

BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

DARCY WYNNE MCSHERRY

Case No. 2016-1200

Registered Nurse License No. 254794

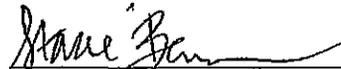
Respondent.

DECISION AND ORDER

Pursuant to Title 16 of the California Code of Regulations, section 1403, the attached Stipulated Settlement is hereby adopted by the Board of Registered Nursing as its Decision and Order in the above-entitled matter.

This Decision shall become effective on May 9, 2017.

IT IS SO ORDERED this 9th day of May, 2017.

for 

Joseph Morris, PhD, MSN, RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

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8
9 **BEFORE THE**
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 2016-1200

12 **DARCY WYNNE MCSHERRY**
13 1001 Sylmar Avenue, #82
14 Clovis, CA 93612

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

15 Registered Nurse License No. 254794.

16 Respondent.

17 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
18 entitled proceedings that the following matters are true:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN was the Executive Officer of the Board of Registered
21 Nursing (Board). She brought this action solely in her official capacity. This matter is currently
22 brought by Joseph L. Morris, PhD, MSN, RN (Complainant) solely in his official capacity as the
23 Executive Officer of the Board and is represented in this matter by Xavier Becerra, Attorney
24 General of the State of California, by Karen L. Gordon, Deputy Attorney General.

25 2. Darcy Wynne McSherry (Respondent) is representing herself in this proceeding and
26 has chosen not to exercise her right to be represented by counsel.

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CONTINGENCY

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2 10. This stipulation shall be subject to approval by the Board. Respondent understands
3 and agrees that counsel for Complainant and the staff of the Board may communicate directly
4 with the Board regarding this stipulation and surrender, without notice to or participation by
5 Respondent. By signing the stipulation, Respondent understands and agrees that she may not
6 withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers
7 and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the
8 Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this
9 paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not
10 be disqualified from further action by having considered this matter.

11 11. The parties understand and agree that Portable Document Format (PDF) and facsimile
12 copies of this Stipulated Surrender of License and Order, including Portable Document Format
13 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

14 12. This Stipulated Surrender of License and Order is intended by the parties to be an
15 integrated writing representing the complete, final, and exclusive embodiment of their agreement.
16 It supersedes any and all prior or contemporaneous agreements, understandings, discussions,
17 negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order
18 may not be altered, amended, modified, supplemented, or otherwise changed except by a writing
19 executed by an authorized representative of each of the parties.

20 13. In consideration of the foregoing admissions and stipulations, the parties agree that
21 the Board may, without further notice or formal proceeding, issue and enter the following Order:

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Exhibit A

Accusation No. 2016-1200

1 KAMALA D. HARRIS
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9 **BEFORE THE**
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
10 **STATE OF CALIFORNIA**

11
12 In the Matter of the Accusation Against:

Case No. 2016-1200

13 **DARCY WYNNE MCSHERRY**
409 Holly Street
14 Oceanside, CA 92058

A C C U S A T I O N

15 **Registered Nurse License No. 254794**

16 Respondent.

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18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing (Board),
22 Department of Consumer Affairs.

23 2. On or about August 31, 1975, the Board issued Registered Nurse License Number
24 254794 to Darcy Wynne McSherry (Respondent). The Registered Nurse License was in full
25 force and effect at all times relevant to the charges brought herein and will expire on February 28,
26 2017, unless renewed.

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1 nurse knew, or should have known, could have jeopardized the client's health or
2 life.

3 COST RECOVERY

4 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
5 administrative law judge to direct a licentiate found to have committed a violation or violations of
6 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
7 enforcement of the case, with failure of the licentiate to comply subjecting the license to not being
8 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
9 included in a stipulated settlement.

10 FACTUAL ALLEGATIONS

11 10. Respondent was employed as a nurse circulator in the operating room (OR) at TriCity
12 Medical Center (TCMC) in Oceanside, California. As a nurse circulator, Respondent was
13 responsible for preparing the operating room for surgery, ensuring the anesthesiologist was set up
14 with their equipment, counting instruments and soft goods, interviewing patients, and obtaining
15 paperwork, among other duties. As to the counting of equipment, including sponges, Respondent
16 was responsible for performing the initial count, closing count and final count. Respondent was
17 required to display the laparotomy sponges so that all sponges could be accounted for before and
18 after surgery.

19 11. On December 23, 2014, a thirty-six year old female patient was admitted to TCMC
20 for an ectopic pregnancy.¹ The patient was scheduled for an exploratory laparotomy² and right
21 partial salpingectomy³ with removal of ectopic pregnancy and evacuation of hemoperitoneum
22 (blood in the peritoneal cavity). Respondent was assigned as the nurse circulator during the
23 scheduled surgery for this patient.

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26 ¹ An ectopic pregnancy or a tubal pregnancy, is a pregnancy where the fetus develops
27 outside the uterus, typically in the Fallopian tube.

28 ² A laparotomy is a surgical procedure involving a large incision through the abdominal
wall to gain access into the abdominal cavity.

³ Salpingectomy refers to the surgical removal of a Fallopian tube.

1 12. Prior to the surgery, Respondent performed an initial count of the sponges. The
2 surgery took place after regular hours, around 5:00 a.m. and was completed around 6:30 a.m. The
3 surgeon used two laparotomy sponges at the start of the procedure to hold up the bowel.
4 Respondent performed a closing count of the laparotomy sponges, which she believed to be
5 correct. Respondent then left the operating room between the closing and final count. While
6 outside of the operating room, Respondent gave a report to the day shift regarding the next
7 scheduled surgery. When Respondent returned to the operating room, she saw the surgeon
8 closing the skin on the incision. Respondent was informed by the surgical technician that she
9 could not find two laparotomy sponges. Respondent did not inform the surgical team that two
10 laparotomy sponges were unaccounted for. The surgeon continued closing the skin and upon
11 closure of the skin, there were still two laparotomy sponges missing. Housekeeping then entered
12 the operating room to prepare for the next surgery. The anesthesiologist had the patient moved
13 from the operating room table and onto the gurney in preparation for transfer to the recovery
14 room. Respondent went with the anesthesiologist and the patient to the recovery room and gave a
15 report to the recovery nurses. When Respondent returned to the operating room, she did not see
16 the surgical technician and assumed that the two unaccounted for sponges had been found.
17 Although Respondent did not perform a final count of the laparotomy sponges, Respondent
18 documented the final count as correct on the intra operative record. Respondent did not follow up
19 with the surgical technician to ensure that the missing sponges had been accounted for.

20 13. Two days later, the patient returned to TCMC complaining of abdominal pain and
21 fever. A CT scan revealed that the patient had a foreign object in her abdomen. The patient
22 underwent an additional surgery to remove the two laparotomy sponges that had been left inside
23 of her during her first surgery. In addition, the patient required a hysterectomy⁴ due to the
24 necrotic tissue⁵ found inside of her caused by the laparotomy sponges.

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26 ⁴ A hysterectomy is a surgery to remove a patient's uterus, rendering her sterile.

27 ⁵ Necrotic tissue is dead tissue, usually resulting from inadequate local blood supply.
28 Necrotic tissue contains dead cells and debris that are a consequence of the fragmentation of
dying cells.

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3. Taking such other and further action as deemed necessary and proper.

DATED: June 6, 2016

Louise R. Bailey
LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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