IN THE MATTER OF A DISCIPLINE HEARING BY A DISCIPLINE COMMITTEE, ESTABLISHED PURSUANT TO *THE LICENSED PRACTICAL NURSES ACT, 2000* AND BYLAWS TO INQUIRE INTO THE CONDUCT OF LICENSED PRACTICAL NURSE ASHLEY STORREY

REASONS FOR DECISION BY:

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES

DISCIPLINE COMMITTEE

INTRODUCTION:

On August 23, 2017, the Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses ("SALPN") held a hearing concerning allegations of professional misconduct and professional incompetence against Licensed Practical Nurse, Ashley Storrey.

At the hearing, Ms. Darcia Schirr, Q.C., appeared as legal counsel for the Counselling and Investigation Committee. The Member, Ms. Storrey was present and represented by legal counsel, Ms. Amanda Quayle.

Legal counsel for the Investigation Committee filed an Affidavit of Service of a process server who affirmed that Ms. Storrey was personally served on May 26, 2017 with a copy of the Notice of Discipline Hearing. Appendix A to the Notice of Discipline Hearing dated May 25, 2017 set out the particulars of the allegations against Ms. Storrey as follows:

1. While you were employed at the Montmartre Health Centre (the "Health Centre") and on or about April 22, 2016, you removed two narcotic pills from compliance packaging, placed those narcotic pills in your pocket and diverted the narcotics to yourself.
2. On April 18, 2016 and while working the day shift at the Health Centre, you were observed to be unsteady on your feet, unfocused and falling asleep.
3. On numerous occasions on April 18, April 21 and April 22, 2016, while working at the Health Centre, you:
    a. On multiple occasions, removed narcotic pills from compliance packaging intended for residents and placed those narcotics in your pocket;
    b. Failed to make appropriate entries on the Medication Administration Records, as in many cased, the time entries made on the Narcotic Control Sheets did not match the time entries made on the Medication Administration Records;
    c. Removed a syringe from the medication room and placed the syringe in your pocket;
    d. Failed to lock the door to the medication room or the drawer containing narcotics in the medication room;
    e. Failed to lock the medication cart;

f. Conducted narcotic counts alone and in the absence of another nurse.

4. On or about April 21, 2016 and without lawful authority, you removed a drug from compliance packaging intended for a resident and provided that drug to G.E., an employee of the Health Centre.

At the hearing Ms. Storrey pleaded guilty to the allegations contained in the Notice of Discipline Hearing.

EVIDENCE:

At the outset of the hearing, the following Agreed Statement of Facts and Documents was filed with the Discipline Committee [the information referenced in the "Tabs" is not included]:

1. Ashley Storrey of the Town of Montmarte in the Province of Saskatchewan is a Licensed Practical Nurse and a member of the Saskatchewan Association of Licensed Practical Nurses (SALPN). At the times material to these proceedings, Ms. Storrey was employed as a licensed practical nurse at the Montmartre Health Centre in Montmartre, Saskatchewan.

2. Ms. Storrey first registered with SALPN on December 11 2008 and she has been a practicing member since that date.

3. Ms. Storrey obtained her nursing education in Sudbury, Ontario in 2006 and worked as a Licensed Practical Nurse in Ontario from 2006 until late 2008. Ms. Storrey began her employment at Montmartre Health Centre on January 4, 2009.

4. On April 10, 2016, SALPN received an on-line complaint from Deborah Dyer. Attached at **Tab A** is the on-line complaint. Ms. Storrey provided a written response to the complaint.

5. On June 17, 2016, SALPN received a letter dated June 13, 2016 from Jacqui Fawcett-Kennett of the Regina Qu'Appelle Health Region (the "Health Region"). Attached at **Tab B** is the complaint letter from Ms. Fawcett-Kennett.

6. Upon receipt of the complaint, the Counselling and Investigation Committee (the "Committee") directed its investigator, Della Bartzen to interview Ms. Storrey.

7. Ms. Bartzen interviewed Ashley Storrey on June 22, 2016. At the conclusion of the interview, Ms. Storrey agreed to execute an Agreement of Non-Practice pending completion of the investigation and any discipline process. Attached at **Tab C** is the executed Voluntary Undertaking and Agreement of Non-Practice. Ashley Storrey has not practiced nursing since executing this Agreement.

8. As indicated in the complaint letter from Ms. Fawcett-Kennett, the Health Region brought a complaint to the Indian Head RCMP in addition to bringing

the complaint to SALPN. As a result of the police investigation, the Committee delayed its investigation for a time. Attached at **Tab D** is a letter dated January 27, 2017 from Corporal Derek Friesen advising that the RCMP had completed the investigation and no criminal charges would be laid.

9. Upon completion of the SALPN investigation, the Committee recommended, pursuant to section 26(2)(a) of the Act, that the Discipline Committee hear and determine the complaint. The charges are set out in Appendix "A" to a Notice of Discipline Hearing dated May 25, 2017.

10. The Committee seeks to amend charge 1 as follows:

> **1. While you were employed at the Montmartre Health Centre (the "Health Centre") and on or about April 22, 2016, you removed two narcotic pills from compliance packaging, placed those narcotic pills in your pocket and ~~diverted the narcotics to yourself~~ <u>failed to deliver them to a patient.</u>**

11. The Committee also seeks to amend charge 3(d) as follows:

> **3(d) ~~Failed to lock the door to the medication room or the drawer containing narcotics in the medication room~~; <u>Failed to lock the drawer containing narcotics in the medication room</u>;**

12. Ashley Storrey admits the allegations described in charge 1 and charge 3(d) as amended and charges 2 through 4 inclusive and admits that the conduct described in those charges constitutes professional incompetence and professional misconduct and a breach of the Regulatory Bylaws, Code of Ethics and Standards of Practice particularized in Appendix "A" to the Notice of Discipline Hearing.

Background to the Complaint

13. On April 2, 2016, the dayshift nurse at Montmartre Health Centre found medication cards that had been tampered with. This is described in the complaint letter at Tab B.

14. As a result of this discovery, Barrie Stricker, Director of Security Services for the Health Region and Frank Ortman, Health Region Investigation Consultant became involved. Two covert surveillance cameras were installed in the medication room at the Montmartre Health Centre and one visible camera was

installed in the main hallway near the front entrance. The cameras were installed on April 12, 2016.

15. Ashley Storrey was called to work overtime on April 18, 2016 and she received the call after she had taken medication to treat migraines. Another nurse observed Ms. Storrey to be drowsy and unsteady on her feet at various occasions through her shift. Ms. Storrey met with her manager about her condition during her shift and she was returned to work to conclude her shift.

16. Ms. Fawcett-Kennett was advised by the facility manager that Ms. Storrey appeared unsteady on her feet during the shift. As a result, Ms. Fawcett-Kennett requested that Barrie Stricker and Frank Ortman review the surveillance video tape. Mr. Ortman, along with other health region officials, reviewed the video tape for April 18, April 21 and April 22, 2016. Ms. Storrey worked a day shift on each of those dates.

17. Ms. Storrey was suspended from her employment on May 5. On May 16, Ms. Storrey was interviewed by Frank Ortman and Ms. Storrey was shown excerpts from video tape for those dates.

18. On June 3, 2016, Ms. Storrey's employment with the Montmartre Health Centre and the Health Region was terminated.

Charge 1

19. Medication passes at the Montmartre Health Centre are at 8:30 a.m., 11:45 a.m. and 16:45.

20. The video tape for April 22, 2016 shows the following:

    (a) At 18:27, Ms. Storrey is seen moving medication cards from the medication cart on to the desk in the medication room. The medication cards are purple and purple medication cards contain narcotics. Ms. Storrey flips through the medication cards, stopping at one package. Ms. Storrey pushes a pill out of the packaging into her left hand and moves her left hand to her left hip. With her right hand, she does the same motion taking another pill out with her hand and moves her right hand into her right pocket. The medication card is then returned to the medication cart.

    (b) From 18:33 until 18:44, Ms. Storrey remains sitting at a desk outside of the medication room. At 18:44, she leaves the desk to return to the medication room and she goes back and forth from the desk to the medication room until 18:56 when she enters the report room.

(c) At 19:13, she exits the report room and heads down the hallway. There are no patient rooms down this hallway. She is not seen again on the video tape after 19:13.

21. Ms. Storrey did not make any entry on the narcotic drug record or the medication administration record for any patient at or shortly after 18:27 when she is seen removing the pills from the medication cards.

22. The last entry she made on the narcotic drug records on April 22, 2016 were 17:00 for resident IE and 17:30 for resident TK.

23. The physician's order for IE provided that IE receive one tablet of hydromorphone 1 mg at noon and at supper. Ms. Storrey's entry at 17:00 on the Medication Administration Record was at 17:00 which would have been the supper medication.

24. The physician's order for TK provided for Hydromorphone 2 mg-1 tablet every 4 hours PRN. Ms. Storrey documented on the April 22 MAR for TK that she administered hydromorphone. The entry is not clear but it appears to indicate 18:00. Ms. Storrey did not document the administration of hydromorphone PRN on the nurse's notes.

25. When Mr. Ortman interviewed Ms. Storrey on May 16, she was specifically asked about this series of events. He played the video tape for Ms. Storrey in her interview and asked questions about her actions. Ms. Storrey responded that she did not remember the specifics of that day and she did not have an explanation for her actions and documentation other than to say if it was a busy day, her practice was to document the administration of narcotics later.

26. Della Bartzen interviewed Ashley Storrey on February 3, 2017 and played various portions of the video tape. Ms. Bartzen asked questions about this portion of the video tape, and Ms. Storrey had a similar response as she had given to Frank Ortman and that was that she could not remember what she was doing.

27. In her interviews with both Mr. Ortman and Ms. Bartzen, Ms. Storrey stated that it was sometimes her practice to put medications in her pocket rather than in a medication cup for delivery of the medication to patients. She acknowledged then and acknowledges now that handling medication in this fashion is not acceptable.

Charge 2

28. The relevant portion of the video tape for April 18, 2016 shows the following:

(a) At 10:30 a.m., Ms. Storrey is observed to be unsteady on her feet and close to falling asleep while standing up. She bumped into the medication cart in the medication room.

(b) At 11:42 a.m., Ms. Storrey is seen standing near the medication cart. She appears to be writing on documents which are on top of the medication cart. She appears to be unsteady as she leans against the cart and her head bobs down.

29. Ms. Storrey's condition attracted the attention of the interim facility manager who spoke with Ms. Storrey, along with a CUPE representative. Ms. Storrey explained that she had recently been discharged from hospital because of a migraine and that she had been prescribed Gabapentin 300 mg. — three times a day. Ms. Storrey further explained that she had taken the medication prior to being called in for the overtime shift. Ms. Storrey advised the manager that she felt capable and confident to accept the shift. After meeting with the facility manager, Ms. Storrey was returned to work for the balance of her shift.

30. Ms. Storrey was asked about her condition and fitness to work during her interview with Mr. Ortman. She stated that she had been discharged from the Indian Head Hospital three days earlier because of a migraine with new medication and she knew one of the side effects was drowsiness. She stated she had taken one pill in the morning and then was called into work. Ms. Storrey admitted that she experienced drowsiness at home that morning but she accepted the shift because she did not get a lot of overtime and she did not expect to be drowsy at work. Although she had been prescribed to take the medication three times a day, Ms. Storrey stated she did not take the medication after the morning.

31. In her interview with Ms. Bartzen, Ms. Storrey provided the same information regarding her hospitalization, discharge and Gabapentin prescription. She further advised that she had taken Gabapentin before but at a lower dose.

Charge 3

32. On all occasions where Ms. Storrey is seen on the video tape handling medication and removing the medication from medication cards, she places the tablets in her left and right pocket. She does not use medication cups which are available.

33. On April 18, 2016 at 15:38, the video tape shows Ms. Storrey removing a plastic bag from a drawer in the medication cart. She is seen removing a large orange syringe from the plastic bag and putting the syringe in her pocket. The syringe contained liquid Morphine for the resident EG. At 15:45, Ms. Storrey returned to the medication room and placed the syringe in the narcotics drawer. She did not lock the narcotic drawer.

34. The narcotic sheet for April 18, 2016 shows that Ms. Storrey signed out hydromorphone for the resident EG at 17:00. The video tape shows that she placed the syringe in her pocket at 15:40. When asked about this by Ms. Bartzen, Ashley Storrey explained that she sometimes signs narcotics out at the end of the day depending on how busy she is.

35. On various occasions, Ms. Storrey is seen in the video tape doing what appears to be a medication count as she uses a calculator and is making notations. She does this alone and in the absence of another nurse. When asked about this by Mr. Ortman, Ms. Storrey explained that she conducted "pre-counts" alone. When asked about this by Ms. Bartzen, Ms. Storrey responded that she was doing this "pre-count" in order to speed up the narcotic count at the end of the shift. Ms. Storrey admitted that this was neither a necessary or good practice.

Charge 4

36. GE is an employee of the Montmartre Health Centre working in the laundry room.

37. On April 21, 2016, at 10:48 a.m., Ms. Storrey is seen in the medication room. GE enters the medication room and Ms. Storrey is seen removing a tablet or pill from a brown envelope, putting the tablet or pill in a medication cup and providing the cup and a glass of water to GE. Ms. Storrey is then seen removing a tablet from a pink medication card and provides this along with a cup of water to GE. Pink medication cards contain resident medications other than narcotics.

38. When asked about this by Mr. Ortman, Ms. Storrey identified the individual in the video as GE and that GE had approached her stating that her knee was sore. In the interview, Ms. Storrey admitted that the medication from the pink medication card was intended for a resident but she could not recall the resident or the nature of the medication.

39. Prior to these complaints, Ashley Storrey has never been the subject of a complaint to SALPN.

40. Ashley Storrey has cooperated with the Committee throughout its investigation and these proceedings.

Ms. Schirr and Ms. Quayle, on behalf of Ms. Storrey executed the Agreed Statement of Facts to demonstrate their agreement. Counsel for the Investigation Committee submitted that the Discipline Committee should accept the facts as set out. Counsel for the Investigation Committee also submitted that Ms. Storrey's conduct in April of 2016 constitutes professional incompetence and professional misconduct under the Act.

Counsel for the Investigation Committee submitted to the Discipline committee a joint recommendation as to penalty as follows:

1. Pursuant to section 30(1)(b) of *The Licensed Practical Nurses Act, 2000* (the "Act)) Ashley Storrey's license to practice shall be suspended for a period of six months commencing June 22, 2016.

2. Pursuant to section (30)(1)(d)(ii) of the Act, Ashley Storrey may continue to practice subject to the condition that she shall successfully complete the Health Record Documentation for LPNs course at Saskatchewan Polytechnic (CE-4022). Ms. Storrey shall bear the costs of the course and shall provide proof of successful completion on or before March 1, 2018.

3. Pursuant to section (30)(2)(a)(ii) of the Act, Ashley Storrey shall pay the costs of the investigation and hearing which costs shall be fixed in the amount of $12,000.00. The costs shall be paid on or before September 1, 2020. Failing payment in full by that date, Ashley Storrey's licence shall be suspended until payment is made pursuant to section (30)(2)(b) of the Act.

4. Pursuant to section 30(1)(f) of the Act, Ashley Storrey shall be required to provide a written copy of the decision of the Discipline Committee to all future nursing employers for a two year period from the date of this Order.

DECISION:

The primary issue before the Discipline Committee is whether the conduct of Ms. Storrey, as summarized in the Agreed Statement of Facts, is professional incompetence and professional misconduct within the meaning of sections 23 and 24 of the Act, and if so, are the proposed agreed-upon penalties are appropriate under section 30 of the Act. Sections 23, 24 and 30 of the Act read as follows:

> *23 Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment or a disregard for the welfare of a member of the public served by the profession of a nature or to an extent that demonstrates that the member is unfit to:*
>
> > *(a) continue in the practice of the profession; or*
> >
> > *(b) provide one or more services ordinarily provided as a part of the practice of the profession;*
>
> *is professional incompetence within the meaning of this Act.*
>
> *24 Professional misconduct is a question of fact, but any matter, conduct or thing, whether or not disgraceful or dishonourable, is professional misconduct within the meaning of this Act if:*

(a) it is harmful to the best interests of the public or the members;

(b) it tends to harm the standing of the profession;

(c) it is a breach of this Act or the bylaws; or

(d) it is a failure to comply with an order of the counselling and investigation committee, the discipline committee or the council.

30(1) Where the discipline committee finds a member guilty of professional misconduct or professional incompetence, it may make one or more of the following orders:

(a) an order that the member be expelled from the association and that the member's name be struck from the register;

(b) an order that the member's licence be suspended for a specified period;

(c) an order that the member's licence be suspended pending the satisfaction and completion of any conditions specified in the order;

(d) an order that the member may continue to practise, but only under conditions specified in the order, which may include, but are not restricted to, an order that the member:

(i) not do specified types of work;
(ii) successfully complete specified classes or courses of instruction;
(iii) obtain medical or other treatment or counseling or both;

(e) an order reprimanding the member;
(f) any other order that the discipline committee considers just.

(2) In addition to any order made pursuant to subsection (1), the discipline committee may order;
(a) that the member pay to the association, within a fixed period:

(i) a fine in a specified amount not exceeding $5,000; and
(ii) the costs of the investigation and hearing into the member's conduct and related costs, including the expenses of the counseling and investigation committee and the discipline committee and costs of legal services and witnesses; and

(b) where a member fails to make payment in accordance with an order pursuant to clause (a), that the member's licence be suspended.

(3) The executive director shall send a copy of an order made pursuant to this section to the member whose conduct is the subject of the order and to the person, if any, who made the complaint.

(4) Where a member is expelled from the association or a member's licence is suspended, the registrar shall strike the name of the member from the register or indicate the suspension on the register, as the case may be.

(5) The discipline committee may inform a member's employer of the order made against that member where that member has been found guilty of professional misconduct or professional incompetence.

In reaching its decision, the Discipline Committee has considered the evidence presented in the Agreed Statement of Facts, the submissions of Ms. Schirr and Ms. Quayle and the Member's acknowledgement that she did commit acts of professional incompetence and professional misconduct within the meaning of sections 23 and 24 of the Act.

The Discipline Committee concluded that Ms. Storrey's conduct while handling narcotics at her place of work was problematic and fell below the standards expected for the profession. Ms. Storrey, despite acknowledging that the practices, as particularized in the Agreed Statement of Facts, were unacceptable handled medications in a way that "cut corners" and potentially placed patients at risk. A failure to properly document and record the dispensing of medication amounts to professional misconduct and professional incompetence. The Discipline Committee agrees with the joint submission as to penalty and the submission of Ms. Schirr that Ms. Storrey requires remedial training and that a successful completion of the Health Record Documentation course is necessary. The Discipline Committee did question the length of time in which Ms. Storrey had to complete the course (March 1, 2018) but were advised by counsel that this was the earliest the course was provided. Ms. Quayle also advised the Discipline Committee that Ms. Storrey had successfully complete the Licensed Practical Nurses Code of Ethics Course on August 17, 2017. It should be noted that had Ms. Storrey not already completed this remedial training it would have formed part of the penalty imposed.

Ms. Quayle on behalf of Ms. Storrey spoke to length of time being provided to provide payment of the penalty. Ms. Storrey was terminated from her position with the Montmartre Health Centre and has been working as a Care Aide since July of 2016 and this has been at a reduced income.

The Discipline Committee understands that the penalty ordered should protect the public and enhance public confidence in the ability of SALPN to regulate licensed practical nurses. This is achieved through a penalty that addresses specific and general deterrence. The Discipline Committee also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Discipline Committee has concluded that the proposed penalty is reasonable and in the public interest. Ms. Storrey has cooperated with SALPN and, by agreeing to the facts and a proposed penalty, has accepted responsibility. Further, Ms. Storrey signed a voluntary undertaking to not practice on June 22, 2016 which as of the date of the hearing has had the practical effect of a 14 month suspension from practice as a Licensed Practical Nurse. The Discipline Committee finds that the penalty satisfies the principles of specific and general deterrence as well as public protection.

ORDERS:

Upon consideration of the evidence and the submissions of Ms. Schirr and Ms. Quayle, the Discipline Committee issued the following Order on August 26, 2017 for the professional misconduct and professional incompetence committed by Ms. Storrey

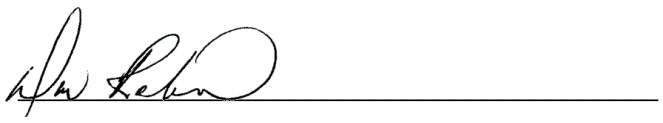
1. Pursuant to section 30(1)(b) of *The Licensed Practical Nurses Act, 2000* (the "Act)) Ashley Storrey's license to practice shall be suspended for a period of six months commencing June 22, 2016.

2. Pursuant to section (30)(1)(d)(ii) of the Act, Ashley Storrey may continue to practice subject to the condition that she shall successfully complete the Health Record Documentation for LPNs course at Saskatchewan Polytechnic (CE-4022). Ms. Storrey shall bear the costs of the course and shall provide proof of successful completion on or before March 1, 2018.

3. Pursuant to section (30)(2)(a)(ii) of the Act, Ashley Storrey shall pay the costs of the investigation and hearing which costs shall be fixed in the amount of $12,000.00. The costs shall be paid on or before September 1, 2020. Failing payment in full by that date, Ashley Storrey's licence shall be suspended until payment is made pursuant to section (30)(2)(b) of the Act.

4. Pursuant to section 30(1)(f) of the Act, Ashley Storrey shall be required to provide a written copy of the decision of the Discipline Committee to all future nursing employers for a two year period from the date of this Order.

DATED at Regina, Saskatchewan, this 6th day of November, 2017.



D. Robinson, Chairperson, Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses on behalf of the Discipline Committee consisting of T. Feucht, K. DeVries, A. Patron and B. Lindsay.