prn pain medication was needed. Respondent did enter notes such as "no complaints," "appear comfortable," or "appear to be sleeping."

d. Patient D was admitted to 8AS on October 8, 2004 with a diagnosis of myeloma. Patient D was alert and oriented, but needed some assistance with ADLs. An order for morphine, one 15 mg tablet prn, was in place for Patient D.

1) Respondent worked third shift on 23 days from January 5 through February 4, 2005. On 10 of the 23 days, Respondent administered one dose of prn pain medication to Patient D. On 8 of the days, Respondent administered two doses of prn pain medication to Patient D.

2) From February 5 through February 28, when Respondent was not on duty, Patient D required prn pain medication on the third shift on only one occasion.

3) From February 5 through February 28, when Respondent was not on duty, Patient D required a dose of prn pain medication on the third shift on only four occasions.

4) Respondent entered few nursing notes in patient D's medical records of the patient's stated level of pain or why the prn pain medication was needed. Respondent did enter notes such as "no complaints," "appear comfortable," or "appear to be sleeping."

e. Patient E was admitted to 8AS on January 20, 2005 with diagnoses of lung cancer, renal insufficiency and CVA. Patient E was alert and oriented, but needed assistance with ADLs. Orders for Percocet prn, and morphine sulfate solution, one 10 mg cup prn, were in place for Patient E.

1) Respondent worked third shift on 14 days from January 20 through February 4, 2005. On 2 of the 14 days, Respondent administered one dose of prn pain medication to Patient E. On 6 of the days, Respondent administered two doses of prn pain medication to Patient E. On 2 of the days, Respondent administered three doses of prn pain medication (two doses of Percocet and one dose of morphine) to Patient E.

2) For 5 of the 10 days, the prn medication that Respondent administered to Patient E on the third shift was the only prn pain medication Patient E received for the entire day.

3) For the 2 days that Respondent was not on duty from January 20 through February 4, Patient E did not require prn pain medication on the third shift.

4) From February 5 through February 28, 2005, when Respondent was not on duty, Patient E required one dose of prn pain medication on the third shift on eight occasions and two doses of prn pain medication on the third shift on only one occasion.

5) Respondent entered few nursing notes in patient E's medical records of the patient's stated level of pain or why the prn pain medication was needed. Respondent did enter notes such as "no complaints," "appear comfortable," or "appear to be sleeping."

6. Respondent's administering of schedule II controlled substances as prn pain medications without documenting any need for the medications and without noting or recording the level of the patients' pain is conduct which violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of the patients.

COUNT II

7. Respondent worked the third shift on 8AS on February 4, 2005 from midnight to 8:00 a.m. During that shift, Respondent checked out three 10 mg/5ml unit dose cups of morphine sulfate for Patient A and one 10 mg/5ml unit dose cup of morphine sulfate for Patient E. Morphine sulfate is a Schedule II controlled substance.

8. Between 7:00 and 7:45 a.m. on February 4, Respondent was in the staff break room on 8AS doing paper work. At approximately 7:45 a.m., the break room was used for report given to staff working the first shift on the unit. Respondent left at the end of her shift and as two other LPNs were leaving the break room after report, they noticed a small brown paper bag on the room's table. One of the staff members looked in the bag and found three unopened 10 mg/5ml unit dose cups of morphine sulfate wrapped in a Bio-hazard bag.

9. The staff person gave the bag and its contents to an RN who took it to the Ward Manager, who in turn reported it to the VA police who commenced an investigation. A medication count was performed that showed no dose cups of morphine sulfate were unaccounted for. Thus, the 3 dose cups in the bag had been checked out to be given to a patient or patients, but had not been given to a patient. The officer conducting the investigation interviewed Respondent the next day when she came to work:

a. Respondent told the officer that the patient who received 1 oral dose of morphine had requested the drug for pain. She told the officer that she determined the other patient needed the 3 doses of oral morphine based on his activity. That patient is unable to communicate because of his condition.

b. Initially Respondent told the officer, when she administered 3 oral doses of medication to one patient and 1 dose to another patient, she opened the peel-back tops and watched the patients consume the medication before she left their rooms.

c. When the officer told her that 3 of the 4 doses she had checked out were not given to a patient, Respondent then said that she must have placed the 3 cups on the patient's bedside table, then gone to assist another patient and upon her return, the cups were gone and she assumed that she had administered them.

d. The officer then told her that they had found fingerprints on the Bio-hazard bag the morphine dose cups had been wrapped in and asked Respondent if they were hers. Respondent replied that they probably were hers. She contended she had taken some bags out to use that night, but had returned them unused to the utility room and her finger prints would be on them.

10. Respondent's leaving three 10 mg/5ml unit dose cups of morphine sulfate on a patient's bedside table without observing whether the patient ingested the medication is conduct which violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of the patients and public.

ALL COUNTS

11. At the time the Board issued the Order on August 30, 2007, which prohibits Respondent from being employed in a setting where she has access to controlled substances, Respondent's employer had not placed her in a setting that would require access. However, the employer was about to begin moving Respondent to other locations which would require access and informed Respondent that her employment would be terminated. The employer would like to continue to employ Respondent but can only do so if Respondent is allowed access to controlled substances. The Division believes that the Order in this Amended Final Decision and Order will adequately protect the public while also allowing Respondent to retain her employment.

12. Respondent last worked as a nurse on September 5, 2007.

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. Respondent, by engaging in the conduct set out in Count I above, has committed misconduct or unprofessional conduct as defined by Wis. Adm. Code § N 7.04(intro), and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

3. Respondent, by engaging in the conduct set out in Count II above, has committed misconduct or unprofessional conduct as defined by Wis. Adm. Code § N 7.04(intro), and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The Final Decision and Order issued in this matter on August 30, 2007, is void and of no effect.

2. The license as a practical nurse of Bobbie J. Cottrell, L.P.N., Respondent, is hereby SUSPENDED for a period of 30 days. The commencement of the 30 days of suspension is retroactive to include September 6, 2007 and the suspension

shall continue until the end of October 5, 2007.

3. Respondent's license is LIMITED as follows:

a. Within 120 days of the date of this Order, Respondent shall provide proof sufficient to the Board or its designee of Respondent's satisfactory completion of a total of six (6) hours of continuing education in administering and documenting prn pain medications, which course(s) shall first be approved by the Board or its designee.

b. Respondent shall provide a copy of this Final Decision and Order immediately to supervisory personnel at all settings where Respondent works, or shall work, as a nurse.

c. 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 has complied with the above limitations.

4. Respondent shall, within 180 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $625.00, pursuant to Wis. Stat. § 440.22(2).

5. Requests, proofs, payment and all reports required by this Order shall be mailed, faxed 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

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 that Respondent fails to complete the continuing education or fails to pay costs as ordered, 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.

Wisconsin Board of Nursing

By: Marilyn Kaufmann 10/4/07
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	AMENDED
	:	STIPULATION
BOBBIE J. COTTRELL, L.P.N., RESPONDENT.	:	LS 0708302 NUR

[Division of Enforcement Case # 06 NUR 446]

It is hereby stipulated and agreed, by and between Bobbie J. Cottrell, L.P.N., 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 446). 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 Amended 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 been provided an opportunity to obtain advice of legal counsel prior to signing this Amended Stipulation.

4. Respondent agrees to the adoption of the attached Amended Final Decision and Order by the Board. The parties to the Amended Stipulation consent to the entry of the attached Amended 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 Amended Order, if adopted in the form as attached.

5. If the terms of this Amended Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Amended Stipulation, and the matter shall be returned to the Division of Enforcement for further proceedings. In the event that this Amended 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 Amended Stipulation are Respondent's current wall and wallet registration certificates. If the Board accepts the Amended Stipulation, Respondent's license shall be reissued at the time the suspension is terminated in accordance with the terms of the attached Amended Final Decision and Order. If the Board does not accept this Amended Stipulation, Respondent's certificates shall be returned to Respondent with a notice of the Board's decision not to accept the Amended Stipulation.

7. The parties to this Amended 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, if any, 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 Amended Stipulation. Additionally, any such case advisor may vote on whether the Board should accept this Amended Stipulation and issue the attached Amended Final Decision and Order.

8. Respondent is informed that should the Board adopt this Amended Stipulation, the Board's Amended 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 Amended Stipulation and issue the attached Amended Final Decision and Order.

_____ _____

Bobbie J. Cottrell, L.P.N. Date
Respondent
2768 N. 50th Street
Milwaukee, WI 53210

_____ _____

John R. Zwieg Date
Attorney for Complainant
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935