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
THOMAS D. PETERSON, R.N., RESPONDENT.	:	Order ~~ORDER~~ 0000994

Division of Enforcement Case No. 11 NUR 095

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

Thomas D. Peterson, R.N.
1731 85th Street
New Richmond, WI 54017

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. Thomas D. Peterson, R.N., (D.O.B. 11/25/1966) is duly licensed in the state of Wisconsin as a registered nurse (license No. 114881-30). This license was first granted on November 12, 1993.

2. Respondent's address of record on file with the Board of Nursing is 1731 85th Street, New Richmond, WI 54017.

3. Respondent is also licensed as a registered nurse in the State of Minnesota (license No. 126880-9).

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. Another registered nurse ("RN") was assigned to the patient and the Respondent was providing assistance to the other RN.

    c. The staff physician gave a verbal order for 0.3 mg (1:1,000) epinephrine intramuscular ("IM").

    d. The Respondent attempted to withdraw the epinephrine as ordered from an automated medication dispensing system ("ADMS") in the patient's room but it was unavailable in the ordered concentration and route. Instead, Respondent withdrew 0.3 mg (1:10,000) epinephrine intravenous ("IV"). Respondent gave the withdrawn medication to the other RN, who then administered the epinephrine in the wrong dose via the wrong route. Respondent documented the other RN's administration of the medication as administered by Respondent. 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.

    e. Respondent was issued a two-day suspension for failing to look to other AMDS machines on the unit for ordered dose of epinephrine.

5. In his written response to the allegations made by the Minnesota Board of Nursing, the Respondent provided the following information:

    a. The Respondent said administration of epinephrine IM was not consistent with the facility's policy for responding to anaphylaxis in the emergency department and he provided a copy of the policy to the Minnesota Board of Nursing. The policy provided for administration of epinephrine subcutaneous ("SC") at 0.3 mg (1:1000) or epinephrine IV at 0.1 mg (1:10,000). Respondent said he read back the verbal order to the prescribing physician and then questioned why he ordered the IM route, but the physician did not respond. The dosage of IV epinephrine (1:10,000) that Respondent withdrew for administration to the patient was 0.3 mg, not 0.1 mg as provided in the policy

    b. Respondent admitted he withdrew epinephrine IV after discovering that the AMDS in the patient's room did not have a dose in the ordered concentration for administration of epinephrine IM. Respondent said that there was one other AMDS that he could have gone to for withdrawal of the ordered medication but

that machine was in the room of a patient who was full-code with approximately ten staff persons in the room. Respondent said he did not want to disrupt the efforts on behalf of that patient.

c. Respondent and the other RN discussed options for their patient because the emergency department physicians were attending to the coding patient and were unavailable. Respondent and the other RN had a brief discussion about the correct way to administer the epinephrine including indications and contraindications. Because they believed the patient was becoming emergent and could suffer a serious demise without intervention, Respondent and the other RN decided to administer 0.3 mg epinephrine (1:10,000) IV. The other nurse administered the medication and Respondent documented its administration. However, Respondent and the other RN did not call a code, seek further clarification from a physician, or obtain a supervisor for assistance.

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 his license to practice as a nurse in the state of Wisconsin, pursuant to Wis. Stat. § 441.07(d), and Wis. Admin. Code § N 7.04(7).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Thomas D. Peterson, R.N., is **REPRIMANDED** for his unprofessional conduct in this matter.

IT IS FURTHER ORDERED that:

2. Respondent's license to practice nursing in the State of Wisconsin, and his 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 his 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 **$170.00**.

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. Weis RN APNP
A Member of the Board

7/21/11
Date

rmd