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Before the
State Of Wisconsin
Board of Nursing

In the Matter of Disciplinary Proceedings Against
Frederick B. Gilhams, R.N., Respondent

FINAL DECISION AND ORDER

Order No. 0004191

Division of Legal Services and Compliance Case No. 13 NUR 128

The State of Wisconsin, Board of Nursing, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, make the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Board of Nursing.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated at Madison, Wisconsin on the 13th day of August, 2015.

Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against
Frederick B. Gilhams, R.N., Respondent

DHA Case No. SPS-15-0046
DLSC Case No. 13 NUR 128

PROPOSED DECISION AND ORDER

The parties to this proceeding for purposes of Wis. Stat §§ 227.47(1) and 227.53 are:

Frederick B. Gilhams, R.N.
13175 West National Avenue, Apt. 202
New Berlin, WI 53151

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53708-8366

Department of Safety and Professional Services, Division of Legal Services and Compliance, by

Attorney Kim M. Kluck
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

PROCEDURAL SUMMARY

These proceedings were initiated when the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), filed a formal Complaint against Respondent Frederick B. Gilhams, R.N. (Respondent), alleging that Respondent had committed an act or omission demonstrating a failure to maintain competence in practice and methods of nursing care, contrary to Wis. Admin. Code § N 7.03(1)(b).[1]

Respondent failed to file an Answer to the Complaint and failed to appear at the prehearing conference on May 28, 2015. As a result, a Notice of Default and Order was issued on May 28, 2015, finding Respondent in default, and the Division filed a recommended proposed decision and order on June 2, 2015.

[1] All references to Wis. Admin. Code § N 7.03 refer to the code as it existed at the time of the alleged conduct, before amendments to the provision, effective August 1, 2014.

FINDINGS OF FACT

Facts Related to the Alleged Violations

Findings of Fact 1-15 are taken from the Division's Complaint against Respondent filed in this matter.

1. Respondent Frederick B. Gilhams, R.N. (DOB April 1, 1959), is licensed in the State of Wisconsin as a professional nurse, having license number 122935-30, first granted on June 7, 1996 and current through February 29, 2016.

2. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 13175 West National Avenue, Apartment 202, New Berlin, Wisconsin 53151.

Allegations Relating to Patient A

3. At all times relevant to this proceeding, Respondent was employed as a professional nurse at a medical center (Center) located in Milwaukee, Wisconsin.

4. On June 5, 2012, a respiratory therapist at the Center asked Respondent if Patient A could be placed on a spontaneous breathing trial. Respondent told the therapist that she could proceed with the trial, even though the documentation regarding Patient A indicated that he was agitated and restless.

5. At 6:10 a.m., Respondent administered fentanyl to Patient A for "agitation/pain."

6. The breathing trial was initiated at approximately 6:16 a.m. During the spontaneous breathing trial (SBT), Patient A experienced a rapid heartbeat and an increase in systolic blood pressure and end tidal CO2 levels. The breathing trial was stopped at approximately 6:40 a.m. due to Patient A's unstable vital signs.

7. At 6:58 a.m., Respondent administered lorazepam 1 mg intravenously due to Patient A being diaphoretic and tachycardic following the attempted SBT.

8. From approximately 6:18 a.m. to 8:00 a.m., Patient A was experiencing significant distress. Respondent failed to report the significant change in condition to a physician during that time.

9. At 8:00 a.m., another nurse (Nurse A) reported to a physician that Patient A "had not tolerated SBT and was hypertensive, diaphoretic, and agitate (sic)." The physician ordered lorazepam 2 mg to be administered intravenously.

10. Shift change occurred at 8:03 a.m., at which time Respondent handed off care of Patient A to Nurse A, the oncoming nurse.

11. At 8:05 a.m., Nurse A requested that the physician evaluate Patient A. The physician evaluated Patient A and found that the patient was "flushed, very diaphoretic, tachypneic, respiratory accessory muscles used – pressures were 160s/80s, saturation in the upper 80s." The physician further noted that "[N]o MDs prior to myself had been notified of this state."

Allegations Relating to Patient B

12. On July 2, 2012, Respondent was assigned to care for Patient B who was chemically paralyzed (cisatracurium) and sedated (Versed), per physician order.

13. Respondent turned off the Versed infusion pump for the sedative during the night shift.[2]

14. The bispectral index monitor for Patient B, which is utilized to measure the level of patient sedation, was off line for approximately one hour (5:45 a.m. – 6:45 a.m.), but Respondent failed to notice this and failed to properly monitor Patient B's sedation level.

15. When the morning shift nurse started at 7:45 a.m., she observed that the Versed sedative was not infusing and the pump was shut off. Patient B grew increasingly agitated, requiring physician intervention and medication adjustments to restore the appropriate level of sedation.

Facts Related to Default

16. The Complaint and Notice of Hearing in this matter were served on Respondent on April 28, 2015, by both certified and regular mail, consistent with Wis. Admin. Code § SPS 2.08. The Notice of Hearing informed Respondent: "If you do not file a proper Answer within twenty (20) days, you will be found to be in default and a default judgment may be entered against you on the basis of the Complaint and other evidence. In addition, the Board may take disciplinary action against you and impose the costs of the investigation, prosecution and decision of this matter upon you without further notice or hearing."

17. On May 22, 2015, the Division received the certified mail copy of the Notice of Hearing and Complaint back with a stamp from the Postal Service indicating, "Return to Sender, Unclaimed, Unable to Forward, Return to Sender." The Notice of Hearing and Complaint sent via regular mail was not returned.

18. Respondent failed to file an Answer as required by Wis. Admin. Code § SPS 2.09(4).

19. Following expiration of the 20-day time period to file an Answer, the undersigned administrative law judge (ALJ) scheduled a telephone prehearing conference for May 28, 2015. Notice of this prehearing conference was sent to both parties, with instructions that Respondent provide the telephone number at which he could be reached for the conference to the ALJ no later than May 22, 2015. The Notice further informed Respondent: "The Respondent's failure

[2] Had Respondent merely "paused" the drip, the machine would have emitted an audible alarm.

to appear at a scheduled conference or hearing may result in default judgment being entered against the Respondent."

20. On May 28, 2015, the telephone prehearing conference was held and Respondent did not appear. The Division moved for default based on Respondent's failure to file an Answer and failure to appear.

21. On May 28, 2015, the ALJ issued a Notice of Default and Order which required the Division to file a recommended proposed decision and order no later than June 11, 2015.

22. The Division timely filed its submission on June 2, 2015.

23. Respondent did not file a response to either the Division's submission or to the ALJ's Notice of Default and Order.

DISCUSSION AND CONCLUSIONS OF LAW

Default

As stated in the May 28, 2015 Notice of Default and Order, Respondent is in default for failing to file an Answer to the Complaint and failing to appear at the prehearing conference held on May 28, 2015. *See* Wis. Admin. Code §§ SPS 2.09(4) and 2.14; Wis. Admin. Code § HA 1.07(3). Accordingly, an order may be entered against Respondent on the basis of the Complaint and other evidence. *See* Wis. Admin. Code § SPS 2.14; Wis. Admin. Code § HA 1.07(3).

Violations of Wisconsin Statute and Administrative Code

Following an investigation and disciplinary hearing, the Wisconsin Board of Nursing (Board) may revoke, limit, suspend or deny a renewal of a license of a registered nurse or may reprimand the nurse if the Board determines that the nurse has violated a provision of Chapter 441, Subchapter I, of the Wisconsin Statutes, or has committed "acts which show the registered nurse . . . to be unfit or incompetent by reason of negligence . . . ." Wis. Stat. § 441.07(1)(b) and (c), respectively (2011-2012). As used in Wis. Stat. § 441.07(1)(c), "negligence" means "a substantial departure from the standard of care ordinarily exercised by a competent licensee," and includes "[a]n act or omission demonstrating a failure to maintain competency in practice and methods of nursing care." Wis. Admin. Code § N 7.03(1)(b).

It is undisputed that Respondent's conduct of failing to report the significant change in Patient A's condition to a physician and turning off Patient B's Versed infusion pump for sedation constitutes negligence under Wis. Stat. § 441.07(1)(c) and Wis. Admin. § N 7.03(1)(c). As a result, he is subject to discipline under Wis. Stat. § 441.07(1)(b) and (c).

Discipline

The three purposes of discipline are: (1) to promote the rehabilitation of the licensee; (2) to protect the public from other instances of misconduct; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich,* 71 Wis. 2d 206, 237 N.W.2d 689 (1976).

The Division requests that Respondent be reprimanded and that his license be limited to complete 12 hours of education on caring for ventilated patients, three hours on the topic of communication and three hours on the topic of documentation. The Division's recommended discipline is warranted.

Respondent's conduct of failing to report the significant change in Patient A's condition to a physician and turning off Patient B's Versed infusion pump for sedation shows that he is currently unsafe to practice and that he is in need of rehabilitation in the form of education. A reprimand will also serve to deter others from such incompetent practice. Moreover, this discipline is consistent with prior Board decisions.

For example, in *In the Matter of Disciplinary Proceedings Against Mary J. Karabe*, Order No. LS0708305NUR (Aug. 30, 2007), a nurse failed to follow a physician's orders, failed to notify the physician of a patient's change in condition, and failed to document any assessment of the patient or of his change in condition. The Board reprimanded the nurse and limited her license with the requirement that she complete education on the topics of diagnosis and treatment of patients with chronic obstructive pulmonary disease, asthma and pneumonia.

In *In the Matter of Disciplinary Proceedings Against Nancy A. Ogden, R.N.* Order No. 002660 (Oct. 10, 2013), a nurse failed to perform and document an appropriate assessment of a patient who was reporting chest pain symptoms and failed to take appropriate action when the patient had a change in condition. The Board reprimanded the nurse and limited her license for a minimum of two years with the following requirements: that the nurse complete education courses on the topics of physical assessment and accountability; that she only work at the place of employment designated in the order under a limited license job description; that she obtain prior Board approval before changing employment; that she provide her nursing employer with a copy of the order before engaging in any nursing employment; that she only work under direct supervision; that she not work in any other home health, assisted living, hospice, agency or pool position; and that she provide the Department Monitor with quarterly reports from her employer.

Under the criteria of *Aldrich*, the facts of this case and prior Board decisions, the discipline imposed is appropriate.

Costs

The Division has the authority to assess costs pursuant to Wis. Stat. § 440.22. With respect to imposition of costs, factors to consider include: (1) the number of counts charged, contested and proven; (2) the nature and seriousness of the misconduct; (3) the level of discipline sought by the prosecutor; (4) the cooperation of the respondent; (5) any prior discipline; and (6) the fact that the Department is a program revenue agency, funded by other licensees. *See In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz* (LS 0802183 CHI).

The Division recommends that full costs be assessed against Respondent. Under the factors set forth in *Buenzli-Fritz* and the facts of this case, imposition of full costs on Respondent is warranted.

Respondent has not presented any evidence regarding any of the above factors that would mitigate the imposition of the full costs of this proceeding. The factual allegations were deemed admitted and proven and there is no argument to apportion any counts that were unproven, or that certain factual findings were investigated and litigated that were unnecessary. In addition, the underlying conduct demonstrates a lack of knowledge and/or skills in nursing practice and methods. Those deficiencies pose a risk of harm to patients. In addition, Respondent's refusal to cooperate in these proceedings demonstrates a lack of appreciation of his misconduct and a refusal to accept responsibility for his actions.

Finally, given the fact that the Department is a "program revenue" agency, whose operating costs are funded by the revenue received for licensees, fairness here dictates imposing the costs of disciplining Respondent upon Respondent and not fellow members of the nursing profession who have not engaged in such conduct.

ORDER

For the reasons set forth above, IT IS ORDERED that:

1. Respondent Frederick B. Gilhams, R.N., is REPRIMANDED.

2. The professional nursing license issued to Respondent to practice nursing in the State of Wisconsin, and Respondent's privilege to practice in Wisconsin pursuant to the Nurse Licensure Compact, is LIMITED as follows:

a. Within 90 days of the date of this Order, Respondent shall at his own expense, successfully complete 12 hours of education on the topic of caring for ventilated patients, three hours on the topic of communication and three hours on the topic of documentation offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.

b. Respondent shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated below. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board or Department, and also may not be used in future attempts to upgrade a credential in Wisconsin.

c. This limitation shall be removed from Respondent's license after satisfying the Board or its designee that Respondent has successfully completed all of the ordered education.

d. Pursuant to Nurse Licensure Compact regulations, Respondent's nursing practice is limited to Wisconsin during the pendency of this limitation. This requirement may be waived only upon the prior written authorization of both the Wisconsin Board of Nursing and the regulatory board in the state in which Respondent proposes to practice.

e. Request of approval of courses, proof of successful course completion and payment of costs (made payable to the Wisconsin Department of Safety and Professional Services) shall be sent by Respondent to the Department Monitor at the address listed in paragraph 3, below.

3. Respondent shall pay all recoverable costs in this matter in an amount to be established, pursuant to Wis. Admin. Code § SPS 2.18. After the amount is established, payment shall be made by certified check or money order payable to the Wisconsin Department of Safety and Professional Services and sent to:

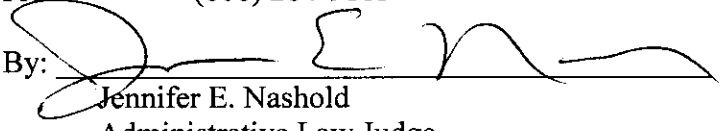
Department Monitor
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190
Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

4. The terms of this Order are effective the date the Final Decision and Order is signed by the Board.

5. IT IS FURTHER ORDERED that the above-captioned matter is hereby closed as to Respondent Frederick B. Gilhams, R.N.

Dated at Madison, Wisconsin on July 2, 2015.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: 
Jennifer E. Nashold
Administrative Law Judge