BCCNP
British Columbia College of Nursing Professionals

Letter of Complaint re: suspected impairment and drug diversion

August 5, 2017

Inquiry & Discipline Department
BC College of Nursing Professionals
900—200Granville St.
Vancouver, BC

Re: KELSEY WHITE, RN

Dear BCCNP:

I'm writing to alert the BC College of Nursing Professionals about serious practice concerns and recent investigation findings about Kelsey White, a nurse in the medicine program at ABC Hospital. Ms. White has been employed part-time with ABC Hospital since May 2014. I have a number of concerns associated with Ms. White's administration of opiate analgesics to patients. Please note that Ms. White has been off on sick leave since July 27, 2017.

On July 20, 2017, Justin Brown, a colleague of Ms. White's, brought a number of concerns forward to Marina Green, the clinical nurse leader (CNL), regarding Ms. White's behavior and handling of hydromorphone. Ms. Green completed a review of the automated dispensing cabinet (ADC) records, and the medication administration records (MARs) for patients assigned to Ms. White on July 10th and 11th. The reconciliation of the records revealed multiple discrepancies and issues in the patient charts for this timeframe. These discrepancies relate to hydromorphone injectable being removed from the ADC that was not administered to patients or documented in patient records. There was also concerning access to the ADC, such as removal of hydromorphone prior to start of shift.

We met with Ms. White on July 25, 2017 to review the findings of the initial investigation. Present at this meeting were Human Resources, union steward, Ms. White, and myself. I

asked Ms. White to explain the discrepancies noted in the investigation documents. She did not have an explanation, other than she "didn't remember", "it was busy on the unit", and she "has been very stressed out".

When I asked Ms. White if she was familiar with the organization's narcotic dispensing policy and procedure, she responded she was aware, and knew the proper procedures to follow.

Here are the specifics about the discrepancies in question. Copies of these records are available to BCCNP upon request.

July 10, 2017- Patient X.Y.

0800	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 2mg (incorrect dose order was for 0.5-1mg Q4H PRN), however the whole amount is shown as wastage. This was co-signed by another nurse. Of note, all patient's other medications while in hospital were orally administered.
0925	Oral hydromorphone (1mg) removed from ADC. Correctly administered and recorded on MAR.
1035	Injectable hydromorphone (2mg/ml) taken from ADC. Dose recorded as 0.2mg (incorrect dose, order was for 0.5-1mg Q4H PRN). No record of wastage in ADC (should have been 1.8mg). This appears unusual as the patient had been receiving oral medications. There was no recorded assessment findings to indicate the patient was unable to tolerate oral (i.e. nausea and vomiting) or that an antiemetic was administered.
1430	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 0.2mg (incorrect dose as order was for 0.5-1mg). No record of wastage in ADC (should have been 1.8mg). MAR indicated 1mg subcutaneous given.
1715	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 2mg (incorrect dose as order was for 0.5-1mg). Not Recorded in patient MAR. Patient was not due for another dose until 1830 (order was q4h).

July 10, 2017, Patient X.Z.

0850	Oral hydromorphone (1mg) removed from ADC. Correctly administered and recorded on MAR.
1015	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 0.2mg. No record of wastage in ADC (should have been 1.8mg). Subcutaneous

butterfly inserted to administer hydromorphone dose. This appears unusual as the patient had been receiving oral medications. There was no recorded assessment findings to indicate the patient was unable to tolerate oral (i.e. difficulty swallowing, nausea and vomiting) or that an antiemetic was administered.

July 11, 2017- Patient X.Y.

0635	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 0.2 mg. No record of wastage in ADC (should have been 1.8mg). Not recorded in MAR. Very unusual as nurse's shift did not start until 0700.
1000	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 1mg (correct). No record of wastage in ADC (should have been 1mg). Not recorded in MAR.
1200	Ibuprofen order on MAR. Nurse writes "patient off unit" and does not administer. The next day, the CNL spoke with the patient. She confirmed she was on a day pass and left the unit at 1130.
1315	Injectable hydromorphone (2mg/ml) taken from ADC. Dose recorded as 1mg (correct). No record of wastage in ADC (should have been recorded 1mg). Not recorded on MAR. Of note patient was off of the unit at this time.
1715	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 2mg (dose incorrect, order was for 0.5-1mg Q4H PRN). Not recorded on MAR.
1800	Ibuprofen order on MAR. Nurse covering for Ms. White's break writes "off unit" and does not administer.
1855	Writes in nurses' notes "patient returned from day pass".

July 11, 2017- Patient X.Z.

0745	Oral hydromorphone (1mg) removed from ADC. Correctly administered and recorded on MAR.
0830	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 0.2mg. Ordered dose was 0.5-1mg. No record of wastage in ADC (should have been 1.8mg).
1315	Patient receives 2mg oral hydromorphone (by nurse covering). Correctly dispensed, administered and documents on MAR. Patient reports increased

	pain documented as 8/10 and denies receiving a dose of injectable pain medication that morning.
1600	Injectable hydromorphone (2mg/ml) removed from ADC. Dose recorded as 1mg. No record of wastage in ADC (should have been 1mg). Dose recorded on MAR. Patient not due for more medication until 1715 (q4h).

Over the past 3 months I have received several complaints about Ms. White and her nursing practice. I have been advised that Ms. White's assigned patients frequently report to other nursing staff their pain has not been effectively treated during her shift. Ms. White frequently offers to administer narcotics to co-workers' patients, and staff have grown suspicious. It has also been reported to me that she is hard to find while she is on shift. For example, the nurses who work with her have reported that Ms. White regularly "disappears" for extended periods of time; she is often seen coming out of the visitor bathroom on the unit, and leaving the unit for a "smoke break" following PRNs. Ms. White has also been picking up more overtime than any other nurse on the medicine unit, while regularly using sick time.

Once our investigative findings were reviewed with Ms. White, her union steward requested a caucus. The meeting resumed about ten minutes later and the steward indicated the meeting was over; the meeting was adjourned. After the meeting Ms. White was excused from nursing duties and placed on leave pending the outcome of a medical assessment. The union steward informed us that Ms. White is unwell, and the union plans on working with her to obtain an assessment to determine if she is suffering from a health condition.

Please don't hesitate to contact me if you require further information.

Sincerely,

Ms. Ranjeet Black

Patient Services Manager
Medicine Program, ABC Hospital
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