COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF
A HEARING UNDER *THE HEALTH PROFESSIONS ACT,*

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF CHLOE KILKENNY

DECISION OF THE HEARING TRIBUNAL
OF THE
COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF CHLOE KILKENNY, LPN #27195, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("THE CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via teleconference on July 12, 2023, with the following individuals present:

Hearing Tribunal:
Michelle Stolz, Licensed Practical Nurse ("LPN") Chairperson
Nicole Searle, LPN
Sarah Gingrich, Public Member
Terry Engen, Public Member

Staff:
Katrina Haymond, Legal Counsel for the Complaints Director, CLPNA
Francesca Ghossein, Legal Counsel for the Complaints Director, CLPNA
Darlene Savoie, Acting Complaints Director, CLPNA

Investigated Member:
Chloe Kilkenny, LPN ("Ms. Kilkenny" or "Investigated Member")
Carol Drennan, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

There were no objections to the members of the Hearing Tribunal hearing the matter, and no Hearing Tribunal member identified a conflict. There were no objections to the jurisdiction of the Hearing Tribunal.

The Hearing was conducted by way of an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Partial Joint Submission on Penalty.

(3) Background

Ms. Kilkenny was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Kilkenny was initially licensed as an LPN in Alberta on June 30, 2004.

On August 19, 2022, the CLPNA received a complaint (the "Complaint") from Ms. Deborah Vass, Manager, at the Medicine Hat Recovery Centre & Detox Services (MHRC), pursuant to s. 57 of the Act. The Complaint stated that Ms. Kilkenny had attended the Brooks Health Centre (the "Facility") and shadowed a physician, Dr. Amirali, during his shift without authorization. During this time, Ms. Kilkenny had access to Alberta Health Services ("AHS") patient information without having a proper purpose.

Ms. Kilkenny was employed with AHS in two capacities at the relevant times. She held an administrative support position with AHS in Medical Affairs – South Zone and was working as an LPN at the Medicine Hat Recovery Centre & Detox Services (the "MHRC"). Following an investigation, she was terminated from both positions on August 4, 2022.

By letter dated August 19, 2022, the CLPNA's former Complaints Director, Sandy Davis (the "Former Complaints Director") provided Ms. Kilkenny with Notice of the Complaint.

In accordance with s. 55(2)(d) of the Act, Ms. Davis appointed Judith Palyga, Investigator for the CLPNA (the "Investigator"), to investigate the Complaint.

Ms. Palyga concluded her investigation on December 16, 2022, and submitted her investigation report to the Former Complaints Director.

Subsequently, Sanah Sidhu was appointed as Complaints Director. In accordance with s. 20(1) of the Act, Ms. Sidhu appointed Darlene Savoie as Acting Complaints Director.

The Acting Complaints Director determined that there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Kilkenny received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations by way of letter dated March 8, 2023.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Kilkenny by way of letter dated June 2, 2023.

(4) Allegations

The Allegations in the Amended Statement of Allegations (the "Allegations") are:

It is alleged that Chloe Kilkenny, LPN, engaged in unprofessional conduct by:

1. On or about July 9, 2022, did one or more of the following when attending at the Brooks Health Centre (the "Facility") with Dr. Amirali during his shift in the Emergency Room:
    a. Failed to obtain approval from AHS before attending for job shadowing;
    b. Breached patient privacy by becoming privy to personal health information about patients while attending with Dr. Amirali, without having a reasonable purpose for doing so.

2. On or about January – March 2022, failed to complete proper documentation on one or more of the following occasions:

    a. On or about January 22, 2022, failed to name the primary substance of concern on client MD's Nursing Admission Assessment after documenting confirmation of substance use;

    b. On or about January 22, 2022, failed to properly complete the Best Possible Medication History (BPMH) and Reconciled Medication Orders for clients JJ and MD;

    c. On or about February 18, 2022, failed to document the medication Aripiprazole on the Best Possible Medication History (BPMH) for client MK;

    d. On or about March 16, 2022, processed the Clinical Opiate Withdrawal Scale (COWS) protocol for client TP when there was no indication to do so;

    e. On or about March 16, 2022, failed to check off the "tick" boxes as required on the Nursing Admission Assessment for client DR;

    f. On or about March 16, 2022, failed to indicate the adverse reactions/allergies on the Nursing Admission Assessment for client DR after checking off "yes" for Adverse reactions/allergies;

    g. On or about March 16, 2022, processed the CIWA protocol for client DR when there was no indication to do so.

3. Failed to follow proper medication administration processes by doing one or more of the following:

    a. On or about March 2, 2022, administered Diazepam 20 mg to client GL at 1700 instead of Diazepam 10 mg;

    b. On or about March 2, 2022, failed to document a time on the Medication Administration Record and/or the Interdisciplinary Progress Notes for the administration of a dose of Diazepam 20 mg to client GL;

    c. On or about March 2, 2022, failed to document on the DSU PRN MAR the dosage of Gravol administered to client GL at 1830 hours;

    d. On or about March 16, 2022, administered Chlordiazepoxide to client TP at 1700 hours prior to the order being verified;

    e. On or about March 16, 2022, documented on client DR's Nicotine Replacement Therapy Medication Administration Record a nicotine patch dose of 21 mg instead of the ordered dose of 14 mg.

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits an investigated member to make an admission of unprofessional conduct. An admission under s. 70 of the Act must be acceptable in whole or in part to the Hearing Tribunal.

Ms. Kilkenny acknowledged unprofessional conduct to all the Allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and verbally admitted unprofessional conduct to all the Allegations set out in the Amended Statement of Allegations during the hearing.

Legal Counsel for the Acting Complaints Director submitted that where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #2:	Attachments to Agreed Statement of Facts
Exhibit #3:	Complaints Director Sanction Materials 1
Exhibit #4:	Partial Joint Submission on Penalty
Exhibit #5:	Document 1 Emails re: Finances (ID 108411)
Exhibit #6:	Document 2 AHS Pay History (ID 108419)
Exhibit #7:	Document 3 Email Thread (ID 108410)
Exhibit #8:	Document 4 2022 T4
Exhibit #9:	Document 5

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #1.

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two-part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #1 and Exhibit #2 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. Kilkenny's admission of unprofessional conduct as set out in the Agreed Statement of Facts and Admission of Unprofessional Conduct as described above. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Ms. Kilkenny.

Allegation 1

Ms. Kilkenny admitted on or about July 9, 2022, she did one or more of the following when attending at the Facility with Dr. Amirali during his shift in the Emergency Room:

a. Failed to obtain approval from AHS before attending for job shadowing;

Ms. Kilkenny had known Dr. Amirali since approximately 2019.

Dr. Amirali was scheduled to work a shift as a physician in the Emergency Department ("ED") at the Facility on July 9, 2022. Prior to Dr. Amirali's shift that night, Ms. Kilkenny and Dr. Amarali were discussing a potential business venture over dinner. Dr. Amirali then invited Ms. Kilkenny to observe and work alongside him during his shift at the Facility. After they finished dinner, Ms. Kilkenny accompanied Dr. Amirali to the Facility and shadowed him while he provided patient care during that shift.

When Ms. Kilkenny arrived at the Facility, Dr. Amirali was already inside the ED. Ms. Kilkenny joined Dr. Amirali and he introduced her to the staff as "Chloe", a nurse from Medicine Hat. She also introduced herself as "Chloe" and a nurse. Ms. Kilkenny was dressed in plain clothing, and was wearing a lanyard with her AHS ID, but it was placed backwards, so her credentials were not visible. The staff working were aware that Ms. Kilkenny was a nurse, but the reason for her attendance was not clear.

In order to shadow a physician in an AHS facility, individuals have to seek and obtain approval by way of an Enrollment Form that the individual would submit. The individual seeking job shadowing must sign a consent and confidentiality statement. Upon approval, the Zone Medical Affairs Director, Medical Affairs distributes a Memo confirming the approval. The AHS Job Shadowing Policy states that Job Shadowing is strictly an observational activity and the job shadower is not to provide any services to AHS patients or clients.

Ms. Kilkenny never submitted the required Enrollment Form, or otherwise sought permission from AHS to job-shadow Dr. Amirali. Accordingly, AHS had no opportunity to consider the request and determine if it should be granted. Further, Ms. Kilkenny did not sign the Form agreeing to the consent and confidentiality statement.

b. Breached patient privacy by becoming privy to personal health information about patients while attending with Dr. Amirali, without having a reasonable purpose for doing so.

At the beginning of the shift, Dr. Amirali was covering C-sections for Dr. Van Estor.

During the shift, RN Golding had a patient who thought she had ruptured a membrane. Dr. Amirali and RN Golding, went to perform a sterile speculum examination. Ms. Kilkenny was standing by the door at first and was privy to the discussions between Dr. Amirali and the patient regarding her medical condition. As the patient became distressed, Ms. Kilkenny came to her side, and held and rubbed the patient's hand and told her to take deep breaths. Ms. Kilkenny did not assist with the examination (other than holding the patient's hand).

Ms. Kilkenny also accompanied Dr. Amirali in other patient interactions. For instance, Amanda Retzlaff, RN, stated that Ms. Kilkenny helped her clean blood off an elderly patient who had fallen and hit her head, causing a laceration. Dr. Amirali and Ms. Kilkenny later discussed a treatment plan for the patient at the nursing desk. The main discussion was around whether the patient required a CT scan or not. As Dr. Amirali assessed patients, Ms. Kilkenny documented patient information on a clipboard, which Dr. Amirali then used to complete electronic patient charting. During her presence at the Facility, and while accompanying Dr. Amirali, Ms. Kilkenny was present during patient assessments, became aware of patients' medical history, and participated in patients' care by charting their information.

Ms. Kilkenny's presence at the Facility was not related to any of her duties as an AHS employee, nor was she authorized by AHS policy to be at the Facility. Ms. Kilkenny stated that she asked Dr. Amirali whether her presence was allowed, and he confirmed that it was. Given that Ms. Kilkenny was not authorized to attend, she had no legitimate purpose for becoming privy to the patient's personal health information, including patient's symptoms, diagnosis or treatment plan.

Patients have a legitimate expectation that those involved in their care will have a legitimate reason to have access to their personal health information. Given that there was no legitimate and authorized reason for Ms. Kilkenny's attendance at the Facility, her presence was unnecessary and breached the patient's right to privacy and confidentiality.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kilkenny's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 and Exhibit #2 prove that the conduct for Allegation 1 did in fact occur.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Kilkenny displayed a lack of knowledge and judgment by failing to obtain proper consent to job shadow Dr. Amarali. By failing to obtain the proper consent, thereby also not signing any agreement on confidentiality, she misled the patients that she saw that day with Dr. Amarali.

In addition, Ms. Kilkenny did not abide by the Code of Ethics for Licensed Practical Nurses in Canada, adopted by the CLPNA on June 3, 2013 ("CLPNA Code of Ethics") and the Standards of Practice for Licensed Practical Nurses in Canada, adopted by the CLPNA on June 3, 2013 ("CLPNA Standards of Practice"). Information as to the particular code provisions and standards that were breached is set out below.

Finally, Ms. Kilkenny harmed the integrity of the profession with these actions. Patients have an expectation that when they are seeking medical attention that the staff they encounter are supposed to be there and that they have taken the necessary steps to ensure that the patient's confidentiality and privacy is maintained. Ms. Kilkenny's actions diminish the public's confidence in the profession.

Allegation 2

Ms. Kilkenny admitted on or about January – March 2022, she failed to complete proper documentation on one or more of the following occasions:

a. On or about January 22, 2022, failed to name the primary substance of concern on client MD's Nursing Admission Assessment after documenting confirmation of substance use;

b. On or about January 22, 2022, failed to properly complete the Best Possible Medication History ("BPMH") and Reconciled Medication Orders for clients JJ and MD;

On January 22, 2022, Ms. Kilkenny worked a shift at MHRC as an LPN from 7:30 am to 3:25 pm, and then as the Charge Nurse from 3:15 pm to 7:15 pm. During that shift, Ms. Kilkenny provided care to clients MD and JJ.

Ms. Kilkenny conducted MD's Assessment during admission. Ms. Kilkenny documented substance use on patient MD's Nursing Admission Assessment. However, she did not record what substances she was referring to. That information would have been noted in the confirmation box of the second page of the Assessment. Ms. Kilkenny was also tasked with filling out MD's BPMH and Reconciled Medication Orders ("RMO") forms. Ms. Kilkenny did not affix a client label to each page of MD's forms.

Ms. Kilkenny indicated that MD was not taking the Lorazepam 1 Mg sublingual medication that had been prescribed but did not specify the reason why MD was not taking his medication. Ms. Kilkenny wrote the two additional medications including Atomoxetine 10 mg capsule and the

Buprenorphine 300 mg, which were listed on page one of the BPMH for a second time on the last page of the form, which constitutes an error.

Ms. Kilkenny therefore failed to properly complete the BPMH and RMO for patient MD.

Ms. Kilkenny was tasked with completing patient JJ's BPMH form. Ms. Kilkenny did not affix a client label to JJ's forms and wrote "suboxone 24 mg" on the back page of the form, which improperly duplicated the entry on page 1 of the form. Additionally, Ms. Kilkenny failed to ensure that each page of JJ's assessment was signed by a physician.

Ms. Kilkenny therefore failed to properly complete the BPMH and RMO for client JJ.

On January 5, 2022, Ms. Kilkenny signed off on the MHRC Review 2021/2022 form, which indicated that she had reviewed and understood the contents of the BPMH binder, including MHRC Policy and Procedure, BPMH Review, and Medication Order Review.

c. On or about February 18, 2022, failed to document the medication Aripiprazole on the Best Possible Medication History (BPMH) for client MK;

On February 18, 2022, Ms. Kilkenny provided care to client MK. Ms. Kilkenny completed a BPMH for MK during her shift. Ms. Kilkenny did not document that MK had a medication prescribed called Aripiprazole.

d. On or about March 16, 2022, processed the Clinical Opiate Withdrawal Scale ("COWS") protocol for client TP when there was no indication to do so;

Patients at MRHC may be treated for drug addiction (in which case the COWS protocol is followed) or for alcohol addiction (in which case the CIWA protocol is followed). Each protocol includes different standing orders. The admitting LPN is responsible for checking off the standing orders which apply, which are then signed off by the admitting physician and transferred into the Medication Administration Record ("MAR").

Ms. Kilkenny worked the day shift on March 16, 2022, from 0730 hours to 1615 hours as an LPN. During this shift, she provided care to client TP, who was detoxing from alcohol. Accordingly, the CIWA protocol applied to TP. When completing the admitting orders for TP, Ms. Kilkenny placed her initials next to the orders for the CIWA Protocol, which was correct, but also placed her initials next to the COWS Protocol, which did not apply since TP did not have a drug addiction. Subsequently, all of the orders were transferred to the DSU PRN MAR and the MAR for TP.

The COWS protocol should not have been filled out for TP as they had not reported taking opiates according to their admission history. The error was recognized and brought to Ms. Kilkenny's attention by her manager on March 17, 2022. Ms. Kilkenny processed the COWS protocol for client TP when there was no indication to do so.

e. On or about March 16, 2022, failed to check off the "tick" boxes as required on the Nursing Admission Assessment for client DR;

f. On or about March 16, 2022, failed to indicate the adverse reactions/allergies on the Nursing Admission Assessment for client DR after checking off "yes" for Adverse reactions/allergies;

g. On or about March 16, 2022, processed the CIWA protocol for client DR when there was no indication to do so.

Ms. Kilkenny worked the day shift on March 16, 2022, from 0730 hours to 1615 hours as an LPN. During this shift, she provided care to client DR, who was detoxing from cocaine. Ms. Kilkenny completed the Nursing Admission Assessment form for client DR.

The Admission Assessment form (left-side column) contains boxes indicating "No present concern" or "Bring to attention of physician on call". Ms. Kilkenny did not tick any of those boxes for some body systems.

Ms. Kilkenny checked off the "Yes" box on the Admission Assessment form which indicated Adverse reactions/allergies and/or special nutritional requirements. However, she did not list what those were. When completing the admitting orders for DR, Ms. Kilkenny placed her initials next to the COWS Protocol, which was correct, but also placed her initials next to the orders for the CIWA Protocol, which was incorrect because DR was not being treated for alcohol addiction.

Subsequently, all of the orders were transferred to the DSU PRN MAR for DR.

Ms. Kilkenny processed the CIWA Protocol for DR when there was no indication to do so.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kilkenny's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 and Exhibit #2 prove that the conduct for Allegation 2 did in fact occur.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Kilkenny demonstrated a lack of judgment, skill and knowledge when she failed to document in a manner that was consistent with Facility's policies and procedures. Documentation is a basic core competency of being an LPN. Thorough, accurate and complete documentation is imperative to ensure the patient receives appropriate care, medication and interventions. Ms. Kilkenny also inaccurately documented assessments of patients, she initiated the wrong protocols on patients and did not completely document important information such as adverse reactions/allergies and/or special dietary requirements. She also admitted to failing to properly label her documentation with the patient's label. She also initiated protocols that were inappropriate. By initiating improper protocols, the patients could receive the wrong medication for their condition, which also demonstrated a lack of knowledge, skill or judgment.

In addition, Ms. Kilkenny did not abide by the CLPNA Code of Ethics CLPNA Standards of Practice. Information as to the particular code provisions and standards that were breached is set out below.

Finally, Ms. Kilkenny's conduct harms the integrity of the profession. The public has an expectation of LPNs to complete assessments, implement appropriate measures and document accurately. The admitted actions of Ms. Kilkenny could bring disrepute to the profession and could have caused serious and adverse reactions to the patients.

Allegation 3

Ms. Kilkenny admitted she failed to follow proper medication administration processes by doing one or more of the following:

- **a. On or about March 2, 2022, administered Diazepam 20 mg to client GL at 1700 instead of Diazepam 10 mg;**
- **b. On or about March 2, 2022, failed to document a time on the Medication Administration Record and/or the Interdisciplinary Progress Notes for the administration of a dose of Diazepam 20 mg to client GL;**
- **c. On or about March 2, 2022, failed to document on the DSU PRN MAR the dosage of Gravol administered to client GL at 1830 hours;**

On March 2, 2022, Ms. Kilkenny worked a shift as an LPN at MHRC from 4:15 pm to 7:15 pm. During this shift, she provided care to client GL.

GL had a physician order from the on-call physician on March 2, 2022, for CIWA – Valium protocol for withdrawal. The Alcohol Assessment Flowsheet for GL had an entry at 1700 hours for a total score of 17 and an entry at 1805 hours for a score of 18. Ms. Kilkenny made entries into GL's Interdisciplinary Progress Notes ("IPN") at 1715 hours and 1830 hours during that shift. The entry at 1715 hours indicated a CIWA score of 19.

Per the AHS Admitting Orders for DSU/CIWA-AR Diazepam protocol, for CIWA scores of 10-19, a dosage of 10 mg of Diazepam could be administered orally every hour, and for scores of 20 or greater, a dosage of 20 mg of Diazepam can be administered every hour.

The appropriate dosage of Diazepam would have therefore been 10 mg, given the CIWA score of 19. Ms. Kilkenny recorded the CIWA score of both 19 and 21 client's GL's MAR. Ms. Kilkenny stated that for the CIWA score of 19 she administered 20 mg of Diazepam, instead of 10 mg.

If the client is below the threshold, a nurse could administer a higher dose of Diazepam, but the nurse would have to complete charting to support her decision. However, the charting completed by Ms. Kilkenny did not provide any explanation as to why she chose to administer the higher dose of the Diazepam.

Aside from the CIWA score of 19, Ms. Kilkenny also recorded a CIWA score of 21 in the MAR but failed to indicate a corresponding time for that score. At 1830 hrs, Ms. Kilkenny recorded an entry into the IPN for GL confirming that she administered 50mg IM Gravol to GL's right bicep. The corresponding entry in the MAR read "CK @ 1830" in the dimenhydrinate box. Ms. Kilkenny recorded in the MAR for GL that she had administered Gravol at 1830 hours. However, she failed to enter the amount of Gravol that she administered on the MAR.

d. On or about March 16, 2022, administered Chlordiazepoxide to client TP at 1700 hours prior to the order being verified;

Ms. Kilkenny reviewed and signed the standing orders for TP dated March 16, 2022.

Ms. Kilkenny administered 50 mg of Chlordiazepoxide at 1700 hours to TP, which was indicated on the MAR. Dr. Dirker, however, did not verify and sign-off on the orders for TP until 1715 hours. Therefore, Ms. Kilkenny administered the 50 mg of Chlordiazepoxide prior to the order for that medication being verified by Dr. Dirker.

e. On or about March 16, 2022, documented on client DR's Nicotine Replacement Therapy Medication Administration Record a nicotine patch dose of 21 mg instead of the ordered dose of 14 mg."

DR was prescribed Nicotine Replacement Therapy in the form of a 14 mg topical nicotine patch to be given daily. Ms. Kilkenny verified the order for the 14 mg nicotine patch. However, Ms. Kilkenny documented a nicotine patch dose of 21 mg on DR's MAR.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kilkenny's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 and Exhibit #2 prove that the conduct for Allegation 3 did in fact occur.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Similar to Allegation 2, for this Allegation Ms. Kilkenny demonstrated a lack of knowledge, skill and judgment. Medication administration and documentation are core competencies of any LPN. On both March 2, 2022 and March 26, 2022, Ms. Kilkenny made multiple medication and documentation errors. These errors led to patients receiving medication that had not yet been verified and wrong doses of medications.

In addition, Ms. Kilkenny did not abide by the CLPNA Code of Ethics and CLPNA Standards of Practice. Information as to the particular code provisions and standards that were breached is set out below.

Finally, this conduct also harmed the integrity of the regulated profession. The public has an expectation that LPN's understand and maintain professional standards in medication administration and documentation. By Ms. Kilkenny's own admission, she failed to uphold these standards and made multiple errors in both documentation and medication administration.

<u>Code of Ethics and Standards of Practice</u>

The conduct found for Allegations 1, 2 and 3 breached the following principles and standards set out in the CLPNA Code of Ethics and the CLPNA Standards of Practice, as acknowledged by Ms. Kilkenny in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out below and that such breaches are sufficiently serious to constitute unprofessional conduct. The specific provisions are set out below.

CLPNA Code of Ethics

> **Principle 1:** Responsibility to the Public - LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically provides that LPNs:
>
> - 1.1 Maintain standards of practice, professional competence and conduct.
>
> **Principle 2:** Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:
>
> - 2.3 Respect and protect client privacy and hold in confidence information disclosed except in certain narrowly defined exceptions.
>
> **Principle 3:** Responsibility to the Profession – LPNs have a commitment to their

profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:

- 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
- 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.

Principle 5: Responsibility to Self - Licensed Practical Nurses recognize and function within their personal and professional competence and value systems.

- 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.

Relating to the CLPNA Code of Ethics, for all three Allegations, Ms. Kilkenny's actions failed to demonstrate all of the above responsibilities. Ms. Kilkenny made multiple documentation and medication errors as detailed above. She also failed to adhere to the policies in place for seeking approval by submitting an Enrollment Form to job shadow at the Facility. Ms. Kilkenny was privy to medical information that she was not permitted to and provided services that she had not been approved to do.

The public expects that LPNs maintain the standards of practice, professional competence and conduct at all times. Ms. Kilkenny failed to demonstrate these expectations that the public has and thereby could cause the public to lose confidence in the profession. She did not practice in a manner that is consistent with the privilege and responsibility of self-regulation. By not seeking the appropriate approval to attend the facility with Dr. Amirali as well as multiple documentation and medication errors, she did not uphold the integrity of the profession.

The above proven allegations clearly demonstrate Ms. Kilkenny failed in her responsibilities to the public, the clients involved in each of the allegations, the public, the profession as well as herself.

CLPNA Standards of Practice

Standard 1: Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

- 1.1. Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.

- 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.

- 1.7. Incorporate established client safety principles and quality assurance/improvement activities into LPN practice;

- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.

- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

Standard 3: Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

- 3.6. Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

- 3.8. Practice within the relevant laws governing privacy and confidentiality of personal health information.

Standard 4: Ethical Practice – LPNs uphold, promote and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

- 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.

- 4.4 Develop ethical decision-making capacity and take responsible action toward resolution.

- 4.7 Communicate in a respectful, timely, open and honest manner.

- 4.8 Collaborate with colleagues to promote safe, competent and ethical practice.

- 4.10 Practice with honesty and integrity to maintain the values and reputation of the profession.

The proven Allegations in this matter clearly breached the standards listed above. Ms. Kilkenny has admitted to failing in her professional responsibility and accountability. She did not practice in a manner that is consistent with the ethical values and obligations, as well as, she did not maintain the standard of ensuring proper documentation and reporting. Ms. Kilkenny made

multiple medication and documentation errors. She also did not adhere to the policy for job shadowing by both failing to obtain the proper authorization to go to the Facility with Dr. Amirali, as well as, going beyond the scope of that of a "job shadower" by being an active participant in patient care.

Ms. Kilkenny failed to practice with honesty and integrity, and she did not practice in a manner that was consistent with the values and beliefs as expressed in the CLPNA Standards of Practice as well as the CLPNA Code of Ethics.

(9) Submissions on Penalty

Partial Joint Submission on Penalty

The Acting Complaints Director and Ms. Kilkenny jointly proposed to the Hearing Tribunal a Partial Joint Submission on Penalty, which was entered as Exhibit #4. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Ms. Kilkenny shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance". Ms. Kilkenny shall provide to the CLPNA, a signed written declaration within **thirty (30) days** of service of the Decision, attesting she has reviewed the following CLPNA documents:

    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;
    c. The CLPNA Policy: Professional Responsibility and Accountability;
    d. The CLPNA Policy: Documentation;
    e. The CLPNA Policy: Medication Management (pg. 11-15);
    f. The CLPNA Interpretive Document: Privacy Legislation in Alberta;
    g. The CLPNA Practice Guideline: Confidentiality;

    If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Acting Complaints Director.

3. Ms. Kilkenny shall complete the following remedial education, at her own cost. Ms. Kilkenny shall provide the CLPNA with certificates confirming successful completion within six months from service of the Decision.

    1. **LPN Code of Ethics** available online at www.learningnurse.org;
    2. **NURS 0162 Documentation in Nursing** available online at www.macewan.ca;

3. **Medication Administration Self-Study Course** available online at www.clpna.com;
4. **Righting a Wrong – Ethics & Professionalism in Nursing** available online at www.icrsncsbn.org.

If any of the required education becomes unavailable, Ms. Kilkenny shall make a written request to the Acting Complaints Director to be assigned alternative education. Upon receiving Ms. Kilkenny's written request, the Acting Complaints Director, in her sole discretion, may assign alternative education in which case Ms. Kilkenny will be notified in writing of the new education requirements.

Legal Counsel for the Acting Complaints Director submitted the primary purpose of orders from the Hearing Tribunal is to protect the public. The Hearing Tribunal is aware that s. 82 of the Act sets out the available orders the Hearing Tribunal is able to make if unprofessional conduct is found.

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should defer to a joint submission unless the proposed sanction is unfit, unreasonable or contrary to public interest. Joint submissions make for a better process and engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions and may significantly impair the ability of the Acting Complaints Director to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Kilkenny and the Acting Complaints Director. They have determined that the Joint Submission on Penalty is appropriate, reasonable and serves to protect the public.

Further Submissions on Penalty – Ms. Haymond

In addition to the Partial Joint Submission on Penalty the Acting Complaints Director requested that the Hearing Tribunal make the following order:

1. Ms. Kilkenny will be required to costs in the amount of $9,500.00. The costs will be payable in equal monthly installments over a period of 36 months from the date of service of the Hearing Tribunal's written decision.

Ms. Haymond submitted a breakdown of the costs of the investigation and hearing. The amount being requested from the Acting Complaints Director is approximately 25% of the total cost of the investigation and hearing.

Ms. Haymond presented other cases that were similar to Allegations 2 and 3 in this case. However, there was no other case that had any similarities with Allegation 1.

Ms. Haymond also presented the 2022 ruling from the Court of Appeal entitled *Jinnah v. Alberta Dental Association and the Appeal Panel of the Alberta Dental Association and College*, 2022 ABCA 336 ("*Jinnah*"). She summarized the ruling, stating that costs should not be awarded in every case unless there is a compelling reason. As the Court wrote in the *Jinnah* decision at para. 130,

> "Professions Should Bear Most, if Not All Costs Associated with the Privilege and Responsibility of Self-Regulation Unless a Member Has Committed Serious Unprofessional Conduct, Is a Serial Offender, Has Failed to Cooperate with Investigators or Has Engaged in Hearing Misconduct, in Which Case, the Disciplined Member Must Assume Some of the Costs."

Ms. Haymond expressed that the Acting Complaints Director felt the proven Allegations were serious in nature. Ms. Kilkenny was terminated following the employer's investigation of Allegation 1, thus demonstrating how serious the employer took the actions of Ms. Kilkenny when she attended the Facility for personal, not professional reasons. The patients at the Facility had no idea that she was not authorized to be there that shift. She was privy to their medical records, assisted in sensitive examinations and discussed treatment plans without any knowledge of the employer. Ms. Kilkenny's actions were a marked departure from the CLPNA Standards of Practice and the requirements on all LPNs when engaging in a job shadow.

The Acting Complaints Director expressed that the proven actions of Ms. Kilkenny in Allegations 2 and 3 were cumulative. There were multiple errors, and those errors were a marked departure from the CLPNA Standards of Practice and CLPNA Code of Ethics. Thereby, in their view, Ms. Kilkenny meets the criteria of serial offender, warranting costs under the *Jinnah* criteria.

Ms. Haymond did acknowledge Ms. Kilkenny has cooperated with investigators and did not engage in hearing misconduct.

The Acting Complaints Director was proposing costs be awarded to the College in the amount of $9500 which she calculated to be approximately 25% of the costs associated with Ms. Kilkenny's case as well as a proposed payment schedule of 36 months after the written decision of the Hearing Tribunal.

Further Submissions on Penalty – Ms. Drennan

The Hearing Tribunal then heard submissions from Ms. Drennan. Ms. Drennan felt that the financial penalty being sought from the Acting Complaints Director did not meet the criteria set out in the *Jinnah* decision.

She stated that the allegations against Ms. Kilkenny are not serious, that there were no fatalities, and that they were mainly documentation errors. Although she had been terminated from employment from AHS, she was subsequently reinstated.

This was the first disciplinary complaint filed against Ms. Kilkenny, so therefore she did not meet the definition of "serial offender". She also claimed that it is just one complaint, even though there are multiple allegations. Ms. Drennan pointed out that one of the cases presented by the Acting Complaints Director had someone who had been disciplined on more than one occasion, therefore meeting the threshold for serial offender.

One of the compelling reasons to assess financial penalty as per the *Jinnah* decision is whether the investigated member failed to cooperate with the investigation and hearing. Ms. Drennan also emphasized that Ms. Kilkenny has cooperated throughout the investigation and hearing.

Ms. Drennan presented material regarding Ms. Kilkenny's finances. Ms. Drennan emphasized that the *Jinnah* case states clearly that the regulatory body should bear the costs of the investigation and hearing unless specific criteria were met. She argued that the criteria in that case had not been met in Ms. Kilkenny's case.

Ms. Drennan did not, however, argue for no costs to be payable. She was asked by the Hearing Tribunal if she had an acceptable amount for costs to be paid by Ms. Kilkenny, and after discussion with her client she stated that Ms. Kilkenny would be agreeable to paying costs of $2,500.00, paid over 36 months.

Further Submissions on Penalty – Ms. Haymond's Reply

On rebuttal, Ms. Haymond addressed the evidence presented by Ms. Drennan regarding Ms. Kilkenny's finances. She stated she had not been able to test the evidence and therefore requested the Hearing Tribunal apply very little weight to it. Ms. Drennan also confirmed that Ms. Kilkenny had been reinstated with AHS following a grievance and that the evidence in that grievance had not been presented.

(10) Decision on Penalty and Conclusions of the Hearing Tribunal

The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable and proportionate, taking into account the facts of this case.

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Kilkenny has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the investigated member

- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

Applying those factors to this case,

The nature and gravity of the proven allegations: The allegations in this case are serious, so much so that Ms. Kilkenny was subsequently terminated from AHS. Patient privacy is at the utmost pinnacle of maintaining the public's confidence in the profession. It is imperative that the public knows that these allegations are taken very seriously by the CLPNA. Medication documentation and errors are also very serious and therefore need to be penalized as such.

The age and experience of the investigated member: Ms. Kilkenny has been a regulated member of CLPNA since 2004. She is a senior member of the profession and therefore the Hearing Tribunal felt that she should have known better on all allegations in this hearing.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: Ms. Kilkenny has not had any previous complaints or convictions.

The age and mental condition of the victim, if any: The Hearing Tribunal was not provided with any direct evidence on the victims in this case. However, Ms. Kilkenny did work at the MHRC. Clients in centers such as these are vulnerable and rely on the staff there to provide safe and competent care, especially in medication administration as they are dependent on the medications provided to help them through the process of recovery and/or detox. The patients at the Facility's ED were also in a vulnerable position as they were seeking emergent medical care. The patients would not be expecting to have someone who was not authorized to be there, be present during exams and take part in discussions on their care. Therefore, The Hearing Tribunal placed significant weight on this factor.

The number of times the offending conduct was proven to have occurred: For Allegation 1, the member only committed the offense once. However, in Allegation 2 and 3 there were multiple occurrences of medication administration and documentation errors. They demonstrated a

pattern of misconduct. The Hearing Tribunal did place significant weight on the number of times the offending conduct was proven to have occurred, especially on Allegations 2 and 3.

The role of the investigated member in acknowledging what occurred: Ms. Kilkenny acknowledged what occurred and cooperated with the investigation. As a result of that cooperation this hearing took place by an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as well as a Partial Joint Submission on Penalty. This demonstrates that Ms. Kilkenny did acknowledge what occurred and is a mitigating factor for the Hearing Tribunal.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Kilkenny held two casual positions with AHS at the time. She was subsequently fired from AHS, thereby losing both positions. Although Ms. Kilkenny has been reinstated after going through the grievance process and is currently working in a casual capacity again; she did not receive any back pay for the time in which she was terminated. As per Ms. Drennan however, AHS did reward Ms. Kilkenny with "3 or 4 additional shifts" to make up for the shifts she missed out on during that time. The Hearing Tribunal placed little weight on the documents provided by the member regarding her finances as the documents were not able to be tested by counsel for the Acting Complaints Director.

The impact of the incident(s) on the victim: There was no evidence that any patient suffered any negative impacts, however there was the potential for serious and significant implications given that Allegations 2 and 3 related to documentation errors in relation to patient's medication.

The presence or absence of any mitigating circumstances: As per the Agreed Statement of Facts, Ms. Kilkenny worked in a casual capacity at the MHRC. As it is the expectation of every LPN to maintain the CLPNA Standards of Practice despite the number of hours worked in a facility, and therefore the Hearing Tribunal did not place any weight on this mitigating factor. In regard to Allegation 1, Dr. Amirali did tell Ms. Kilkenny it was okay for her to attend the Facility with him; however, Ms. Kilkenny would have had multiple annual modules and continuing education on maintaining patients' confidentiality and privacy. The Hearing Tribunal did not place any weight on Ms. Kilkenny accepting Dr. Amirali's statement that it was okay. She should have known it was not appropriate to attend the Facility without the proper authorization.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: It is imperative that the decision in this case provide both specific and general deterrence. Specific deterrence is needed to ensure Ms. Kilkenny understands the seriousness of the proven allegations. The penalties in this hearing focus on education and remediation to help Ms. Kilkenny move forward with her career with success. General deterrence is needed to let members of the CLPNA know that allegations such as those in this case will be taken seriously and will not be tolerated. The Hearing Tribunal feels the penalties imposed in this case provide both specific and general deterrence.

The need to maintain the public's confidence in the integrity of the profession: The Hearing Tribunal placed a very significant weight on this factor. In Allegation 1, Ms. Kilkenny breached

patients' privacy and confidentiality by attending the Facility with Dr. Amirali and taking part in exams, discussions regarding their treatments and documenting. Her actions could bring serious disrepute to the profession. In Allegations 2 and 3, Ms. Kilkenny deviated from the CLPNA Standards of Practice regarding medication administration and documentation. The decision in this case needs to ensure the public's confidence is maintained in the integrity of the profession. The public needs to know that the CLPNA takes these offenses seriously.

The range of sentence in other similar cases: The Acting Complaints Director presented two similar cases in regard to Allegations 2 and 3, however there were no similar cases presented to the Hearing Tribunal regarding Allegation 1. The sentences imposed in this case are in keeping with the range of sentences presented to the Hearing Tribunal. The other case the Hearing Tribunal referenced was *Jinnah*. After very careful deliberation, it was determined that Ms. Kilkenny's actions did meet the criteria for an award of partial costs, as set forth in the *Jinnah* case.

It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and the CLPNA Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

In addition to the Joint Submission on Penalty, the Hearing Tribunal has chosen to order that Ms. Kilkenny pay costs in the amount of $6,000.00 in equal monthly installments over 48 months. These payments are to commence 30 days after Ms. Kilkenny is served with the written decision. In making this award, the Hearing Tribunal considered the submissions of both Ms. Haymond and Ms. Drennan, along with the *Jinnah* decision.

Ultimately, the amount of $6,000.00 was determined to be an appropriate amount of costs to be paid by Ms. Kilkenny because her actions were a marked departure from the CLPNA Standards of Practice. The Allegations 2 and 3 were cumulative. There were multiple errors, and those errors were a marked departure from the CLPNA Standards of Practice and CLPNA Code of Ethics. The Hearing Tribunal does acknowledge Ms. Kilkenny's cooperation in the investigation and the subsequent Agreed Statement of Facts, Acknowledgement of Unprofessional Conduct and a Partial Joint Submission on Penalty.

(11) Orders of the Hearing Tribunal

The Hearing Tribunal is authorized under s. 82(1) of the Act to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Ms. Kilkenny shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance". Ms. Kilkenny shall provide to the CLPNA, a signed written declaration within **thirty (30) days** of service of the Decision, attesting she has reviewed the following CLPNA documents:

    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;
    c. The CLPNA Policy: Professional Responsibility and Accountability;
    d. The CLPNA Policy: Documentation;
    e. The CLPNA Policy: Medication Management (pg. 11-15);
    f. The CLPNA Interpretive Document: Privacy Legislation in Alberta;
    g. The CLPNA Practice Guideline: Confidentiality;

    If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Acting Complaints Director.

3. Ms. Kilkenny shall complete the following remedial education, at her own cost. Ms. Kilkenny shall provide the CLPNA with certificates confirming successful completion within **six months** from service of the Decision.

    a. **LPN Code of Ethics** available online at www.learningnurse.org;
    b. **NURS 0162 Documentation in Nursing** available online at www.macewan.ca;
    c. **Medication Administration Self-Study Course** available online at www.clpna.com;
    d. **Righting a Wrong – Ethics & Professionalism in Nursing** available online at www.icrsncsbn.org.

    If any of the required education becomes unavailable, Ms. Kilkenny shall make a written request to the Acting Complaints Director to be assigned alternative education. Upon receiving Ms. Kilkenny's written request, the Acting Complaints Director, in her sole discretion, may assign alternative education in which case Ms. Kilkenny will be notified in writing of the new education requirements.

4. Ms. Kilkenny shall pay $6,000.00 of the costs of the investigation and hearing in equal monthly installments over 48 months. These payments are to commence 30 days after Ms. Kilkenny is served with the Decision.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, s. 87(1)(a),(b) and 87(2) of the Act, the Investigated Member has the right to appeal:

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.
>
> **(2)** A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 14th of AUGUST 2023 IN THE CITY OF CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

M. Stolz
Michelle Stolz, LPN
Chair, Hearing Tribunal