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
CATHERINE ELAINE SEVERIN, R.N., RESPONDENT.	:	LS07100413NUR

[Division of Enforcement Case # 04 NUR 217]

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

Catherine Elaine Severin, R.N.
2107 Hickory Drive
Plover, WI 54467

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

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 of Nursing. The Board has reviewed this Stipulation and considers it acceptable.

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

FINDINGS OF FACT

1. Catherine Elaine Severin, R.N., Respondent, date of birth February 11, 1954, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 90517, which was first granted April 15, 1985.

2. Respondent's last address reported to the Department of Regulation and Licensing is 2107 Hickory Drive Plover, WI 54467.

3. From September 2003 until April 4, 2004, Respondent was employed as a nurse by a nursing agency and worked as a registered nurse (RN) at Wisconsin Veterans Home (WVH) in King, Wisconsin. From April 4 until he employment was terminated on May 28, 2004, Respondent was employed by, and worked at, WVH as a RN.

Mr. A

4. On April 16, 2004, Mr. A was discharged from a hospitalization at Riverside Medical Center in Waupaca Wisconsin, for a myocardial infarction and admitted to VHW. Mr. A (DOB 10/18/14), was nearly blind and had a severe hearing loss. He had additional diagnoses of arteriosclerotic heart disease, congestive heart failure, hypertension, atrial fibrillation, diabetes and renal insufficiency. Respondent, who was working the AM shift, was the admitting RN.

a. Respondent had a copy of Mr. A's hospital discharge summary. The summary, prepared by the physician who treated Mr. A during his hospitalization, included:

1) "Current/Discharge Medications," including three anticoagulants: aspirin (81 m.g.), clopidogrel (75

m.g.), and Coumadin (5 m.g.).

2) "Discharge Instructions," including "INR each day" [INR (International Normalized Ratio) is a measurement of the coagulation or clotting tendency of a patient's blood. It is used to determine if there is a risk of uncontrolled bleeding, which can lead to death.]

b. Admission orders at WVH were required to be approved by the admitting physician. Mr. A's admitting physician was the physician assigned as his primary physician at WVH. That physician had never provided Mr. A with care and was not present at WVH that day.

c. Respondent faxed a copy of the discharge summary to the admitting physician and called her to obtain the admission orders.

d. The physician approved all of the orders except the order for the daily INR. The physician made the statement that the INR testing was a "hospital order" and said she would determine if the order was needed when she saw Mr. A on the unit.

e. Respondent recorded the admission orders given by the physician. Respondent mentioned to the PM shift RN that the physician had not ordered the INR. Respondent failed to make any record that INRs had been ordered at the time of hospital discharge, or that the physician had not included INRs in the admission orders to WVH.

5. Mr. A's primary physician did not see him. Over the next few weeks, Mr. A had nose bleeds, blood in his urine an unusually large bruise, excessive bleeding from a site of a lancet puncture for a glucose test and blood in his stool. All of these conditions could be the result of uncontrolled bleeding which could ultimately lead to death. No INR was ordered until an on-call physician ordered one to be performed on May 2.

6. The INR for a patient on anticoagulants should be between 2.0 and 3.0. An INR of 4 or more indicates a risk of uncontrolled bleeding. Mr. A's INR on May 2 was over 9.5. Because this was a critical value, the lab called the results to WVH at 2:50 p.m. The charge nurse on duty notified the on-call physician who directed that Mr. A's aspirin and Coumadin continue to be held until his primary physician could be contacted. Mr. A's primary physician saw Mr. A for the first time on the morning of May 3.

Mr. B

7. On March 11, 2004, Mr. B (DOB 12/31/17) was admitted to WVH with a variety of medical diagnoses: atrial fibrillation, congestive heart failure, chronic lower extremity edema, hypogonadism, dementia, glucose intolerance and chronic sinus tract with MRSA and pseudomonas drainage of the lower back from a previous L4-5 fusion with hardware.

8. On May 3, 2004, Mr. B was transferred to Appleton Medical Center to undergo dual chamber pacemaker insertion because of excessive bradycardia and congestive heart failure. On May 4, Mr. B was difficult to arouse and had left sided facial weakness and hemiparesis. A CAT scan of Mr. B's head showed an enlarged left temporoparietal infarct as well as evidence of an old infarct. It was determined that Mr. B had a complete occlusion of his left internal carotid artery. Mr. B's family was notified that this was felt to be a significant stroke and that Mr. B would likely not survive long term. A decision was made to return Mr. B to WVH for comfort measures only.

9. On May 6, 2004, Mr. B was returned to WVH on comfort care.

a. Respondent was working the unit at the time of Mr. B's return. Respondent failed to document that any admission database assessment was performed of Mr. B.

b. Mr. B was short of breath. Respondent directed other staff members to provide Mr. B with oxygen for comfort. WVH required a physician's order for oxygen to be provided and there was no such order. Respondent's supervisor directed Respondent to obtain a physician's order for the oxygen. Respondent did not obtain an order for the oxygen but asked the next shift to follow up to obtain the order. Respondent failed to make a record of any of the requests or actions related to the oxygen.

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 failing to make proper documentation of the events set out above, has committed negligence a defined by Wis. Adm. Code § N 7.03(1), which subjects Respondent to discipline pursuant to Wis. Stat. § 441.07(1)(c).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. Respondent, Catherine Elaine Severin, R.N., is hereby REPRIMANDED for the above conduct.

2. 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 three (3) hours of continuing education i documentation, which course(s) shall first be approved by the Board, or its designee.

b. Upon Respondent providing proof sufficient to the Board, or its designee, that she has completed the education, the Board shall issue an Order removing this limitation of Respondent's license.

3. Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensi costs of this proceeding in the amount of $490.00, pursuant to Wis. Stat. § 440.22(2).

4. All payments, requests and evidence of completion of the education required by this Order shall be mailed, fax 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

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

6. 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	:	
	:	STIPULATION
CATHERINE ELAINE SEVERIN, R.N., RESPONDENT.	:	LS _____ NUR

[Division of Enforcement Case # 04 NUR 217]

It is hereby stipulated and agreed, by and between Catherine Elaine Severin, R.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 04 NUR 217). 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 been provided an opportunity to obtain 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. 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, 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 Stipulation. Additionally, any such case advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

7. 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.

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

Catherine Elaine Severin, R.N.
Respondent
2107 Hickory Drive
Plover, WI 54467

Date

_____

_____

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

Date