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 BAILEY-JANE PETROV

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 BAILEY-JANE PETROV, LPN #36512, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted at the offices of the College of Licensed Practical Nurses of Alberta in Edmonton, Alberta on October 2, 2019 with the following individuals present:

Hearing Tribunal:
Nancy Brook, Public Member, Chairperson
Mohamed Beltaifa, Licensed Practical Nurse ("LPN")
Deanna Lang, LPN

Staff:
Jason Kully, Legal Counsel for the Complaints Consultant, CLPNA
Caitlyn Field, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Bailey-Jane Petrov, LPN ("Ms. Petrov" 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 Joint Submission on Penalty.

(3) Background

Ms. Petrov was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Petrov was initially licensed as an LPN in Alberta on May 15, 2013.

On January 5, 2018, the CLPNA received a complaint from Laurie Loowell, Director, HR Business Partnerships for Alberta Health Services ("AHS") in Edmonton, (the "Complaint"), dated January 4, 2018. The Complaint was sent pursuant to s. 57 of the Act notifying the College that there were concerns regarding Ms. Bailey-Jean Petrov, LPN's practice, including unskilled practice allegations against Ms. Petrov.

The Complaint included a copy of a letter dated October 2, 2017, from Laurie Nickerson, Patient Care Manager with AHS, to Ms. Petrov indicating that she was subject to a one day suspension due to the serious nature of the conduct.

In accordance with s. 55(2)(d) of the Act, Ms. Sandy Davis, Complaints Director for the CLPNA (the "Complaints Director"), delegated her authority and powers under Part 4 of the Act to Susan Blatz, Complaints Consultant for the CLPNA (the "Complaints Consultant"), pursuant to s. 20 of the Act. The Complaints Consultant appointed Judith Palyga, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint.

Ms. Petrov received notice of the Complaint, investigation, and appointment of the Investigator by letter dated January 10, 2018.

On May 15, 2019, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Consultant determined 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. Petrov received notice that the Complaint was referred to a hearing as well as a copy of the Investigation Report and Statement of Allegations under cover of letter dated July 15, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce were served upon Ms. Petrov under cover of letter dated July 30, 2019.

(4) Allegations

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

"It is alleged that **BAILEY-JANE PETROV, LPN**, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. Inappropriately accessed narcotics from the Pyxis system without justification, for patients who did not have a Physician's order for the narcotic, then wasted the narcotics on one or more of the following occasions:
    a) August 11, 2017 Oxycodone 20 mg removed at 2110 hours for patient IL;
    b) August 16, 2017 Oxycodone 20 mg removed at 1642 hours for patient JG;

c) August 18, 2017 Oxycodone 20 mg removed at 1717 hours for patient IL;

d) August 21, 2017 Oxycodone 20 mg removed at 1848 hours for patient MB;

e) August 21, 2017 Oxycodone 15 mg removed at 2056 hours for patient ED;

f) August 22, 2017 Oxycodone 20 mg removed at 1650 hours for patient WS; and

g) August 28, 2017 Oxycodone 20 mg removed at 2106 hours for patient GW.

2. On or about August 18, 2017 did one or more of the following with regards to patient JG:

    a) Inappropriately accessed Oxycodone 20 mg at 2054 hours from the Pyxis when JG did not have a Physician's order for Oxycodone 20 mg, and

    b) Failed to document the administration and/or disposal of Oxycodone 20 mg removed from the Pyxis at 2054 hours.

3. On or about August 28, 2017 failed to complete a Narcotic and Controlled Substances Discrepancy Reporting Form and/or failed to notify the Unit Manager/Clinical Supervisor as required after identifying a discrepancy in the narcotic count.

4. On or about August 31, 2017 did one or more of the following with regards to patient LR:

    a) Inappropriately removed Oxycodone 30 mg at 2128 hours from the Pyxis when LR did not have a Physician's order for Oxycodone 30 mg, then wasted the Oxycodone 30 mg; and

    b) Failed to show her co-worker the two tablets of Oxycodone to be wasted prior to wasting them."

(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. Petrov acknowledged unprofessional conduct to all the allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. She also verbally admitted unprofessional conduct to all the allegations set out in the Statement of Allegations during the hearing.

Legal Counsel for the Complaints Consultant submitted, 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:	Statement of Allegations
Exhibit #2:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3:	Partial Joint Submission on Penalty
Exhibit #4:	Additional Order Sought by the Complaint's Consultant Regarding Costs
Exhibit #5:	Estimated Hearing Costs
Exhibit #6	Petrov Family Income vs Costs

(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 #2.

Explanation for actions

Ms. Petrov denies taking the Oxycodone for her own personal use or for the use of any other person, and there is no evidence that would confirm that she did so. Her explanation for her actions is set out in a document she wrote called Back Story Explanation – Bailey Jane Petrov, which is included as part of **Exhibit #2**.

(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 #2**, and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. Petrov's admission of unprofessional conduct as set out in the Agreed Statement of Facts 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. Petrov.

Allegation 1

Bailey-Jane Petrov admitted she inappropriately accessed narcotics from the Pyxis system without justification, for patients who did not have a Physician's order for the narcotic, then wasted the narcotics on one or more of the following occasions:

a) **August 11, 2017 Oxycodone 20 mg removed at 2110 hours for patient IL;**

b) **August 16, 2017 Oxycodone 20 mg removed at 1642 hours for patient JG;**

c) **August 18, 2017 Oxycodone 20 mg removed at 1717 hours for patient IL;**

d) **August 21, 2017 Oxycodone 20 mg removed at 1848 hours for patient MB;**

e) **August 21, 2017 Oxycodone 15 mg removed at 2056 hours for patient ED;**

f) **August 22, 2017 Oxycodone 20 mg removed at 1650 hours for patient WS; and**

g) **August 28, 2017 Oxycodone 20 mg removed at 2106 hours for patient GW.**

August 11, 2017

Ms. Petrov was working at Medicine Unit 5F4 at the UAH from 1500 hours to 2315 hours on August 11, 2017. A copy of the Daily Flow Sheet for August 11, 2017 showing that Ms. Petrov worked on Medicine Unit 5F4 is in **Exhibit #2.**

On August 11, 2017, Ms. Petrov provided care to patient IL.

During this time, Ms. Petrov accessed the Pyxis machine station UAM5F4 at 9:10:27 PM, and withdrew two, 10 mg tablets of Oxycodone totaling 20 mg under patient name IL. At 9:11:24 PM, Ms. Petrov wasted the 20 mg of Oxycodone, which was witnessed by her colleague Vicki Voong, RN. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2**.

There was no physician's order for Oxycodone for patient IL on August 11, 2017. A copy of patient IL's Patient Medication Profile as of August 11, 2017 and a copy of Patient IL's Progress Notes for August 11th through August 14th, 2017 are in **Exhibit #2.**

Ms. Petrov did not administer any Oxycodone medication to patient IL during her August 11, 2017 shift. A copy of patient IL's Medication Administration Record is **Exhibit #2**. A copy of patient IL's Nursing Assessment and Care Records for August 11, 2017 is in **Exhibit #2.**

Ms. Petrov acknowledged at the time of the investigation that there was no physician's order for Oxycodone for patient IL on August 11, 2017, and that Ms. Petrov wasted the withdrawn Oxycodone 20 mg.

August 16, 2017

Ms. Petrov was working at Medicine Unit 5F4 at the UAH from 1500 hours to 2315 hours on August 16, 2017. A copy of the Daily Flow Sheet for August 16, 2017 showing that Ms. Petrov worked on Medicine Unit 5F4 is in **Exhibit #2.**

On August 16, 2017, Ms. Petrov provided care to patient JG.

During this time, Ms. Petrov accessed the Pyxis machine station UAM5F4 at 4:42:29 PM, and withdrew two, 10 mg tablets of Oxycodone totaling 20 mg under patient name JG. At 4:44:02 PM, Ms. Petrov wasted the 20 mg of Oxycodone, which was witnessed by her colleague Vicki Voong, RN. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2**

There was no physician's order for Oxycodone for patient JG on August 16, 2017. A copy of patient JG's Patient Medication Profile as of August 16, 2017 is in **Exhibit #2.**

Ms. Petrov did not administer any Oxycodone medication to patient JG during her August 16, 2017 shift. A copy of patient JG's Medication Administration Record and a copy of patient JG's Nursing Assessment and Care Records for August 16, 2017 are in **Exhibit #2.**

Ms. Petrov acknowledged at the time of the investigation that there was no physician's order for Oxycodone for patient JG on August 16, 2017, and that Ms. Petrov wasted the withdrawn Oxycodone 20 mg.

August 18, 2017

Ms. Petrov was working at Medicine Unit 5F4 at the UAH from 1500 hours to 2315 hours on August 18, 2017. A copy of the Daily Flow Sheet for August 18, 2017 showing that Ms. Petrov worked on Medicine Unit 5F4 is in **Exhibit #2.**

On August 18, 2017, Ms. Petrov provided care to patient IL.

During this time, Ms. Petrov accessed the Pyxis machine station UAM5F4 at 5:17:35 PM, and withdrew two, 10 mg tablets of Oxycodone totaling 20 mg under patient name IL. At 5:18:37 PM, Ms. Petrov wasted the 20 mg of Oxycodone, which was witnessed by her colleague Vanessa Tennant, RN. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2.** There was no physician's order for Oxycodone for patient IL on August 18, 2017. A copy of patient IL's Progress Notes of August 18, 2017 which outlines that patient IL did not require pain medications is in **Exhibit #2**.

Ms. Petrov did not administer any Oxycodone medication to patient IL during her August 18, 2017 shift. A copy of patient IL's Nursing Assessment and Care Records for August 18, 2017 is in **Exhibit #2.**

Ms. Petrov acknowledged at the time of the investigation that there was no physician's order for Oxycodone for patient IL on August 18, 2017, and that Ms. Petrov wasted the withdrawn Oxycodone 20 mg.

August 21, 2017

Ms. Petrov was working at Medicine Unit 5E2 at the UAH from 1500 hours to 1915 hours on August 21, 2017. A copy of the Daily Flow Sheet for August 21, 2017 showing that Ms. Petrov worked on Medicine Unit 5E2 is in **Exhibit #2.**

On August 21, 2017, Ms. Petrov provided care to patient MB.

During this time, Ms. Petrov accessed the Pyxis machine station UAM5E2 at 6:48:17 PM, and withdrew two, 10 mg tablets of Oxycodone totaling 20 mg under patient name MB. At 6:49:03 PM, Ms. Petrov wasted the 20 mg of Oxycodone which was witnessed by her colleague Jennifer Horvath, RN. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2**.

There was no physician's order for Oxycodone for patient MB on August 21, 2017. A copy of patient MB's Patient Medication Profile as of August 21, 2017 is in **Exhibit #2.**

Ms. Petrov did not administer Oxycodone medication to patient MB during her August 21, 2017 1500 hours to 1915 hours shift. However, she did administer two tablets of Oxycodone 5 mg – Acetaminophen 325 mg (Percocet) to patient MB at 1530 hours. A copy of patient MB's Medication Administration Record and a copy of patient MB's Nursing Assessment and Care Records for August 21, 2017 are in **Exhibit #2.**

Ms. Petrov acknowledged at the time of the investigation that there was no physician's order for Oxycodone for patient MB on August 21, 2017, and that Ms. Petrov wasted the withdrawn Oxycodone 20 mg.

Ms. Petrov was working at Medicine Unit 5D3 at the UAH from 1900 hours to 2300 hours on August 21, 2017. A copy of the Daily Flow Sheet for August 21, 2017 showing that Ms. Petrov worked on Medicine Unit 5D3 is in **Exhibit #2.**

On August 21, 2017, Ms. Petrov provided care to patient ED.

Ms. Petrov accessed the Pyxis machine station UAM5D3 at 8:56:37 PM, and withdrew three, 5 mg tablets of Oxycodone totaling 15 mg under patient name ED. At 8:57:22 PM, Ms. Petrov wasted the 15 mg of Oxycodone which was witnessed by her colleague Anna Trimble, LPN. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2.**

There was no physician's order for Oxycodone for patient ED on August 21, 2017. A copy of patient ED's Patient Medication Profile as of August 21, 2017 is in **Exhibit #2.**

Ms. Petrov did not administer any Oxycodone medication to patient ED during her August 21, 2017, 1900 hours to 2300 hours shift. A copy of patient ED's Medication Administration Record and a copy of patient ED's Nursing Assessment and Care Records for August 21, 2017 are in **Exhibit #2.**

Ms. Petrov acknowledged at the time of the investigation that there was no physician's order for Oxycodone for patient ED on August 21, 2017, and that Ms. Petrov wasted the withdrawn Oxycodone 15 mg.

August 22, 2017

Ms. Petrov was working at Medicine Unit 5C3 at the UAH from 1500 hours to 2315 hours on August 22, 2017. A copy of the Daily Flow Sheet for August 22, 2017 showing that Ms. Petrov worked on Medicine Unit 5C3 is in **Exhibit #2.**

On August 22, 2017, Ms. Petrov provided care to patient WS.

During this time, Ms. Petrov accessed the Pyxis machine station UAM5C3 at 4:50:54 PM, and withdrew two, 10 mg tablets of Oxycodone totaling 20 mg under patient name WS. At 4:52:34 PM, Ms. Petrov wasted the 20 mg of Oxycodone, which was witnessed by her colleague Mae Anne Nadyahan, LPN. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2.**

There was no physician's order for Oxycodone for patient WS on August 22, 2017. A copy of patient WS's Patient Medication Profile as of August 22, 2017 is in **Exhibit #2.**

Ms. Petrov did not administer any Oxycodone medication to patient WS during her August 22, 2017 shift. A copy of patient WS's Medication Administration Record and a copy of patient WS's Nursing Assessment and Care Records for August 22, 2017 are in **Exhibit #2.**

Ms. Petrov acknowledged at the time of the investigation that there was no physician's order for Oxycodone for patient WS on August 22, 2017, and that Ms. Petrov wasted the withdrawn Oxycodone 20 mg.

August 28, 2017

Ms. Petrov was working at Medicine Unit 5C3 at the UAH from 1500 hours to 2315 hours on August 28, 2017. A copy of the Daily Flow Sheet for August 28, 2017 showing that Ms. Petrov worked on Medicine Unit 5C3 is in **Exhibit #2.**

On August 28, 2017, Ms. Petrov provided care to patient GW.

During this time, Ms. Petrov accessed the Pyxis machine station UAM5C3 at 9:06:07 PM, and withdrew two, 10 mg tablets of Oxycodone totaling 20 mg under patient name GW. At 9:07:01 PM, Ms. Petrov wasted the 20 mg of Oxycodone which was witnessed by her colleague Lin

Wang, RN. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2.**

There was no physician's order for Oxycodone for patient GW on August 28, 2017. A copy of patient GW's Patient Medication Profile as of August 28, 2017 is in **Exhibit #2.**

Ms. Petrov did not administer any Oxycodone medication to patient GW during her August 28, 2017 shift. A copy of patient GW's Medication Administration Record and a copy of patient GW's Nursing Assessment and Care Records for August 28, 2017 are in **Exhibit #2.**

Ms. Petrov acknowledged at the time of the investigation that there was no physician's order for Oxycodone for patient GW on August 28, 2017, and that Ms. Petrov wasted the withdrawn Oxycodone 20 mg.

Ms. Petrov, over a period of six days, withdrew Oxycodone seven times for patients who were not prescribed this medication by their physician. Although Ms. Petrov told the investigator that these medications were not given and were wasted, this practice demonstrates poor practice skills as well as a lack of judgment on Ms. Petrov's part. It also makes tracking a patient's proper care difficult and can create confusion for staff working with Ms. Petrov.

Further, the Hearing Tribunal finds that Ms. Petrov's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice;

<u>Allegation 2</u>

Bailey-Jane Petrov admitted on or about August 18, 2017, she did one or more of the following with regards to patient JG:

a) Inappropriately accessed Oxycodone 20 mg at 2054 hours from the Pyxis when JG did not have a Physician's order for Oxycodone 20 mg, and

b) **Failed to document the administration and/or disposal of Oxycodone 20 mg removed from the Pyxis at 2054 hours**.

Ms. Petrov was working at Medicine Unit 5F4 at the UAH from 1500 hours to 2315 hours on August 18, 2017. A copy of the Daily Flow Sheet for August 18, 2017 showing that Ms. Petrov worked on Medicine Unit 5F4 is in **Exhibit #2.**

On August 18, 2017, Ms. Petrov provided care to patient JG.

During this time, Ms. Petrov accessed the Pyxis machine station UAM5F4 at 8:54:39 PM, and withdrew two, 10 mg tablets of Oxycodone totaling 20 mg under patient name JG. There was no wastage of the Oxycodone recorded on the Pyxis report. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2.**

There was no physician's order for Oxycodone for patient JG on August 18, 2017. A copy of patient JG's Patient Medication Profile, dated August 18, 2017 is in **Exhibit #2.**

There is no record that patient JG was administered any Oxycodone by Ms. Petrov. A copy of patient JG's Medication Administration Record is in **Exhibit #2.**

Ms. Petrov failed to document the administration and/or disposal of the withdrawn Oxycodone 20 mg during her August 18, 2017 shift.

Ms. Petrov acknowledged at the time of the investigation that there was no physician's order for Oxycodone for patient JG on August 18, 2017.

Withdrawal of a narcotic such as Oxycodone for a patient when it has not been ordered by a doctor is certainly a demonstration of lack of skill and judgement. Then, not recording whether this drug had been administered or destroyed can cause a great deal of confusion for other staff members caring for the patient. In addition, this wasn't a single event with patient JG. This withdrawal of Oxycodone happened on two occasions. This practice could cause serious problems to arise in JG's care and continuity of care.

Further, the Hearing Tribunal finds that Ms. Petrov's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice.

Allegation 3

Bailey-Jane Petrov admitted on or about August 28, 2017, she failed to complete a Narcotic and Controlled Substances Discrepancy Reporting Form and/or failed to notify the Unit Manager/Clinical Supervisor as required after identifying a discrepancy in the narcotic count.

As above, Ms. Petrov was working at Medicine Unit 5C3 at the UAH from 1500 hours to 2315 hours on August 28, 2017. A copy of the Daily Flow Sheet for August 28, 2017 showing that Ms. Petrov worked on Medicine Unit 5C3 is in **Exhibit #2.**

On August 28, 2017, Ms. Petrov identified a Pyxis discrepancy that was "unresolveable". A copy of the Pyxis Discrepancy Audit Detail Report, dated August 1, 2017 to August 31, 2017, is in **Exhibit #2.**

The UAH's policy CAD 2.3.11 and 2.3.12 "Resolving Narcotic Discrepancies", in force from May 2012, establishes the process of documenting and reporting missing narcotics in the workplace. This policy establishes that if a discrepancy cannot be resolved, nurses must document the discrepancy in Pyxis, complete the "Narcotic and Controlled Substances Discrepancy Reporting Form", leave the completed form for the Unit Manager/Clinical Supervisor, and if a patient is involved, also completed a Reporting Learning System report. A copy of the UAH Policy "Resolving Narcotic Discrepancies" is in **Exhibit #2.**

Alberta Health Services Directive "Automated Medication Distribution", in force from June 21, 2004 and revised on November 24, 2009, states at section 5.0 "Controlled Substances Discrepancies" that if a discrepancy cannot be resolved it shall be reported to the charge nurse immediately. A copy of the AHS policy "Automated Medication Distribution: Controlled Substances Discrepancies" is in **Exhibit #2.**

Ms. Petrov did not follow the Resolving Narcotic Discrepancies policy as she failed to complete and/or file a Narcotic and Controlled Substances Discrepancy Reporting Form with her Unit Manager/Clinical Supervisor.

Further, Ms. Petrov did not follow the AHS policy "Automated Medication Distribution: Controlled Substances Discrepancies" as she failed to inform the charge nurse of the unresolved discrepancy logged August 28, 2017.

During the course of the Investigation, Ms. Petrov admitted that she was aware of the procedures to be followed in the event of a discrepancy being found in Pyxis.

In this situation, Ms. Petrov, not only demonstrated a lack of skill and judgment, she clearly failed to follow the policies clearly laid out in AHS policy "Automated Medication Distribution: Controlled Substances Discrepancies". These policies are in effect to protect the safety of the patients, as well as the critical tracking of narcotic substances. This is a serious disregard of safety practices and policies.

Further, the Hearing Tribunal finds that Ms. Petrov's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice.

Allegation 4

Bailey-Jane Petrov admitted on or about August 31, 2017, she did one or more of the following with regards to patient LR:

a) **Inappropriately removed Oxycodone 30 mg at 2128 hours from the Pyxis when LR did not have a Physician's order for Oxycodone 30 mg, then wasted the Oxycodone 30 mg; and**

b) **Failed to show her co-worker the two tablets of Oxycodone to be wasted prior to wasting them.**

Ms. Petrov was working at Medicine Unit 5F2 at the UAH from 1500 hours to 2315 hours on August 31, 2017. A copy of the Daily Flow Sheet for August 31, 2017 showing that Ms. Petrov worked on Medicine Unit 5F2 is in **Exhibit #2.**

On August 31, 2017, Ms. Petrov provided care to patient LR.

During this time, Ms. Petrov accessed the Pyxis machine station UAM5F2 at 9:28:41 PM, and withdrew three, 10 mg tablets of Oxycodone totaling 30 mg under patient name LR. A copy of the Pyxis Report, dated August 1, 2017 to August 31, 2017, and a summary of Ms. Petrov's Pyxis activity from August 3, 2017 to August 31, 2017 are in **Exhibit #2.**

A few minutes following this withdrawal of Oxycodone 30 mg, Ms. Petrov asked her coworker Exelea Gelasque, RN, to witness the wastage of Dilaudid medication. Ms. Gelasque agreed, and logged into the Pyxis machine in order to witness and confirm the wastage of Dilaudid.

Ms. Petrov entered a wastage dose of 30 mg, and quickly hit the "accept" button on the Pyxis machine before Ms. Gelasque was able to fully review the wastage.

The dosage amount of 30 mg seemed odd to Ms. Gelasque, as she understood that the most common dose for Dilaudid is usually 2 mg. Upon review, Ms. Gelasque realized that the medication wastage she witnessed was actually for 30 mg of Oxycodone.

Ms. Gelasque reported the incident to the on-call manager, and at that time Ms. Petrov admitted that she had actually withdrawn Oxycodone 30 mg, and instead of following proper wastage policy had disposed of the Oxycodone in a SHARPS container without a witness.

There was no physician's order for Oxycodone for patient LR on August 18, 2017. A copy of patient LR's Medication Administration Record is in **Exhibit #2.**

Alberta Health Services Directive "Automated Medication Distribution", in force from June 21, 2004 and revised on November 24, 2009, states at section 7.3 "Medication Waste" that an additional qualified staff member shall witness any wastage of controlled substances. A copy of the AHS policy "Automated Medication Distribution: Controlled Substances Discrepancies" is in **Exhibit #2.**

Ms. Petrov failed to properly show her co-worker the dose of Oxycodone prior to wastage.

During the course of the Investigation, Ms. Petrov admitted that she was aware of the procedures to be followed in the event of narcotic wastage.

Ms. Petrov acknowledges she knew the policies and procedures regarding the disposition of narcotics and yet she did not follow the procedures as the policy indicated. This flagrant ignoring of such important policies and procedures is certainly a demonstration of a lack of skill, and good judgment. Ms. Petrov, in ignoring these policies and practices, has been dishonest in her practice, and in so doing, has tarnished the integrity of the profession.

Further, the Hearing Tribunal finds that Ms. Petrov's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

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

<u>Code of Ethics</u>

The Hearing Tribunal finds that Ms. Petrov's misconduct breached the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

a. 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; and

- 1.5 Provide care directed to the health and well-being of the person, family, and community.

b. Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:
    - 2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities;
    - 2.8 Use evidence and judgement to guide nursing decisions; and
    - 2.9 Identify and minimize risks to clients.

c. 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; and
    - 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.

d. Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 specifically provides that LPNs:
    - 5.1 Demonstrate honesty, integrity and trustworthiness in all interactions; and
    - 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.

A copy of the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 is in **Exhibit #2.**

Ms. Petrov's behaviour breached these Principles of the Code of Ethics in that her actions had the potential to place patients at risk of serious harm by interfering with their care. This resulted in a failure of responsibility to those patients, their families and the community more broadly. Her actions also undermined the work of her colleagues and fellow professionals and failed to demonstrate a level of practice commensurate with recognition of being a regulated professional. Finally, Ms. Petrov has undermined her own trustworthiness and integrity and her actions were not consistent with the principles, standards of practices, laws and regulations under which she is accountable.

Standards of Practice

The Hearing Tribunal finds that Ms. Petrov's misconduct breached the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which state as follows:

e. 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;
   - 1.2. Engage in ongoing self-assessment of their professional practice and competence, and seek opportunities for continuous learning;
   - 1.4. Recognize their own practice limitations and consult as necessary;
   - 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; and
   - 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

f. Standard 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice. Standard 2 specifically provides that LPNs:

   - 2.1. Possess current knowledge to support critical thinking and professional judgement;
   - 2.2. Apply knowledge from nursing theory and science, other disciplines, evidence to inform decision making and LPN practice;
   - 2.7. Demonstrate understanding of their role and its interrelation with clients and other health care colleagues; and
   - 2.11. Use critical inquiry to assess, plan and evaluate the implications of interventions that impact client outcomes.

g. 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:

    - 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice;

    - 3.4 Promote a culture of safety by using established occupational health and safety practices, infection control, and other safety measures to protect clients, self and colleagues from illness and injury;

    - 3.5. Provide relevant and timely information to clients and co-workers; and

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

h. 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; and

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

A copy of the Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 is in **Exhibit #2.**

Ms. Petrov's actions are breaches of the Standards of Practice in that she failed to ensure that her practice was conducted in accordance of the requirements binding on her. Further, her actions placed patients in harm's way rather than worked to minimize or avoid harm. She failed to apply her knowledge and professional judgment. Her actions were such that they diminished, not enhanced, the interests of the patient, the public and the profession and did not demonstrate an ethical practice.

(9) Partial Joint Submission on Penalty

The Complaints Consultant and Ms. Petrov made a partial joint submission with respect to penalty, which was entered as **Exhibit #3**. The parties jointly submitted the following proposal to the Hearing Tribunal for consideration:

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

2. Ms. Petrov shall, within 30 days of service of the Decision, read and reflect on the following CLPNA documents located on the CLPNA website at http://www.clpna.com under the "Governance" tab, and provide the Complaints Consultant a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact her professional practice:

    (a) Code of Ethics for Licensed Practical Nurses in Canada;

    (b) Standards of Practice for Licensed Practical Nurses in Canada;

    (c) CLPNA Practice Policy: Professional Responsibility & Accountability;

    (d) CLPNA Practice Policy: Documentation;

    (e) CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

    (f) CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

    (g) CLPNA Competency Profile U: Medication Administration; and

    (h) CLPNA Competency Profile W: Professionalism.

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

3. In the event the reflective paper is not satisfactory to the Complaints Consultant, Ms. Petrov shall submit a revised paper that is acceptable to the Complaints Consultant, within two (2) weeks of being notified the reflective paper was not satisfactory, or such longer period as determined by the Complaints Consultant at her sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

4. Ms. Petrov shall, within 30 days of service of the Decision, complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses, and provide the Complaints Consultant with a certificate confirming successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

5. Ms. Petrov shall, within 30 days of service of the Decision, complete the **Critical Thinking in Medical Administration** available online at www.pedagogyeducation.com, and provide the Complaints Consultant with a certificate confirming successful

completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Ms. Petrov shall, within three months of service of the Decision, undergo a Fitness to Work Assessment, at her own cost, provided by a psychologist who is a registered member of the College of Alberta Psychologists (the "Assessor") subject to the following terms and conditions:

   (a) The Assessor will be provided with a copy of the Agreed Statement of Facts and Admission of Unprofessional Conduct, and a copy of the Hearing Tribunal's written decision;

   (b) The Assessor will conduct an assessment to determine whether Ms. Petrov is currently fit to practice as an LPN;

   (c) The Assessor will indicate whether they are making any recommendations for ongoing counselling or treatment;

   (d) The assessment will be provided to Ms. Petrov and to Susan Blatz, Complaints Consultant.

7. In the event that the Assessor determines that Ms. Petrov is not to fit to practice, her practice permit will be suspended immediately, and the suspension will remain in place until the Assessor, a different registered member of the College of Alberta Psychologists, or another treatment provider approved by the Complaints Consultant, has confirmed that Ms. Petrov is fit to practice.

8. Ms. Petrov shall provide the CLPNA with her contact information, including her home mailing address, home and cellular telephone numbers, current e-mail address and her current employment information. Ms. Petrov will keep her contact information current with the CLPNA on an ongoing basis.

9. Should Ms. Petrov be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

10. Should Ms. Petrov fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, one or more of the following steps may occur:

    (a) the Complaints Consultant may refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty; and

(b) the Complaints Consultant may treat Ms. Petrov's non-compliance as information under s. 56 of the *Health Professions Act*.

Legal Counsel for the Complaints Consultant 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 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.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Petrov and the Complaints Consultant.

(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 Bailey-Jane Petrov 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)("*Jaswal*"), 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

The nature and gravity of the proven allegations
Ignoring procedure and policy, as well as taking out narcotics without a physician's request for those medications is a serious infraction and can cause confusion for other staff members providing care to patients. This is a serious situation, and could have led to serious and even dangerous outcomes. This was also an intentional conduct of the member; she knew that what she was doing was wrong.

The age and experience of the investigated member
Ms. Petrov had been an LPN for four years when these incidents happened. Although this is not a long time as a practicing LPN, it is still enough time at practice to be proficient at one's profession. In addition, it is basic nursing to know the rules, procedures, and policies surrounding narcotics. These were not the mistakes of a new nurse. These incidents were intentional acts of a qualified LPN who should know better.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
The Hearing Tribunal has no evidence of prior complaints

The number of times the offending conduct was proven to have occurred
Ms. Petrov, on numerous occasions and on numerous patients, withdrew Oxycodone that wasn't ordered by a doctor, for patients who did not receive the drug. On all of these occasions, Ms. Petrov claims she wasted the drug but there is no evidence of that wasting happening. This is a serious situation, because all sorts of misunderstanding could arise from this type of repeated behavior, including the possibility of treatment confusion among staff members on shift with Ms. Petrov.

The role of the investigated member in acknowledging what occurred
Ms. Petrov cooperated with investigators, and worked with the College and her representative to prepare an Agreed Statement of Facts.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
Ms. Petrov had a one day suspension in relation to the same matters which formed the basis for this hearing.

It is important to the profession of LPNs to maintain the Code of Ethics and 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.

(11) Additional Order Sought by the Complaints Director

The Complaints Consultant requested the Hearing Tribunal make the following additional order.

1. **Bailey-Jane Petrov shall pay 25% of the costs of the investigation and hearing over a period of 24 months from service of the Hearing Tribunal's written reasons for decision.**
2. **In the case of non-payment of the costs described in paragraph 1 above, the Complaints Consultant may suspend Ms. Petrov's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant**.

Ms. Petrov opposed this request.

In support of this additional sanction for costs, counsel for the Complaints Consultant argued that such a sanction is in keeping with previous sanctions of other members. He acknowledged that Ms. Petrov did admit to her unprofessional conduct and agreed to a joint submission; however, pointed out that there were still costs involved in bringing this complaint to a hearing. Counsel referred the Hearing Tribunal to paragraph 50 in *Jaswal* where the Court addresses the issues of costs.

Counsel submitted that it would be unfair for the members of the CLPNA to bear the full costs of the hearing. The hearings costs to date amount to $16,427.28 (see **Exhibit #5)** so 25% of this amount would be $4,106.43.

Counsel for the Complaints Consultant presented three decisions in which other members of the CLPNA had been ordered to pay 25% of the costs of the hearing which he argued demonstrated that this amount is a fair amount and one for which there is precedent in similar cases:

- In one case the Hearing Tribunal determined that member, JB, must pay 25% of costs to a maximum of $3,500 based on a hearing cost of $14,002.00. This was to be paid over 24 months.

- In another decision relating to member MP, the Hearing Tribunal directed this member pay 25% of the costs to a maximum of $3,500 to be paid over 36 months.

- Finally, another member, MN, was directed to pay 25% of costs up to a maximum of $5,000 over 24 months.

Ms. Drennan, for Ms. Petrov, argued that 25% of the costs (spread over 24 months equalling $171 per month) would be a hardship for Ms. Petrov. Ms. Drennan argued that Ms. Petrov couldn't afford this cost every month, and presented the Hearing Tribunal with **Exhibit #6,** Ms. Petrov's family costs per month, while she is on maternity leave. According to this accounting the family expenditure is $4,850.92 per month with an income of only $4,302.00 per month. However, these costs were not backed up with documentary evidence.

The parties did not agree on a time to start payments. Ms. Petrov wanted payments to start in or around October 2020, and counsel for the Complaints Consultant suggested January 2020.

The requested order relates to the partial payment of costs. *Jaswal* offers guidance on sanctioning for costs at and the factors to consider in imposing an order for the payment of costs. The factors relevant to this matter are:

5. Whether the [member] cooperated with respect to the investigation and offered to facilitate proof by admissions, etc.
6. The financial circumstances of the [member] and the degree to which [their] financial position has already been affected by other aspects of any penalty that has been imposed.

The Hearing Tribunal has considered all the arguments and decided that 25% of the hearing costs is a fair amount to require of Ms. Petrov, and that the 24 month time frame for payment was acceptable as well, and was well within the range of costs paid in the past. While Ms. Petrov admitted unprofessional conduct it was still necessary to hold a hearing. Further, there was no evidence that other aspects of any penalty have affected Ms. Petrov financially. It would be unfair to ask that the CLPNA membership bear the full costs of this hearing.

The Hearing Tribunal considered the time for payments to start. Starting payments in October of 2020, would certainly give the member plenty of time to adjust to making payments; however, that delay in time is very long. The Hearing Tribunal also thought that it was fair to give Ms. Petrov time to arrange her finances and believed that starting payments in January 2020 was too soon. Therefore the Hearing Tribunal decided that payments should begin at the beginning of March 2020, in order to give Ms. Petrov time to get her finances organized.

The Hearing Tribunal already advised counsel to the Complaints Director and Ms. Drennan for Ms. Petrov, of their finding, and both agreed with the determination of the Hearing Tribunal.

(12) 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. Petrov shall, within 30 days of service of the Decision, read and reflect on the following CLPNA documents located on the CLPNA website at http://www.clpna.com under the "Governance" tab, and provide the Complaints Consultant a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact her professional practice:

   (a) Code of Ethics for Licensed Practical Nurses in Canada;

   (b) Standards of Practice for Licensed Practical Nurses in Canada;

   (c) CLPNA Practice Policy: Professional Responsibility & Accountability;

   (d) CLPNA Practice Policy: Documentation;

   (e) CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

   (f) CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

   (g) CLPNA Competency Profile U: Medication Administration; and

   (h) CLPNA Competency Profile W: Professionalism.

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

3. In the event the reflective paper is not satisfactory to the Complaints Consultant, Ms. Petrov shall submit a revised paper that is acceptable to the Complaints Consultant, within two (2) weeks of being notified the reflective paper was not satisfactory, or such longer period as determined by the Complaints Consultant at her sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

4. Ms. Petrov shall, within 30 days of service of the Decision, complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses, and provide the Complaints Consultant with a certificate confirming successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

5. Ms. Petrov shall, within 30 days of service of the Decision, complete the **Critical Thinking in Medical Administration** available online at www.pedagogyeducation.com, and provide the Complaints Consultant with a certificate confirming successful

completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Ms. Petrov shall, within three months of service of the Decision, undergo a Fitness to Work Assessment, at her own cost, provided by a psychologist who is a registered member of the College of Alberta Psychologists (the "Assessor") subject to the following terms and conditions:

   (a) The Assessor will be provided with a copy of the Agreed Statement of Facts and Admission of Unprofessional Conduct, and a copy of the Hearing Tribunal's written decision;

   (b) The Assessor will conduct an assessment to determine whether Ms. Petrov is currently fit to practice as an LPN;

   (c) The Assessor will indicate whether they are making any recommendations for ongoing counselling or treatment;

   (d) The assessment will be provided to Ms. Petrov and to Susan Blatz, Complaints Consultant.

7. In the event that the Assessor determines that Ms. Petrov is not to fit to practice, her practice permit will be suspended immediately, and will remain in place until the Assessnor, a different registered member of the College of Alberta Psychologists, or another treatment provider approved by the Complaints Consultant, has confirmed that Ms. Petrov is fit to practice.

8. Ms. Petrov shall provide the CLPNA with her contact information, including her home mailing address, home and cellular telephone numbers, current e-mail address and her current employment information. Ms. Petrov will keep her contact information current with the CLPNA on an ongoing basis.

9. Ms. Petrov shall pay 25% of the costs of the investigation and hearing over a period of 24 months starting March, 2020.

10. Should Ms. Petrov be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

11. Should Ms. Petrov fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, one or more of the following steps may occur:

   (c) the Complaints Consultant may refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty; and

(d) the Complaints Consultant may treat Ms. Petrov's non-compliance as information under s. 56 of the *Health Professions Act*.

The Hearing Tribunal believes these orders adequately balance the factors referred to in Sections 10 and 11 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 22nd DAY OF NOVEMBER, 2019 IN THE VILLAGE OF RYLEY ALBRTA

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Nancy Brook, Public Member
Chair, Hearing Tribunal