STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Amy Matthews, RN Lic. #048273-21	Docket No.: 2022-NUR-016 **ORDER OF EMERGENCY SUSPENSION - 05/26/22**

I. 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 later learned that OPLC Enforcement had received information on 05/12/22 that the Hospital had suffered additional significant loss and/or diversion of Fentanyl between 04/10/22 and 05/12/22 with Licensee still acting as CNO. On 05/26/22, the Board held an emergency meeting during its public session pursuant to pursuant to RSA 541-A:30(III), RSA 326-B:37(IV), and N.H. Code Admin. R., Title Nur 402.03(a) ("Rules").

> **In cases involving imminent danger to public health, safety, or welfare, the board may order the immediate suspension of a license pending an adjudicative proceeding.**

On 05/26/22, Nikolas Frye, Esq., OPLC Hearings Examiner, acted as presiding officer under N.H. Code Admin. R. Nur Rule 202.01(l) and 208.01(b)("Rules").

II. EVIDENCE PRESENTED AND CONDUCT OF HEARING:

The Board was presented with and/or considered 1) a 05/25/22 Confidential Memorandum from Michael Porter, OPLC Investigations Bureau Chief; 2) a 02/02/22 New Hampshire Controlled Drug Loss Form and accompanying letter filed by the Hospital; 3) a 03/08/22 New Hampshire Controlled Drug Loss Form and accompanying letter filed by the Hospital; 4) 03/25/22-03/29/22 email correspondence between OPLC and the Hospital; 5) a 03/29/22 New Hampshire Controlled Drug Loss Form and accompanying letter filed by the Hospital; 6) a 03/07/22 Hospital Corrective Action Plan Draft; 7) a 05/12/22 DEA Form 106 Report of Theft or Loss of Controlled Substances filed by the Hospital ; 8) a 05/18/22 Letter from OPLC to Hospital; 9) a 05/12/22 New Hampshire Controlled Drug Loss Form; 10) 05/12/22-05/24/22 email correspondence among OPLC staff and Hospital; 11) a 04/20/22 public order from the Board of Pharmacy in Docket #22-PHAR-002; and 12) Testimony from Michael Porter OPLC Investigations Bureau Chief. The Board also relied on its medical expertise in determining Fentanyl poses a significant danger to the public when used without proper medical recommendation and administration. A review of the evidence presented, and the reasonable inferences taken there from, allows the Board to find as follows below.

The Licensee is actively licensed in New Hampshire as a Registered Nurse ("RN") with license number #048273-21. Currently, the Hospital employs her as CNO, a position she has held for the relevant time frame of this matter, which is September of 2021 through May 12, 2022. As CNO, the Licensee manages nursing operations at the Hospital, including those related to the security, accounting, and management of controlled substances within the possession and control of nursing staff. On or about 02/04/22 the Licensee filed a complaint alleging that Alexandra Towle, RN had been diverting Fentanyl solution bags from the Hospital since October of 2021. At the time the complaint was filed, the Hospital had determined that at least 23 bags of Fentanyl solution were removed by Nurse Towle without being

wasted or provided to patients. That same day OPLC Enforcement also received a self-reporting complaint from Towle in which she admitted to diverting Fentanyl from the Hospital.

In addition to the complaints filed by the Licensee and Nurse Towle, OPLC also received around this time a 02/02/22 NH Loss of Controlled Substance form and an accompanying letter from the Hospital. The Hospital had determined there were 23 bags or 1,150 ml of Fentanyl diverted by Nurse Towle but anticipated the numbers would change because the internal investigation was ongoing. On 03/08/22, the Hospital updated OPLC with a new NH Loss of Controlled Substance form and accompanying letter. The Hospital had now attributed 283 lost bags of Fentanyl to Nurse Towle but still could not account for 163 bags. The accompanying letter explained that the Hospital did not believe those 163 bags were diverted but rather the challenges of the Hospital work setting brought about by the COVID-19 winter surge "impacted the ability of nursing staff to consistently document Fentanyl infusion and administration." *See* accompanying letter dated 03/07/22. Toward the end of March 2022, the Hospital again supplemented the 03/08/22 report. An 03/29/22 NH Controlled Drug Loss Form from the Hospital shows a reported loss of 15,200 ml of Fentanyl now identified. The updated form also included other missing controlled substances, but the amounts were comparatively small. By 04/14/22 the Hospital had reported to OPLC additional losses. The cumulative amount of lost/unaccounted for Fentanyl was now approximately 583 bags or 7.7 gallons. All this loss was attributable to the period between September 2021 through January 2022.

The Hospital responded to the loss/diversion issue in February and March of 2022 by implementing remedial measures intended to improve its ability to detect diversion and avoid losses. Among those measures were 1) the second floor medication room at the Hospital being permanently locked; 2) a reduction of Fentanyl bags stored in the Omnicell; 3) training of nursing and pharmacy staff on preventing and detecting diversion; 4) practice updates for nursing and pharmacy staff as it relates to

controlled substance administration; 5) two pharmacist technicians trained and assigned to the Omnicell reports; 6) working closely with technicians at Dartmouth to review the reports; and 7) reinstitution of ICU dual sign-off at the point of nursing documentation. Under the Hospital's 03/07/22 Corrective Action Plan Draft the Hospital was also to implement daily accounting of its controlled substances. According to the Corrective Action Plan both the Hospital's Pharmacy Director and CNO held responsibility with respect to implementation of this process. *See* Corrective Action Plan at sections 2.01 and 2.02.

On 05/12/22, after the Hospital had instituted remedial measures, OPLC Enforcement received a NH Controlled Drug Loss Form from the Hospital showing that 553.93 ml of Fentanyl were lost or unaccounted for during the period of 04/10/22 and 05/07/22. To date, OPLC has not received evidence that the Hospital conducted daily reviews per the Corrective Action Plan, despite efforts to obtain this information. According to OPLC Investigator Elsa Croteau's email dated 05/13/22, this calculated to approximately 11.079 bags of Fentanyl that were removed from the Hospital's Omnicell and are either unaccounted for and/or lost. The Hospital also filed a DEA Form 106 Report of Theft or Loss of Controlled substances reflecting the same amount of Fentanyl lost or stolen. An emailed statement from the Hospital's Director of Pharmacy and Pharmacist in Charge at that time indicates that the 05/12/22 NH Controlled Drug Loss from the Hospital explains that the lost bags of Fentanyl were:

> … withdrawn from the Omnicell cabinets by nurses at the hospital during the time frame of April 10, 2022 – May 7, 2022. This loss represents Fentanyl solution not able to be accounted for in nursing documentation. Cheshire Medical Center's investigation is ongoing, and at this time it does not have reason to believe that unaccounted for Fentanyl solution was diverted. Corrective action measures including nursing education around documentation requirements for controlled substance administration and wasting are underway to improve the quality of documentation…
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> Email from Hospital to OPLC dated 05/12/22.

Attorney Porter approximated the total loss of Fentanyl at the Hospital at this time to be approximately 7.84 gallons.

III. DISCUSSION AND FINDINGS OF FACTS / CONCLUSIONS OF LAW:

The Board finds there is a reasonable basis to suspend the Licensee's New Hampshire license on an emergency basis. 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.

IV. CONCLUSION AND DECISION:

Pursuant to RSA 541-A:30(III) and 326-B:37(IV), the Board hereby orders the immediate emergency suspension of Amy Matthews's license as an RN, pending a follow up emergency hearing in this matter. A Notice of Emergency Hearing with an appropriate date/time shall follow forthwith.

DATED: 5/31/2022

___/s/ Nikolas Frye, Esq.____________
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