# STATE OF NEW HAMPSHIRE
## OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

_____

## BOARD OF NURSING

| | |
|---|---|
| **In Re: Amy Matthews,**<br>**RN Lic. # 048273-21** | **NARRATIVE ORDER VACATING EMERGENCY SUSPENSION – 06/23/22** |
| Docket No.: 2022-Nur-011 | |

**I. ATTENDEES:**

Samantha O'Neill, Board Member and Chair
Gene Harkless, Board Member
Wendy Stanley Jones, Board Member
Melissa Tuttle, Board Member
Maureen Murtagh, Board Member
Michele Melanson-Schmitt, Board Member
Melissa Underhill, Board Member
Ashley Czechowicz, Administrator
Nikolas K. Frye, Esq., Presiding Officer
Collin Phillips, Esq., Hearing Counsel
John Garrigan, Esq., Hearing Counsel
Alysia M. Cassotis, Esq., Attorney for Licensee
Amy Matthews, Licensee

**II. CASE SUMMARY/PROCEDURAL HISTORY:**

On or about 01/31/22 and 02/04/22, the Office of Professional Licensure and Certification, Division of Enforcement ("OPLC Enforcement"), acting on behalf of the Board of Nursing ("Board"), received complaints alleging diversion and significant loss of fentanyl from the Intensive Care Unit ("ICU") at Cheshire Medical Center in Cheshire, New Hampshire ("Hospital"). Enforcement's investigation into those complaints later implicated Amy Matthews ("Licensee"), Chief Nursing Officer ("CNO"). After further investigation, the Board learned the Hospital had suffered additional loss and/or

diversion of fentanyl between 04/10/22 and 05/12/22 with Licensee still acting as CNO. Consequently, the Board voted on 05/26/22 to suspend Licensee's license on an emergency basis pursuant to RSA 541-A:30(III), RSA 326-B:37(IV), and N.H. Code Admin. R., Title Nur 402.03(a) ("Rules"). Upon the request of the parties, the Board continued the hearing on emergency suspension to 06/23/22. On 06/09/22, 06/16/22, 06/21/22 and 06/23/22, respectively, the Board, through its Presiding Officer, held prehearing conferences in this matter. Following the emergency suspension hearing held on 06/23/22, the Board issued a 06/24/22 Order Vacating Emergency Suspension. This Narrative Order Vacating Emergency Suspension follows.

## III. SUMMARY OF THE EVIDENCE:

The Board received the following evidence pursuant to RSA 541-A:33 and Rule 207.09:

A. Exhibits were submitted by Hearing Counsel, labeled as follows:

1. Towle Complaint Form from Cheshire Medical Center, dated 02/04/22
2. Towle Complaint Form from A. Towle, dated 02/04/22
3. New Hampshire Controlled Drug Loss Form with Narrative, dated 02/02/22
4. Cheshire Medical Center Diversion Incident Corrective Action Plan, effective 03/07/22
5. New Hampshire Controlled Drug Loss Form with Email and Narrative, dated 03/08/22
6. New Hampshire Controlled Drug Loss Form, dated 03/29/22
7. New Hampshire Controlled Drug Loss Form with Email, dated 04/14/22
8. DEA 106 Form, dated 05/12/22
9. New Hampshire Controlled Drug Loss Form with Email, dated 05/12/22
10. New Hampshire Controlled Drug Loss Forms with Email, dated 05/31/22
11. OPLC Enforcement Chart of NH Controlled Substance Loss as of 06/05/22 (E. Croteau)
12. Confidential Memorandum, dated 05/25/22 (M. Porter)
13. Board of Pharmacy Narrative Order Vacating Emergency Suspension of M. Siciliano – 04/20/22.

B. Exhibits were submitted by Licensee, labeled as follows:

a. Curriculum Vitae, Amy Matthews
b. Chronology
c. Policy 1627 – Controlled Substances
d. Med Safety – CS Reminder
e. Procedure 26779 – CS Waste of Infusions
f. Update to 16267 re: Hand-off
g. CS Discrepancy Follow-up Flow Chart
h. Discrepancy Resolution Training
i. Pandora Anomalous Usage Report Training

j. Updated Corrective Action Plan
k. Simoneau Confidential Memo
l. NH Board of Pharmacy Order of Emergency Suspension re: Melissa Siciliano
m. NH Board of Pharmacy Order of Emergency Suspension re: Richard Crowe
n. Procedure 22447 – Waste Disposal Environmental & Pharmaceutical
o. Job Aide 21962- CS, disposal, environmental, pharmaceutical, waste
p. Discrepancy Resolution PPT and Knowledge Check
q. Resolving Discrepancy Quick Reference Guide
r. Resolving Discrepancy Education Tips & Hints
s. Skills Check- Resolving Discrepancy
t. Surveillance Training
u. Dose Discrepancy Occurrence Tasking in OWLS
v. Controlled Substances Discrepancy Job Aides (2)
w. Nurse Leader Training Surveillance Reports
x. Dose Discrepancy Occurrence Tasking
y. Nurse Leader Training Record Audit Tool
z. Common Risky Behaviors Checklist
aa. Interventions for CS Safety
bb. Policy 27284- Ambulatory Controlled Substance Compliance
cc. Job Aid 27277- Controlled Substances Storage, Management & Discrepancies
dd. Diversion Prevention Annual Training
ee. How to Waste Controlled Substances in Omnicell
ff. eDH Documenting the Handoff of Controlled Substances
gg. Procedure- Documentation Procedure for Fentanyl Containing Infusions
hh. After Hours Conveyance of Controlled Substances
ii. Documenting Medications Pulled Without an Order
jj. Procedures- Virtual Rapid Sequence Intubation Kits
kk. Temporary Discrepancy Resolution Plan
ll. ICU Reminder/Posting
mm. Nursing Town Hall Slides
nn. ICU Fentanyl Workflow for First Bag
oo. BON Report of LD
pp. OPLC Letter: Attorney Porter to Attorney Troland
qq. Response Letter: Attorney Troland to Attorney Porter
rr. Controlled Substance Infusion Tip sheet
ss. Controlled Substance Skills Verification
tt. Job Aide- Tube Changing Practice for IV Solution
uu. Procedure 27287- CS, Fentanyl, Infusion
vv. Updated Fentanyl Audit Tool
ww. Tips & Tricks for Omnicell Wasting
xx. Immediate Response Checklist in the Event of Actual or Suspected Drug Diversion
yy. Cheshire Medical Center Letter to BOP
zz. Cheshire Medical Center Letter to OPLC/Attorney Porter (response to 05/18/22 Letter)
aaa. NH DHHS Report

B. Sworn testimony was received from:

1. Elsa Croteau, OPLC Pharmacy Inspector (called by Hearing Counsel)
2. Michael Porter, OPLC Investigations Bureau Chief (called by Hearing Counsel)
3. Matthew Choate, RN, BSN, CNO of Central Vermont Medical Center (called by Licensee)
4. Amy Matthews, RN and Licensee (called by Licensee)

## IV. PRELIMINARY MATTERS

Before the hearing, the Board's Presiding Officer held multiple prehearing conferences with the parties at which the admissibility of evidence was discussed and determined. In summary, Licensee stipulated to the admission of Hearing Counsel's Exhibits 1-13 as full exhibits. After review, the Presiding Officer determined Exhibits 1-13 were admissible as full exhibits. On 06/21/222, the Licensee stipulated to the admissibility of the anticipated testimony of Elsa Croteau and Michael Porter. As discussed at the outset of the 06/23/22 adjudicatory hearing, Hearing Counsel had agreed to present most of its case through an offer of proof, with Elsa Croteau and Michael Porter subject to cross examination and Board questioning.[1] On 06/23/22, the Presiding Officer determined Hearing Counsel could deviate from that format by providing direct testimony from Ms. Croteau that was intended to rebut the anticipated testimony of Licensee's expert witness.[2]

Hearing Counsel stipulated to the admissibility of Licensee's Exhibits A through ZZ. Hearing Counsel objected to Exhibit AAA based upon relevance. After reviewing Exhibits A through ZZ, the Presiding Officer determined they were admissible as full exhibits, except Exhibit B.[3] After reviewing

[1] The Board allotted three hours for the hearing. Hearing Counsel presented primarily by offer of proof to ensure Licensee had the maximum amount of the three hours to present her case. When deciding whether to emergently suspend a license, the Board receives evidence from OPLC Enforcement to consider on an ex parte basis. In some respects, this makes it easier for OPLC Enforcement to present their case more succinctly at an emergency suspension hearing.

[2] During the hearing, Hearing Counsel was also offered the opportunity to ask direct examination questions of Investigator Porter, so long as it did not involve evidence that was ruled inadmissible during the prehearing conferences.

[3] The Presiding Officer determined Exhibit B is a chronology of events assembled by Licensee, as opposed to an exhibit. It was therefore accepted as a stipulation of fact.

Exhibit AAA, the Presiding Officer determined it was relevant because it establishes the Hospital recently passed an inspection conducted by the New Hampshire Department of Health and Human Services related to controlled substance laws and regulations. The parties stipulated to the admissibility of Licensee's testimony, but Hearing Counsel objected to the admissibility of the expert testimony of Matthew Choate. The Presiding Officer determined Mr. Choate's testimony was admissible insofar as it assists the Board in understanding the role and responsibilities of a CNO.

## V. CONDUCT OF HEARING AND EVIDENCE PRESENTED:

The Board's inquiry is narrow: whether the Licensee practicing as a registered nurse poses an imminent danger to public health, safety, or welfare, such that her license should remain suspended pending further board action. Put another way, pursuant to Rule 207.10, Hearing Counsel has the burden of proving, by a preponderance of the evidence, that the Licensee being licensed pending further Board action presents an imminent danger to public health, safety, or welfare. The credible evidence presented allows the Board to find the following facts with respect to that inquiry.

The Licensee currently holds New Hampshire Registered Nurse ("RN") license #048273-21. On 05/26/22, the Board suspended her license on an emergency basis. The Board explained that decision as follows:

> The central facts are straightforward—Licensee is the CNO at the Hospital, which has lost approximately 7.84 gallons of Fentanyl, 553.93 ml of which occurred after the Hospital implemented remedial measures. As is clear from the Hospital's email of 05/12/22, the most recent losses were "withdrawn from the Omnicell cabinet by nurses", the very individuals and daily processes the Licensee is tasked with managing, supervising, and overseeing. To have such a significant amount of Fentanyl lost under her management, even after remedial measures were implemented, indicates the Licensee is negligent and/or careless in her work such that she poses an imminent threat to the public health, safety, or welfare. The Licensee's conduct on its face between 04/10/22 and 05/07/22, especially when viewed in the context of the entire history of Fentanyl loss at the Hospital since September of 2021, warrants immediate emergency suspension of her license pursuant to RSA 541-A:30(III) and RSA 326-B:37(IV), pending a follow-up emergency suspension hearing.
>
> Ord. of 05/31/22 at page 5.

## HEARING COUNSEL'S CASE-IN-CHIEF

**Hearing Counsel's Offer of Proof:**

Hearing Counsel opened has case-in-chief with an offer of proof[4] attested to by two witnesses: Elsa Croteau, OPLC Pharmacy Compliance Inspector, and Michael Porter, OPLC Investigations Bureau Chief. The exhibits submitted by Hearing Counsel sufficiently clarify each witness' role in this matter. *See, i.e.,* Exhs. 11 and 12. Inspector Croteau has been assisting the New Hampshire Board of Pharmacy in investigating diverted, lost, and unaccounted for controlled substances at the Hospital since February of 2022. Likewise, Investigator Porter has been investigating diverted, lost, and unaccounted for controlled substances at the Hospital for multiple New Hampshire boards (including this Board) since February of 2022.

Hearing Counsel explained that the New Hampshire Controlled Drug Loss forms submitted by the Hospital show a cumulative 1.675 million micrograms of fentanyl unaccounted for in its nursing documentation since August of 2021.[5] He also represented that the Licensee has worked as CNO at the Hospital since 2018 and therefore oversaw nursing practices until her license was emergently suspended. Hearing Counsel's offer of proof next revealed that between August of 2021 and January of 2022, the Licensee, in concert with other decisionmakers at the Hospital, relaxed multiple controlled substance measures, including but not limited to dual sign-off for controlled substance recordkeeping, override

[4] An offer of proof is when an attorney summarizes the evidence it would have presented if it put on a trial through witness testimony and exhibits. The exhibits are accepted as full exhibits to be considered by the judicial body deciding the matter and the witnesses are present and sworn in under oath and asked to correct any misstatements made by the attorney presenting the summary. The opposing party then can cross examine those witnesses. In a Board case, the Board also can ask the witnesses questions. Finally, the attorney summarizing may respond within the scope of those questions either through further summary or questioning the witness. It is a means of having a more time-efficient trial.

[5] This figure accounts for controlled substance loss forms submitted to OPLC through 06/05/22. *See* Exhs. 3, 5, 6, 7, 9, 10, and 11.

access to the Omnicell[6], and removal of lockboxes. These measures were only reimplemented in February of 2022— after the Hospital first discovered the fentanyl issues. Hearing Counsel explained that in April and May of 2022, the Licensee participated in three audits that uncovered an additional 553 ml of fentanyl were lost or unaccounted for at the Hospital between 04/10/22 and 05/07/22. These losses occurred after the Hospital had implemented remedial measures.

Hearing Counsel also highlighted that, aside from the initial complaint filed with respect to the nurse diverting fentanyl, the Licensee never filed a complaint with the Board relating to the 1.675 million micrograms of unaccounted for fentanyl. He explained that this occurred even though the Hospital had attributed unaccounted for amounts to nursing practices. He argued that the Hospital's losses occurring after February of 2022 showed that nursing practices were still "poor" under Licensee's supervision, approximately three months after discovery of the fentanyl issues. Hearing Counsel asserted that because of the Licensee's failure to correct nursing practices, the Hospital eventually decided to eliminate all administration of fentanyl on 05/13/22. Lastly, he noted that since Licensee had been emergently suspended by the Board, there had been no additional controlled substance loss forms submitted by the Hospital.

**Elsa Croteau:**

Inspector Croteau offered very brief and specific direct testimony. She testified that she inspects hospital pharmacies in New Hampshire and was unaware of any other hospital that had reported fentanyl loss between August of 2021 and 06/05/22. Based on her training and experience, she described the Hospital's losses as "astronomical". To provide context, she explained that any amount of loss was reportable to the Board of Pharmacy.

[6] For a more particular explanation of what an Omnicell is and how it operates, *see* Exhibit 13, which is also available online at: STATE OF NEW HAMPSHIRE (nh.gov).

The Licensee next cross examined the witness.[7] Inspector Croteau agreed that the Licensee had filed a complaint with the Board on 02/02/22 relating to the nurse who diverted fentanyl from the Hospital. Inspector Croteau also admitted that the Licensee, along with other Hospital personnel, had met with her in March of 2022 to discuss measures the Hospital was taking to investigate and resolve the matter. Inspector Croteau characterized the Licensee as being cooperative during this meeting. Cross examination next highlighted the difference between the Hospital's controlled substance reconciliation audits occurring before April of 2022 and those afterward. Inspector Croteau explained that the audits occurring afterward included manual documentation of each bag and interviewing nurses to learn why unaccounted for fentanyl was not documented in the records. Ms. Croteau also agreed that Hospital personnel, including the Licensee, represented to her that challenges brought about by the COVID-19 surge had exacerbated the Hospital's fentanyl problem.

The Licensee also questioned Ms. Croteau about the Hospital's corrective action plan. Ms. Croteau agreed that early on Licensee and other Hospital personnel had told her the investigation into the losses occurring before February of 2022 were ongoing and the corrective action plan would take time to implement. She acknowledged that at the same time the Hospital was conducting its internal investigation and implementing the corrective action plan it was also fielding inquiries and requests from the local police, DEA, and OPLC. She admitted that she deemed the corrective action plan appropriate at various stages of revision and implementation. Additionally, she acknowledged that after 02/02/22 the Licensee had participated in revising the Hospital's controlled substance processes and educating its employees on controlled substance policy and procedure. Inspector Croteau clarified that her concern was that the Hospital was still reporting losses in May of 2022, despite having had time to implement remedial measures.

[7] The witness was cross examined not only on her direct examination but on Hearing Counsel's offer of proof and the admitted exhibits.

In a follow-up line of questioning, Inspector Croteau acknowledged that between February of 2022 and May of 2022, the Licensee and other Hospital Personnel took several steps to attempt stopping fentanyl loss at the Hospital. The last of those steps was ending fentanyl infusions all together on 05/13/22. Ms. Croteau explained this occurred after the Hospital's most recent audits showed further unaccounted for amounts of fentanyl cropping up between 04/10/22 and 05/12/22. She agreed those unaccounted for amounts were not full bag losses and averaged out to about 5-6 ml per bag of fentanyl administered during that period. She explained, however, that any variance is a discrepancy. Lastly, Inspector Croteau acknowledged that the Hospital was trying to obtain a new syringe pump system that its leadership thought would help improve the situation, but the product was on back order.

Board questioning delved into the Inspector's knowledge of fentanyl loss at other New Hampshire hospitals. Inspector Croteau explained that she recently reviewed statistics for controlled substance related losses at New Hampshire hospitals dating back to 2020. In 2021, 9 out of 35 hospitals reported controlled substance losses. In 2020, 2 out of 35 reported controlled substance losses, but none were fentanyl. She later clarified that several of these hospitals, like the Hospital, use Omnicell. She further testified that in her experience hospitals have good reporting and respond thoroughly to even relatively small losses. She explained that a significant loss is considered 2% or 15 units or greater.[8]

**Michael Porter:**

Neither Hearing Counsel nor Licensee had questions for Investigator Porter. Upon Board questioning, Investigator Porter clarified that the investigation into this matter remains ongoing. He referenced recently receiving 453 pages of discovery from the Hospital. He explained that the discovery contained a report from the Hospital he had not had the opportunity to review thoroughly. He noted that the report appears to provide a variety of explanations for potential loss including underreporting, pump

[8] Having a significant loss triggers a requirement of a hospital to report it within 24 hours of determining the amount cannot be reconciled.

issues, and improper record keeping on wasting, etc. He clarified that OPLC Enforcement was concerned about the Licensee practicing pending further action by the Board because her nursing practices having contributed to the substantial cumulative fentanyl loss at the Hospital, as well as the most recent losses occurring after remedial measures were implemented.

## LICENSEE'S CASE-IN-CHIEF:

### Matthew Choate:

The Licensee's first witness was Matthew Choate. He testified that he has been the CNO at Central Vermont Medical Center for five years, is a member of the Vermont Board of Nursing, and has no prior affiliation with the Licensee. He explained that he reviewed documentation related to the Licensee's actions in response to the fentanyl losses first noticed at the Hospital in February of 2022.[9] Based upon his review of the documentation, Nurse Choate testified that it appeared the Licensee, as a part of a larger multidisciplinary team, was taking appropriate action to address the matter. Nurse Choate further concluded that the Hospital appeared to be primarily having a documentation issue and that the Licensee, as part of the multidisciplinary team, had organized a thoughtful process to further control and tighten where the issues were.[10] He explained that a CNO's duties in this type of a situation is to reeducate, develop policy and procedures aimed at ensuring future compliance, and investigate the matter. While a CNO is ultimately responsible for the nursing staff, Nurse Choate explained that they often oversee hundreds of subordinates. He clarified direct supervision usually only occurs in the context of shadowing a nurse or if a matter is elevated to the CNO's attention. He also indicated he would not anticipate immediate results in the Hospital's process and would expect having to reeducate staff on multiple

[9] Counsel for Licensee explained that this documentation was the chronology labeled as Exhibit B.

[10] The implication being that diversion was not the central cause of the unaccounted for fentanyl.

occasions. He testified that although there was additional loss in April and May of 2022, the documentation he reviewed showed the Hospital made demonstrable progress since February of 2022.

On cross examination, Nurse Choate acknowledged he was no longer licensed as a nurse in New Hampshire, was unaware of New Hampshire law and nursing standards, had never seen the Licensee practice, had never been to the Hospital, and had conducted no interviews in relation to his conclusions. Nurse Choate also testified that although the Hospital had made progress since February of 2022, the losses incurred in April and May of 2022 were 10%, which was greater than 2%.[11] Board questioning elicited further information on the role and duties of a CNO. Nurse Choate testified a CNO is responsible for drafting and implementing practice standards and guidelines, as well as ensuring systems are in place to help nurses practice according to standards. He represented that a CNO relies on hospital staff to follow those guidelines and procedures. He further testified it was reasonable for a CNO to delegate responsibilities to employees and acknowledged the significant challenges that the COVID-19 surge had on hospitals in 2021 and early 2022.

**Licensee:**

Licensee testified last and started by providing background information on her training and experience and role at the Hospital. She explained she has worked at the Hospital since 2000 and been its CNO for three and a half years. As CNO she oversees approximately 700 clinical and non-clinical nurses. She stated she has three roles at the Hospital: as an executive on the Hospital team of chiefs, as a vice president at the Hospital, and as CNO. According to her testimony, these positions have her considering the communities needs, working on provision of acute care services, delegating nursing practices, implementing policies, and ensuring that nurses practice within their scope. She next explained the chain

[11] For the significance of 2% *see Supra* at 9 *and* footnote 8.

of command in nursing at the Hospital. Below her in order of authority are the assistant chief nursing officer, nursing directors, and nursing support managers. The latter works most closely with the nurses.

After providing context as to what she does as CNO at the Hospital, the Licensee began describing her response to the original 02/02/22 complaint she had filed with the Board. The Licensee stated that she and other chiefs first started an investigation and took steps to ensure office security and limit points of access. As part of this process, the nurse diverting the medications had her access to the Hospital "frozen" and was asked to come in for an interview. The Licensee explained that since the focus of the investigation was a nurse, she initially "stepped back" and allowed the other team leaders to handle it to ensure it was unbiased. She testified she did, however, meet with the other team leaders about the investigation, communicated with staff about the incident, and reimplemented some controlled substance best practices that had been relaxed because of the COVID-19 pandemic.

According to Licensee's testimony, among those best practices reimplemented almost immediately was a reduction in time of 60 to 30 minutes from when a controlled substance is accessed/dispensed to when it is used, wasted, or returned by a nurse. Another change was reinstituting a requirement of dual signoff by nurses in controlled substance records. The Licensee additionally explained that the Hospital's use of the Pandora generated anomalous reports was reestablished on 02/07/22. Her testimony revealed these reports were previously interrupted and/or not running for a variety of reasons, including software issues. The Licensee also admitted that the Hospital had relaxed the standards for overriding the Omnicell during the COVID-19 surge. She explained that this allowed charge nurses to access medication for a patient before a doctor sends the prescription to the pharmacy for transmission to the Omnicell. The Licensee conveyed to the Board that she and other executives at the Hospital redefined the ability to override an Omnicell to situations that are emergent only. Although not necessarily

sanctioned, the Licensee also acknowledged that the investigation revealed some staff were loosening other normal controlled substance guidelines on their own to adapt to the COVID-19 surge.

The Licensee next provided context as to why the reinstituted controlled substance best practices had been relaxed between August of 2021 and January of 2022. She described the COVID-19 surges occurring during this period as being "stressful", "difficult", "high pressure", and "high moral distress" for Hospital staff. The Licensee stated the Hospital had patients for "weeks and months", and patients were being sedated at a higher level then she had ever seen in her 20 to 30 year career. She described situations in which healthcare workers— whom she said were "tired and working hard to provide good care"— were trying to communicate with patients and each other while wearing personal protection equipment and facilitating end of life conversations with patient relatives over Zoom. The Licensee also noted that at the height of the 2021-2022 COVID-19 winter surge, the Hospital's ICU was completely full. This resulted in a makeshift ICU being opened in the Hospital's endoscopy suite. This environment had resulted in the staff requesting relaxation of some of the controlled substance guidelines.

The Licensee's testimony then turned to her involvement in the Hospital's internal investigation. She testified that she became more involved about a week after 02/02/22. According to her testimony, her involvement included providing any information to assist with the investigation, facilitating staff interviews, figuring out the loss and impact on patient safety, and learning whether losses were happening with nurses other than Nurse Towle.[12] The Licensee noted that the Hospital also collected information on patients hospitalized during the surge to determine if there had been any patient harm. She stated, the review indicated that there was no patient harm. According to her testimony, the Hospital's leadership brought in two diversion specialists to assist in developing a corrective action plan and to help the Hospital better understand what was known about the diverted and unaccounted for fentanyl losses. The Licensee

[12] She was the nurse who the Licensee had reported to the Board on 02/02/22.

described the scope of the unaccounted for fentanyl and investigation as "enormous", "shocking", and "devastating". She testified her primary goal in assisting in the investigation and remedial measures was to ensure that something like this never happens at the Hospital again.

The Licensee next described some of the efforts she and other Hospital leadership members took to educate staff after 02/02/22. She testified the Hospital instituted daily huddles, had larger weekly meetings, instituted interdisciplinary work, and provided presentations and policies for staff to review. *See also, i.e.,* Exhs. C-J, N-NN, RR-XX. Her testimony also revealed that once the initial stages of the investigation were completed, the Hospital learned that there was unaccounted for fentanyl beyond the diverted amount attributed to the nurse. She explained this led to leadership updating waste procedure, reinforcing controlled substance best practices with staff, rolling out other education for staff (including for controlled substance updates and wasting procedure), and increasing and bettering surveillance of controlled substances in the Hospital. She also stated the Hospital used a common risky behavior check list to compare with anomalous reports. This comparison allowed the Hospital to determine if there were nursing staff whose practices needed to be scrutinized. The Licensee described the education process as ongoing and informed by what was constantly being learned about the diversion and unaccounted for fentanyl. While the Licensee felt confident in what the Hospital was doing, she explained that she did not expect 100% effective practices on day 1. She testified that the changes between February and March of 2022 were best described as broad strokes and "back to the basics".

The Licensee then explained the Hospital's controlled substance audit practice that was in place between April of 2022 and early May 2022.[13] She explained that the hospital elected to do manual audits

[13] Earlier in her testimony, the Licensee had described the normal reconciliation process, which consisted of the following standard reports: weekly cycle counts, account discrepancy reports, dose reconciliation reports, and anomalous usage reports. The weekly cycle count confirms the number of controlled substances in each drawer of the Omnicell and is monitored by the Hospital's pharmacy. The account discrepancy report looks at when an individual comes to an Omnicell machine to access a drawer of controlled substances. The individual is supposed to enter what is in the drawer. If entered incorrectly, it creates a discrepancy that must be resolved by nursing and pharmacy. The dose reconciliation report is information taken from the Omnicell machine and electronic medical record (EMAR) used to align what was dispensed from the Omnicell with what is

in April and May of 2022 because there were limitations to what standard reports can show and the Hospital was trying to learn any issues with its processes. She described the manual audits as complicated and time consuming because they attempt to account for every ml of fentanyl by comparing bags of fentanyl dispensed versus bags of fentanyl hung. She testified some of the issues learned during these audits was that the Hospital's current tubing, pump systems, and fentanyl drip bags are areas where variance naturally occurs.[14] Consequently, she explained the Hospital has elected to move to a syringe pump system that has a clear line, no drip chamber, and only 2 cc's of tubing error. Her testimony also confirmed that the only reason the syringe pump system had not yet been implemented was because they were on back order. The Licensee also noted that the audit highlighted areas for improvement in practice and documentation, including waste concerns.

The Licensee closed her direct testimony by addressing the results of the manual audits, which showed approximately 553 ml of unaccounted for fentanyl between 04/10/22 and 05/12/22. In broad strokes, she described the process as showing moments where the Hospital was "headed in the right direction" and moments where it needed to "get it right." She noted there were no full lost bags, which the Hospitals diversion specialist had indicated meant none of it was likely diverted. Her testimony revealed the Hospital's chiefs met to discuss the reports and decided to reinforce best practices with staff and made some minor changes to its controlled substance policy. In addition, the Hospital engaged in real time auditing, moved back to an incident command structure, increased the availability of charge nurses, and limited the number of patients in the ICU starting on 05/06/22. The Licensee relayed that while the

recorded as wasted, administered, or returned in the EMAR. If there is a discrepancy, it is provided to nursing and pharmacy for review. The anomalous usage report is a statistical analysis of withdrawals conducted by various staff.

[14] The current pump system does a high volume at a time, so it is difficult to account for every ml of fentanyl currently. The Licensee also testified that the Hospital learned the pump systems had at times automatically defaulted to telling the Omnicell that fentanyl was being pushed through the tubing at a rate of 1 cc when in fact the rate was 6 cc. Further, the IV tubing can hold anywhere between 15-20 ccs that could be thrown away. Likewise, the infusion bags are for 50 cc but have an over under tolerance of 3%. In addition, there is the possibility of human error in visually eyeing the amount in the infusion bag once it is hung.

Hospital saw improvements after implementation of these procedures, they were ultimately not enough; the amount of unaccounted for fentanyl was still outside the acceptable limit. The Licensee explained that on 05/13/22 the leadership team therefore decided to stop all fentanyl infusions until more education could be provided to staff and the new syringe pumps could be obtained. The Licensee finished her direct testimony by explaining she did not report any other nurses other than Nurse Towle because there was no further indication of diversion. The Licensee stated she did not believe any individual nurse should be reported unless they had received reeducation and all proper tools were in place and they were still unwilling or unable to follow procedures and policies.

On cross examination, the Licensee agreed that the expectation was that documentation of controlled substances at the Hospital is done correctly. She also admitted she and other Hospital team members had agreed to relax controlled substance policies while the use of fentanyl was increasing at a rate she had never previously observed. Her testimony also revealed that there were other controlled substances lost during the relevant time frames involved in this matter other than just fentanyl. She agreed that the Hospital had been using its current pump system for five years and most of the staff was very experienced with using it. Lastly, Board questioning revealed the Licensee's explanation as to why she believed other New Hampshire hospitals did not have similar issues with fentanyl loss during the COVID-19 surge. According to the Licensee, the Hospital had a "culture of high trust", did not see the issues, and was vulnerable in surveillance.

## V. DISCUSSION AND FINDINGS OF FACTS / CONCLUSIONS OF LAW:

After reviewing all the evidence and accounting for the credibility and demeanor of the witnesses, the Board finds Hearing Counsel has not met his burden of proof by a preponderance of the evidence that the Licensee practicing pending adjudication poses an imminent danger to public health, safety, or welfare. RSA 326-B:37, IV. Although this case involves a large quantity of lost or unaccounted for Fentanyl, the

Board is tasked with assessing the imminency of the threat to the public based upon the facts before it. As noted in its Order of 05/26/22, the thrust of the Board's concern was that the Hospital continued to have lost/unaccounted for fentanyl after it had implemented remedial measures. The evidence presented demonstrates that between February of 2022 and May of 2022 the Licensee, in her capacity as CNO and as a leadership member at the Hospital, actively involved herself in the investigation into the diverted and unaccounted for fentanyl, helped adopt policies and procedures to address the concerns raised during the ongoing investigation, and collaboratively developed and implemented education and system changes pertaining to controlled substances. These actions relieve the Board's original concern that since February of 2022, "the Licensee had been negligent and/or careless in her work such that she poses an imminent threat to the public health, safety, or welfare." 05/26/22 Ord at page 5. To be clear, the Board is nonetheless troubled by the events at the Hospital leading up to 02/02/22 and the role the Licensee may have played in them. The Board recognizes that the investigation is ongoing and reserves further judgment based upon all the evidence that investigation yields. When appropriate, the Board will timely issue a notice of hearing or otherwise dispose of this matter.

## VI. CONCLUSION AND DECISION:

Pursuant to RSA 326-B:27(IV), and Rule 402.03, the Board hereby vacates the emergency suspension of Amy Matthews's license as an RN in New Hampshire as of 06/23/22.

DATED: 7/8/2022

___/s/ Nikolas K. Frye, Esq._____
Nikolas K. Frye, Esq., Hearings Examiner
Authorized Representative of the Board of Nursing-
New Hampshire Office of
Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301