WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF	:	
DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
TINA L. COOPER, R.N.,	:	LS0802281NUR
RESPONDENT.	:	

Division of Enforcement Case # 07 NUR 205

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

Tina L. Cooper, R.N.
4207 Karmichael Court
Madison, WI 53718

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

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 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. Tina L. Cooper, R.N., (DOB 12/19/1963) is duly licensed as a registered nurse in the state of Wisconsin (license # 30-146052). This license was first granted on December 11, 2003.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 4207 Karmichael Court, Madison, Wisconsin, 53718.

3. The following medication errors were reported by Respondent's former employer:

(a) On or about May 23, 2007, Respondent administered what she thought were four tuberculosis skin tests intradermally, at a dose of 0.1cc. It was later discovered that she had in fact injected the Tetanus/Diptheria vaccine, which is to be given intramuscularly. The bottles of the two vaccinations do not look the same, and are different sizes. The label on the Tetanus/Diptheria vaccine states that it should be given intramuscularly and

at a dose of 0.5 cc.

(b) On or about August 6, 2006, Respondent administered Pediarix combination vaccine when she should have administered regular DTP/DTaP. As a result, the patient received two doses of polio vaccine.

(c) On or about January 4, 2006, Respondent left eight doses of polio vaccine in a treatment room exposed to room temperature for over 48 hours. This error was discovered prior to administration and the vaccinations were destroyed.

(d) On or about October 26, 2005, Respondent gave a second pneumonia vaccination to a patient who should not have received it under standing medical orders.

(e) On or about September 14, 2005, Respondent gave Hepatitis A vaccination to a patient who should not have received it under standing medical orders.

(f) On or about September 14, 2005, Respondent administered Twinrix to a patient who should not have received it under standing medical orders.

(g) On or about May 13, 2005, Respondent administered adult DT to a two year old patient, who should have received DtaP.

4. Respondent responds to these allegations as follows:

(a) Respondent states that she has been diagnosed with Attention Deficit Hyperactivity Disorder ("ADHD") and is undergoing treatment and taking medication to address ADHD as well as depression. At the time of the May 23, 2007 incident, her prescribed medication for ADHD and depression was being altered and she was suffering from side effects of these changes.

(b) With regard to the August 6, 2006 incident, she believes the error occurred due to the lack of proper organization and preparation by the clinic, which provided only one cooler of supplies for two nurses contrary to policy.

(c) With regard to the January 4, 2006 incident, Respondent states that a walk-in patient arrived late in the day, and in her haste to provide immunizations she neglected to return the vaccine vial to the refrigerator.

(d) With regard to the October 26, 2005 incident, Respondent states that she expected that a secretary or heath aide would have validated the history and vaccination needs of the patient before she arrived and the paperwork was consistent with that.

(e) With regard to the September 14, 2005 incident, Respondent states that she was a newer employee and was unable to obtain guidance from her superiors when the patient arrives, so she administered the vaccination.

(f) With respect to the September 14, 2005 incident, Respondent states that she was not fully familiar with relevant guidelines regarding travel vaccines and followed the wishes of the patient.

(g) With respect to the May 13, 2005 incident, Respondent had only been employed at that time for approximately three weeks and was unable to contact her supervisor and attempted to assess and process vaccinations herself.

5. Respondent participated in a training and education program designed by her employer. During a real patient demonstration, her supervisor intervened to prevent her from administering a vaccination in the wrong area of the patient's arm. Respondent then properly administered the injection.

6. Respondent has independently reviewed Fundamentals of Nursing Practice and viewed educational videotapes Preventing Medication Errors and Safe Medication Administration.

7. Respondent has been employed at a new agency since August of 2007, and has not been notified of any medication errors at that new agency.

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 in paragraphs 3-7 above constitutes a violation of Wisconsin Administrative Code § N 7.04(2) and N 7.03(1) and subjects Respondent to discipline pursuant to Wis. Stat. § 441.07(1)(c) and (d).

ORDER

IT IS ORDERED:

1. Tina L. Cooper is REPRIMANDED.

2. The license of Tina L. Cooper, R.N. to practice as a nurse in the State of Wisconsin, and her privilege to practice pursuant to the Multi-State Nursing Compact, is LIMITED as follows:

(a) Within 60 days of the date of this Order, Respondent shall, at her own expense, undergo an assessment by a mental health care practitioner with experience in assessing health care professionals with ADHD and depression.

1. The practitioner performing the assessment shall not have treated Respondent and prior to the assessment being performed, must be approved by the Board or its designee, with an opportunity for the Division of Enforcement to make its recommendation.

2. Prior to the evaluation being performed, the Division of Enforcement shall have the opportunity to provide the practitioner with any materials within the investigative file in this matter. Respondent may provide the practitioner with any information she deems relevant.

3. Respondent shall provide the Board with the practitioner's written report and provide the Board and the Division with the opportunity to discuss the evaluation and findings with the practitioner. The Board may limit Respondent's license in a manner to address the findings in this matter and any recommendations resulting from the assessment.

(b) Respondent shall practice only under the direct supervision of a licensed nurse or other licensed health care professional approved by the Board or its designee and only in a work setting pre-approved by the Board or its designee. Respondent may not work in a home health care, hospice, pool nursing, or agency setting. Direct supervision is defined by Wis. Admin. Code § N 6.02(6) to mean immediate availability to continually coordinate, direct and inspect at first hand the practice of another.

(c) 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 care giver or provides health care, currently or in the future.

(d) 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 include the number of hours of active nursing practice worked during that quarter.

(e) Respondent shall report to the Board any change of employment status, residence, address or telephone number within five (5) days of the date of a change.

(f) Within ninety days of the date of this order, Respondent shall provide satisfactory proof of completion of six (6) hours of continuing education in medication administration and the prevention of medication errors. Courses taken in satisfaction of this requirement must be pre-approved by the Board.

3. Pursuant to Uniform Nursing Licensure Compact Regulation No. 3, Respondent's nursing practice is limited to Wisconsin during the pendency of this Order and any subsequent related orders. This requirement may be waived only upon the prior written authorization of both the Wisconsin Board of Nursing and of the regulatory board in the state in which Respondent proposes to practice.

4. After two years, Respondent may petition the Board for modifications to these limitations. Any such petition should be supported by the written recommendations of a mental health professional. The Board may require a

personal appearance by Respondent, in its discretion. If Respondent has complied with the requirements set forth in paragraph 2 and has no reported instances of medication errors during the two year period, the Board shall grant Respondent's petition unless the Board in its discretion finds a reasonable basis for the limitation set forth in paragraph 2 to continued. If Respondent is dissatisfied with the Board's decision she may seek a class 1 hearing pursuant to Wis. Stat. § 227.01(3)(a), in which the burden shall be on Respondent to show that the Board's decision is arbitrary or capricious. Requesting a hearing does not stay the Board's decision on the petition during the pendency of the hearing process.

5. Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of Four Hundred Dollars ($400.00), pursuant to § 440.22(2), Stats.

6. All petitions, requests, reports and payments 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

7. 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 pay costs as ordered the Respondent's license (#30-146052) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

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

Board of Nursing

By: Marilyn Kaufmann 2/28/08
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF	:	
DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
TINA L. COOPER, R.N.,	:	LS# _____
RESPONDENT.	:	

Division of Enforcement Case # 07 NUR 205

Tina L. Cooper, R.N., personally and by her attorney Michael Herbert; and Jeanette Lytle, attorney for the Department of Regulation and Licensing, Division of Enforcement, stipulate:

1. This Stipulation is entered into as a result of a pending investigation of Respondent's licensure by the Division of Enforcement (case # 07 NUR 205). Respondent consents to the resolution of this investigation by stipulation.

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 the advice of legal counsel prior to signing this stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Board of Nursing. 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 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 of Nursing ever assigned as an 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 Board 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.

_____ _____

Tina L. Cooper, R.N.
4207 Karmichael Court
Madison, WI 53718

Date

_____

_____

Michael Herbert
Hal Harlowe & Associates
Attorneys for Tina L. Cooper, R.N.
519 N. Pinckney Street
Madison, WI 53703

Date

_____

_____

Jeanette Lytle, Attorney
Division of Enforcement
Wisconsin Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Date