WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY	
PROCEEDINGS AGAINST	

FINAL DECISION AND ORDER

SUE R. SCHINDLER, R.N., RESPONDENT.

Order _____

ORDER 0000993

Division of Enforcement Case No. 11 NUR 094

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

Sue R. Schindler, R.N. 680 Baker Road Hudson, WI 54016

Wisconsin Board of Nursing P.O. Box 8935 Madison, WI 53708-8935

Department of Regulation and Licensing Division of Enforcement 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. 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. Sue R. Schindler, R.N., (D.O.B. 10/26/1971) is duly licensed in the state of Wisconsin as a registered nurse (license No. 118805-30). This license was first granted on February 11, 1995.
- 2. Respondent's address of record on file with the Board of Nursing is 680 Baker Road, Hudson, WI 54016.

- 3. Respondent is also licensed as a registered nurse in the State of Minnesota (license No. 135950-1).
- 4. While Respondent was employed at a hospital in St. Paul, MN, on June 20, 2010, the following occurred:
 - a. A patient was admitted to the emergency department with difficulty breathing, hives, swelling of her tongue and possible anaphylaxis.
 - b. The staff physician gave a verbal order for 0.3 mg (1:1,000) epinephrine intramuscular ("IM"). The Respondent did not read back the order and later denied the physician specified the concentration of the epinephrine.
 - c. The Respondent requested assistance from another registered nurse ("RN"). The other RN attempted to withdraw the epinephrine as ordered from an automated medication dispensing system (AMDS) that was in the patient's room but it was unavailable in the ordered concentration and route. Instead, the other RN withdrew 0.3 mg (1:10,000) epinephrine, which was prepackaged for intravenous ("IV") administration. The other RN gave the withdrawn medication to the Respondent. The Respondent noted the medication was not in the correct concentration or prepared for the right route, she expressed concern, but then proceeded to administer the withdrawn epinephrine via IV. The other RN documented the Respondent's administration. The patient immediately experienced bigemeny and symptoms of cardiac effects as a result of the incorrect dose and route of administration. The patient required hospitalization.
 - d. Respondent was issued a one-day suspension for changing the route and dose of the medication without authorization, failing to clarify the concentration of the medication with the physician, and allowing the other RN to document the medication administration in the patient's record.
- 5. In her written response to the allegations made by the Minnesota Board of Nursing, the Respondent provided the following information:
 - a. The Respondent admitted she administered the wrong drug and the wrong route and that she did not read the verbal order back to the physician.
 - b. The Respondent acknowledged it was the hospital's policy that staff persons document their own medication administrations and she admitted the other RN documented the Respondent's administration of the epinephrine.
- 6. On February 3, 2011, Respondent entered into a Stipulation and Consent Order with the Minnesota Board of Nursing for failure to perform professional nursing with reasonable skill and safety, unprofessional conduct and practicing outside the scope of authorized practice. Respondent was reprimanded and ordered to pay a forfeiture of \$1,500.

CONCLUSION OF LAW

By the conduct described above, Respondent is subject to disciplinary action against her license to practice as a nurse in the state of Wisconsin, pursuant to Wis. Stat. \S 441.07(d), and Wis. Admin. Code \S N 7.04(7).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Sue. R. Schindler, R.N., is **REPRIMANDED** for her unprofessional conduct in this matter.

IT IS FURTHER ORDERED that:

- 2. Respondent's license to practice nursing in the State of Wisconsin, and her privilege to practice in Wisconsin pursuant to the Nurse Licensure Compact, is **LIMITED** as follows:
 - a. Within ninety (90) days of the date of this order, Respondent, at her own expense, shall complete six (6) hours of pre-approved continuing education addressing safe medication administration practice. Respondent is responsible for finding appropriate course(s) and submitting the course information to the Board, or its designee, for approval prior to taking the course and in sufficient time to obtain Board approval within the 90-day time frame, taking into account the board's meeting schedule.
- 3. Respondent shall, within 90 days of the date of this Order, pay the **COSTS** of this proceeding in the amount of \$190.00.
- 4. Any requests, evidence of completion of educational program(s) and payment shall be mailed, faxed 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 or provide proof of completion of education as ordered, Respondent's license may, in the discretion of the Board or its designee, be

SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs and provided proof of completion of education.

WISCONSIN BOARD OF NURSING

By: L. Weig RNAPNOP

A Member of the Board

Date

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