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	:	
BARBARA R. HATZ, R.N., RESPONDENT.	:	FINAL DECISION AND ORDER LS0906042NUR

[Division of Enforcement Case # 09 NUR 008]

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

Barbara R. Hatz, R.N.
2598 County Highway L
Tomahawk, WI 54487

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 in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Barbara R. Hatz, R.N., Respondent, date of birth February 12, 1958, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 112502, which was first granted March 24, 1993.

2. Respondent's address of record with the Department of Regulation and Licensing is 2598 County Highway L, Tomahawk, WI 54487.

3. At all times relevant to this matter, Respondent was employed as a registered nurse at Community Memorial Hospital in Menomonee Falls, Wisconsin.

4. On May 7, 2008, DS (DOB 12/14/30), presented at the emergency room at Community Memorial Hospital, with severe pain in her lower abdomen. A CT scan revealed a mass in DS's left colon. At admission, the patient's blood pressure was 152/80.

5. On May 9, 2008, a surgeon found a closed loop large-bowel obstruction due to adenocarcinoma of the proximal sigmoid colon. As a result, DS underwent a Hartmann procedure with med-transverse colostomy. DS was a medically complex patient who, for years, had declined medical intervention for a number of symptoms. The surgery was complex, in part because the mass had extended through the colonic wall and was attached to the peritoneum of the left

flank and the middle "loop" of the transverse colon. The surgeon reported that DS tolerated the surgery well and had no complications.

6. A physician's order instructed nurses to notify the anesthesiologist and surgeon if the patient's systolic blood pressure fell below 100 and to give IV bolus of lactated ringers, 500 ml over 30 minutes.

7. The surgeon ordered full adult parenteral nutrition, along with humulin, dextrostix every six hours. The surgeon implemented a sliding scale, which required that if the dextrostix indicated a blood glucose level of 201-250, 10 units were to be administered, at 251-300, 12 units were to be administered, and with greater than 300, staff were to call the physician.

8. At approximately 11:45 p.m., Respondent was the nurse responsible for DS's care and documented a "drastic" change in DS's mood and wrote:

> Very paranoid, hit writer across the head. Swinging/pinching aide. Will not get into bed. Threatening to pull out PICC line and epidural if "Someone doesn't' come clean." Has IV Poles and NG Gompko tipped over. MD notified and orders received.

9. The surgeon ordered Haldol 5 mg, IM now, .25 mg Ativan IV, "Restrain for safety if above do not help." Respondent documented the order and indicated she'd read it back to the surgeon.

10. At midnight on May 10, 2008, Respondent documented that the patient's blood pressure was 86/32. At 12:15 a.m., her blood pressure was 88/38. Beginning at 1:15 a.m., the patient's blood pressure had to be taken manually. Her blood pressure at 2:00 a.m. was 95/42, at 3:00 a.m. it was 101/53, at 4:00 a.m. it was 94/48, and at 5:00 a.m. it was 92/42.

11. At 1:15 a.m., Respondent learned that DS's pulse had fallen to 53.

12. On May 10, 2008 at 4:00 a.m., the nurse documented:

> BP still low after bolus of LR 500cc. Need to do manual. Fingers cool, radials intact with restraints. Pulse 90-53. Very sleepy after Haldol and Ativan. Metoprolol not given. Functioning Colostomy.

13. There was no documentation concerning the period of time over which the lactated ringers were administered, and the physician was not notified.

14. At 6:00 a.m., Respondent wrote: "found pulseless and without respirations." "hospitalist and [surgeon] notified."

15. Patient DS was pronounced dead at 6:10 a.m.

16. Patient DS's medical record includes a blood glucose management flow sheet. The patient's blood glucose level was documented on May 9, at 12:30 a.m. (149), at 5:30 a.m. (67), 6:00 a.m. (141) and 6:00 p.m. (213). Respondent failed to check the patient's blood glucose level after 6:00 p.m. on May 9, 2008. No insulin was administered after that date and time.

17. Respondent failed to notify the surgeon that the patient's blood glucose levels had not been monitored pursuant to the physician's order, even after the patient exhibited the drastic change in mood at 11:00 p.m. Irregularities in Patient DS's blood glucose level might have explained the change in her mood and behavior. Standards of the nursing profession required the surgeon be notified that his order had not been carried out.

18. The physician's order for the patient required that if the patient's systolic blood pressure fell below 100, the physician was to be notified. Respondent failed to do so.

19. The decrease in the patient's blood pressure, which was first recorded at midnight, constituted a significant change of condition. Standards of the nursing profession required that a physician be notified. Respondent failed to do so.

20. The change in the patient's pulse, which fell to 53, constituted a significant change of condition. Standards for the nursing profession required that the physician be notified and Respondent failed to do so.

21. In response to the Board's inquiries, Respondent explained that she was a travel nurse on assignment. She said she was assured that she would have CNA assistance, but did not. Respondent had six complex patients for whom she was solely responsible and she felt staffing levels were unsafe. Although Respondent recalls discussing the patient's blood pressure with the physician, the physician denies being alerted to the problem, and no such conversation was documented.

22. Respondent reports that this was the first time she had ever been struck by a patient, that she had been hit across the head very hard and that no one came to help her for some time.

23. Respondent believes the patient should have been in an intensive care setting and stated, "I admit that this shift was one in which I had trouble managing the workload. I am usually careful in my documentation but it does seem I missed something that shift which I am sorry for."

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).

COUNT ONE

2. Respondent, by engaging in the conduct set out in paragraph 16, above, has committed negligence as defined by Wis. Adm. Code § N 7.03(1)(d) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

COUNT TWO

3. Respondent, by engaging in the conduct set out in paragraph 17, above, has committed negligence as defined by Wis. Adm. Code § N 7.03(1)(c) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

COUNT THREE

4 Respondent, by engaging in the conduct set out in paragraph 18, above, has committed negligence as defined by Wis. Adm. Code § N 7.03(1)(d) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

COUNT FOUR

5. Respondent, by engaging in the conduct set out in paragraph 19, above, has committed negligence as defined by Wis. Adm. Code § N 7.03(1)(c) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

COUNT FIVE

6. Respondent, by engaging in the conduct set out in paragraph 20, above, has committed negligence as defined by Wis. Adm. Code § N 7.03(1)(c) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The license of Barbara R. Hatz, R.N., Respondent, to practice as a registered nurse in the State of Wisconsin is hereby SUSPENDED for a period of two (2) weeks.

2. Respondent's license is further LIMITED as follows:

a. Within 180 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 twelve (12) hours of continuing education in the following areas: eight (8) hours in monitoring for and intervening in complications of the post-op patient and four (4) hours in staffing issues, with emphasis on a nurse's responsibility to address unsafe practices and assertive techniques in dealing with unsafe practices, 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 Licensing costs of this proceeding in the amount of $780.00 pursuant to Wis. Stat. § 440.22(2).

4. Requests for approval, notification of completion of educational programs and payment shall be faxed, 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

5. 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 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.

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

Wisconsin Board of Nursing

By: Marilyn Kaufmann 6/4/09
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

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

[Division of Enforcement Case # 09 NUR 008]

It is hereby stipulated and agreed, by and between Barbara R. Hatz, R.N., Respondent; and Sandra L. Nowack, 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 09 NUR 008). 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 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.

_____ _____

Barbara R. Hatz, R.N.
Respondent
2598 County Highway L
Tomahawk, WI 54487

Date

_____

_____

Sandra L. Nowack
Attorney for Complainant
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Date