

MAINE STATE BOARD OF NURSING

IN RE: William J. Sevigny, R.N. )  
 ) DECISION AND ORDER  
Licensure Disciplinary Action )

PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S.A. Sec. 2105-A(1-A)(D), et seq., 5 M.R.S.A. Sec. 9051, et seq. and 10 M.R.S.A. Sec. 8001, et seq., the State of Maine Board of Nursing (Board) met in public session at the Board's offices located in Augusta, Maine on January 2, 2003 for the purpose of determining whether William Sevigny, R.N. engaged in unprofessional conduct as a registered nurse while employed at Maine Medical Center in Portland, Maine. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Richard L. Sheehan, M.S., R.N., Chairman, Charyl Kelley, L.P.N., Jeanne Delicata, R.N.C., Therese Shipps, R.N. and Jody L. Deegan, M.S.N., R.N.C. John H. Richards, Ass't. Attorney General, presented the State's case. Mr. Sevigny did not appear either personally or by counsel. James E. Smith, Esq. served as Presiding Officer. The Respondent was timely served with notice of this proceeding by regular mail which was posted by December 10, 2002.

Subsequent to the opening statement by counsel, the State introduced exhibits 1-14 into the Record. Following the taking of testimony, submission of exhibits, and closing argument, the Board deliberated and made the following findings of fact by a preponderance of the credible evidence regarding the violations alleged in the Notice of Complaint.

FINDINGS OF FACT

William Sevigny, a Registered Nurse since 1994, was employed at Maine Medical Center from February 20, 2001 until his termination from that facility on May 9, 2002. His initial 10 week probationary period was extended by 3 months due to tardiness and absenteeism. Nurse Sevigny was assigned primarily to the cardiac-thoracic unit. Patients in that unit included those recovering from post-operative open heart surgery.

The complaint in this matter was generated as follows. Toward the end of April 2002, a Registered Nurse at Maine Medical Center approached the assistant nurse manager and stated that she had observed the Respondent to be in the process of drawing oxycodone, a narcotic drug, for one of her patients without her consent. Hospital protocol requires the nurse assigned to the patient to give his/her consent prior to another nurse administering drugs to that individual. The patient in question had been taking Tylenol for the past 36 hours and there did not appear to be a need for the administering of a stronger medication since she was resting comfortably. The Respondent cancelled the transaction once he was confronted by the caregiver.

Subsequently, a patient who was competent and reliable complained that he had not received his prescribed pain medication which was oxycodone. However, William Sevigny, who had retrieved that drug from the dispenser, noted on the patient's chart that the patient had received the drug. Additionally, on or about April 19, 2002, a patient of nurse Sevigny requested that she

receive Ultram, a non-narcotic, rather than Lortab, a narcotic, for his pain since the latter caused him problems. The Respondent administered Lortab.

The above instances of substandard nursing practices raised the suspicions of the assistant nurse manager who contacted the hospital pharmacist who oversaw the dispensing of narcotic medications. He, in turn, investigated the requests for medication by nurse Sevigny by utilizing the Pyxis computerized program. This system, among other things, accurately records the identity of all employees who request and receive medications and the amount and type thereof.

Some of the conclusions drawn from this investigation were that:

1. Williams Sevigny withdrew a significantly increased number of Lortab and Oxycodone pills in comparison with other caregivers.
2. Some of the medications were double charted.
3. Some medications were charted to patients who were not assigned to nurse Sevigny.
4. Nurse Sevigny wasted medications more often than others.
5. Nurse Sevigny failed to properly document pain levels in patients on the required forms, and information that was provided on one form was often conflicting with or missing from other documents where it should have been noted.
6. Even though patients usually require more pain medication during the day than the evening, the reverse was often the case with nurse Sevigny's patients. Pending the above investigation, the Respondent was placed on probation and was terminated on May 9, 2002 due to suspicion of drug diversion. He was notified that he had 15 days to grieve this personnel action but chose not to do so. Additionally, he failed to appear before the Unemployment Commission which reversed its preliminary decision to award him unemployment benefits.

#### CONCLUSIONS OF LAW

The Board, by a vote of 5-0, found and concluded that William Sevigny violated the following statutory and regulatory provisions regarding the above matter and as stated in the Complaint/Notice of Hearing.

32 M.R.S.A. Sec. 2105-A.2 Grounds for discipline. The board may suspend or revoke a license pursuant to Title 5 Section 10004. The following are grounds for an action to issue, modify, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

A. The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued.

William Sevigny did not provide some of the services that he noted on patients' charts and falsified some patients' records.

E. A licensee is considered incompetent in the practice if the licensee has:

1. Engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or
2. Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed.

William Sevigny diverted drugs, falsified patients' records, did not provide medication that was prescribed, and provided the wrong medication to a patient.

F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed.

H. A violation of this chapter or a rule adopted by the board.

Rules and Regulations of the Maine State Board of Nursing, Chapter 4.1. Disciplinary Action.

3. Definition of Unprofessional Conduct. Nursing behavior which fails to conform to legal standards and accepted standards of the nursing profession, and which could reflect adversely on the health and welfare of the public shall constitute unprofessional conduct and shall include, but not be limited to, the following:

K. Inaccurate recording, falsifying or altering a patient or health care provider record.  
William Sevigny inaccurately recorded pain assessments and falsified at least one patient's records by recording medication that was not given to him.

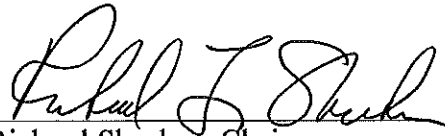
P. Diverting drugs, supplies or property of patients or health care provider.  
William Sevigny diverted drugs, did not provide medication that was prescribed, and provided the wrong medication to a patient.

Q. Possessing, obtaining, furnishing or administering prescription drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs.  
William Sevigny obtained drugs not directed by the caregiver and not furnished according to direction.

The Board, by a vote of 5-0, imposed the following sanctions on the Registered Nurse's license held by William Sevigny:

1. William Sevigny's license to practice as a Registered Nurse is hereby **REVOKED**.
2. The Respondent shall forward to Myra Broadway, Executive Director, **payment of costs totaling \$905** made payable to the State of Maine Board of Nursing by March 15, 2003. (Hearing officer-4 hours and 30 mins. @ \$100 = \$450; Board members attendance/mileage/per diem - \$455).

Dated: February 13, 2003

  
Richard Sheehan, Chairman  
Maine State Board of Nursing

APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S.A. Sec. 10051.3 and 10 M.R.S.A. Sec. 8003, any party that appeals this Decision and Order must file a Petition for Review in the Maine District Court within 30 days of receipt of this Order.

The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Maine Board of Nursing, all parties to the agency proceedings and the Attorney General.