

**BEFORE THE OREGON
STATE BOARD OF NURSING**

**In the Matter of
April Miotke, LPN**

) **STIPULATED ORDER FOR
) REPRIMAND OF PRACTICAL NURSE
LICENSE**

**License No. 000029769CNA,
201130524LPN**

) **Reference No. 12-02411**

April Miotke (Licensee) was issued a Licensed Practical Nurse license by the Oregon State Board of Nursing (Board) on October 10, 2011.

On or about May 29, 2012, the Board received information that Licensee failed to administer a medication according to physician orders. During a personal interview with Board staff, Licensee admitted that she made a medication error when she administered insulin to resident JA, which was not in accordance with the physician order.

JA was admitted to a nursing home in October 2011 with multiple diagnoses including diabetes. The physician orders dated October 22, 2011 indicated Lispro insulin (Humalog; rapid acting regular insulin) was to be given according to the results of JA's CBG's taken before meals. The physician's orders were written as "Insulin Lispro 100 unit/ml sub-Q; inject 1-12 units subcutaneous three times a day before meals (7:30 am, 11:30 am and 5:00 pm) for CBG over 150. No insulin for CBG less than 150."

The resident progress notes dated November 3, 2011 revealed that JA's CBG was 103 that morning. Licensee gave JA 50 units of Humalog insulin. Licensee said she mis-read the physician order for Humalog insulin 100 units/ml. Licensee said JA's insulin order had recently been changed from a maintenance dose to a sliding scale and she assumed that 100 units was the maintenance dose. Licensee said she drew up 50 units of Humalog, as that was as much solution the insulin syringe could hold. Licensee stated that she gave 50 units to JA and planned to return to administer another 50 units, making the dosage 100 units of Humalog insulin. Licensee said it was at that time she realized her error and did not draw up the additional 50 units of Humalog as she had intended to do.

Records indicate that Licensee realized her mistake, and notified the facility RN of the error. JA's vital signs were stable at this time. JA was transported to the emergency room per MD request for further evaluation. JA returned to the facility in stable condition with no adverse side effects.

The above conduct is a violation of the provisions of ORS **678.111 (1) (f)**, and OAR **851-045-0070 (1) (c); (4) (b)**.

678.111 Causes for denial, revocation, or suspension of license or probation,

reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by endorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(f) Conduct derogatory to the standards of nursing.

Conduct Derogatory to the Standards of Nursing Defined

851-045-0070

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to the following:

(1) Conduct related to the client's safety and integrity:

(c) Failing to develop, implement and/or follow through with the plan of care.

(4) Conduct related to achieving and maintaining clinical competency:

(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

That the Licensed Practical Nurse license of April Miotke be reprimanded.

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Licensed Practical Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

April Miotke, LPN

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

Kay Carnegie, RN, MS
Board President

Date

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE