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STATE OF WISCONSIN BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST

LS0407141NUR

SANDRA KAY SECK, R.N., RESPONDENT.

ESPONDENT.

FINAL DECISION AND ORDER

The parties to this action for the purposes of § 227.53, Stats., are:

Sandra Kay Seck, R.N. 1237 Carlisle Street Racine, WI 53404

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

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 this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

- 1. Sandra Kay Seck, R.N., Respondent, date of birth April 15, 1967, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 131603, which was first granted March 3, 1999.
- 2. Respondent's last address reported to the Department of Regulation and Licensing is 1237 Carlisle Street, Racine, WI 53404.
- 3. During the events of this matter, Respondent was employed as a registered nurse by Intelistaf Healthcare, a temporary staffing agency in Wauwatosa, Wisconsin. From March 10, 2001 until May 16, 2001, Respondent worked at Lincoln Lutheran Care Center (LLCC), a 305 bed nursing home located in Racine, Wisconsin. On May 15, Respondent worked the second shift on a unit at LLCC.
- 4. LLCC's medication count policy followed standard nursing practice which required an accounting of all controlle substances at the time the nursing shifts changed. The outgoing and incoming nurses were to conduct a count of controlled substances in a manner which allowed each nurse to observe the count. The purpose of the policy was to identify the shift during which any discrepancy in the count occurred and the person who was responsible for the controlled substances at the time of the occurrence. Any discrepancies were to be reported to the nursing supervisor and director of nursing immediately. I the outgoing nurse failed to do a count of controlled substances with the incoming nurse, the outgoing nurse was held responsibl for any drug discrepancies. Any nurse failing to complete the count of controlled substances was required to take a drug test immediately.

- 5. Respondent and the first shift nurse she relieved completed a count of controlled substances when Respondent began her shift at 2:00 p.m. on May 15. All controlled substances were accounted for at that time.
- 6. During her shift, only Respondent had the keys for the med cart and the narcotic box in which all controlled substances were located.
- 7. At the end of her shift at approximately 10:45 p.m., Respondent and the night nurse who replaced her did not count the controlled substances together.
 - a. Respondent, in a letter she faxed to Intelistaf human resources on May 21, 2001, contends the night nurse counted the controlled substances alone and told Respondent the count was correct and that Respondent accepted that statement and left.
 - b. Records made by LLCC the morning of May 16, 2001 indicate the night nurse told her shift supervisor that Respondent had left without counting the controlled substances with the night nurse; the night nurse did the count herself and found that a card of 30 oxycodone, a schedule 2 controlled substance, was missing and the night nurse reported the discrepancy to the shift supervisor.
- 8. The following day, May 16, 2001, Respondent was required to provide a urine sample for a drug screen. Respondent willingly did so and the results of the screen were negative. There is no evidence that Respondent diverted the oxycodone and Respondent has no known history of drug or alcohol abuse or dependency.
- 9. As a result of Respondent's failure to follow LLCC's policies regarding controlled substances, it could not be determined what happened to the missing drugs.
- 10. Neither the Board nor the Division of Enforcement has ever received any other complaint regarding Respondent's practice as a nurse.

CONCLUSIONS OF LAW

- 1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to § 441.07, Stats. and authority to enter into this stipulated resolution pursuant to § 227.44(5), Stats.
- 2. Respondent, by engaging in the conduct set out above, has committed negligence as defined by Wis. Adm. Code N 7.03(1) and is subject to discipline pursuant to § 441.07(1)(c), Stats.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

- 1. Respondent, Sandra Kay Seck, R.N., is hereby REPRIMANDED for the above conduct.
- 2. Respondent shall, within 120 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of \$500.00 pursuant to § 440.22(2), Stats.
 - 3. Payment shall be mailed or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264

Dated at Madison, Wisconsin this 16th day of September, 2004.

Jacqueline A. Johnsrud, R.N. Chairperson Board of Nursing