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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
WILLIAM A. CLIFFORD, R.N., RESPONDENT.	:	Order 0000522

Division of Enforcement Case #07 NUR 134

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

William A. Clifford, R.N.
1855 Grant Rd.
Kronenwetter, WI 54455-8427

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 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. William A. Clifford, R.N., (DOB February 23, 1947) is duly licensed as professional nurse in the state of Wisconsin (license # 73717). This license was first granted on September 1, 1979.

2. At all times relevant to this action, Respondent was working as professional nurse at Aspirus Wausau Hospital in Wausau, Wisconsin.

3. On March 22, 2007, Respondent was responsible for providing care to a patient who was also an L.P.N., who had undergone a bilateral knee replacement surgery. The patient was having pain because the surgical pain block that she had received was only effective on one knee. Postoperatively, her physician had ordered oxycodone controlled-release 10 mg twice a day, which could be increased in subsequent doses by 10 mg to a maximum dose of 30 mg, to control pain. Respondent told the patient that she should expect some pain, and made a statement which the patient interpreted as a criticism of the patient's decision to have both knees repaired at the same time. The Board finds that the patient's interpretation was predictable, and that Respondent should have foreseen that his statement would be so interpreted.

4. Patient's pain had increased hourly, beginning at 6 on a scale of 1 to 10, and finally reaching 8 by the time that Respondent finally administered ketorolac to the patient for her pain around 9:34 p.m., nearly eight hours after she had been admitted to the floor. Respondent did not record in the medical record that ketorolac had been given to the patient. Respondent incorrectly documented the patient's pain level as being a 3 on a scale of 1 to 10.

5. Respondent never asked the patient to rate her pain and he did not offer her any other immediate-release pain medication, and did not increase her controlled-release dosage.

6. Respondent had not noted the physician's order for morphine for breakthrough pain on the MAR, and there was no indication in the medical record that any of this pain medication had been given to the patient. The Board notes that the unit clerk had failed to process this order, but given that the patient was a post-surgical patient, any reasonable nurse would expect that there would be an order for an immediate-release opioid for breakthrough pain, and would have looked for it if it was not on the MAR.

7. Respondent did not provide the ordered incentive spirometer treatment to the patient until after she had requested it twice. Incentive spirometer treatment was finally given to the patient at 6:30 p.m., nearly six hours after her surgery.

8. After being on her back for many hours, the patient asked Respondent to turn her in bed. Respondent told the patient that bilateral knee patients were not normally repositioned and that repositioning would be quite painful on the day of surgery, so he couldn't reposition her, but that he would tilt her to one side and prop her up with pillows to take the pressure off her buttocks. The Board finds that any reasonable nurse would have repositioned the patient, as requested.

9. The patient asked the Respondent on four separate occasions to have her ordered compression stockings put back on. Respondent told the patient that she didn't need them and refused to put them on. A few hours later, the patient's husband arrived for a visit and the patient asked her husband to help her put on her compression stockings. Respondent immediately stopped her husband from putting them on the patient and told the patient that she didn't need them. Respondent documented in the medical record that compression stockings were put on the

patient at 4:00 p.m., when, in fact, a nursing assistant actually put them on the patient around 10:30 p.m.

10. The patient requested and was given a new nurse to provide care to her.

11. On March 21, 2007, Respondent was also responsible for providing care to another patient after orthopedic surgery. Respondent did not administer the 2 oxycodone tablets that the operating surgeon had ordered. Instead, Respondent called the orthopedic surgeon on call for a different pain med and did not chart why he had done so, although he later informed the Board that the patient had reacted to an earlier-administered dose of oxycodone with itching and the beginning of a rash (which reactions were not charted).

12. Respondent was terminated by his employer following this incident, and has, for the past two years, been working in a skilled nursing residential facility, without other complaints and with good evaluations.

CONCLUSIONS OF LAW

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

B. Respondent's conduct as described in paragraphs 4-90, above, is violation of Wis. Admin. Code § N 7.03(1)(b) and (d). Such conduct constitutes unprofessional conduct, within the meaning of the statutes and Code.

C. Respondent's conduct in failing to chart an apparent adverse reaction to a medication, as described in paragraph 11, above, is a violation of Wis. Adm. Code § N 7.03(1)(c). Such conduct constitutes unprofessional conduct, within the meaning of the statutes and Code.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the attached stipulation is accepted, and William A. Clifford, R.N. is hereby REPRIMANDED for his unprofessional conduct in this matter.

IT IS FURTHER ORDERED that:

1. Respondent shall, within 12 months from the date of this Order, pay the Costs of the investigation of this matter in the amount of $900. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

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

2. In the event Respondent fails to timely pay costs, as ordered, the Respondent's license (# 73717) may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has paid them in full, including any accrued interest.

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

Wisconsin Board of Nursing

By: _____ November 4, 2010
A Member of the Board Date

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