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 ERIN BURK

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 ERIN BURK, LPN #38011, 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 December 10, 2019 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Marie Concepcion, LPN
James Lees, Public Member

Staff:
Tessa Gregson, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
Erin Burk, LPN ("Ms. Burk or "Investigated Member")
Sophie Parsons, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

Ms. Burk was unable to attend in person and the parties agreed to the Investigated Member participating by Skype.

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. Burk was an LPN within the meaning of the Act at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Burk was initially licensed as an LPN in Alberta on March 17, 2014.

By letter dated September 14, 2018, the CLPNA received a complaint (the "First Complaint") from Ms. Dale Flanders pursuant to s. 54 of the *Health Professions Act* (the "Act"). The First Complaint raised concerns with a breach of confidentiality related to documents from Ms. Burk, LPN, containing medical information, which were found in garbage that had spread into Ms. Flanders' property and on a roadway.

In accordance with s. 55(2)(d) of the Act, the Complaints Director determined she would conduct an investigation into the First Complaint. Ms. Burk received notice of the First Complaint and the investigation by letter dated September 18, 2018.

Prior to completion of the investigation into the First Complaint, by letter dated October 24, 2018, the CLPNA received a further complaint (the "Second Complaint") from Sherri Whiffen, Manager, Medicine Unit, at the Northern Lights Regional Health Centre in Fort McMurray, Alberta, pursuant to s. 57 of the Act, stating that Ms. Burk had been suspended for three days as a result of her bringing Hub Report Sheets containing personal and health information of patients to her residence, not properly disposing of these documents, and bringing Dimenhydrinate (Gravol) home and self-administering the medication.

The Complaints Director determined she would investigate the Second Complaint. Ms. Burk received notice of the Second Complaint and the investigation by letter dated November 2, 2018.

The Complaints Director investigated the First Complaint and the Second Complaint together.

In September 2019, the Complaints Director concluded the investigation and 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. Burk received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report under cover of letter dated October 23, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Burk under cover of letter dated November 12, 2019.

(4) Allegations

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

> "It is alleged that **ERIN BURK, LPN**, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:
>
> 1. On or between September 4, 2018 and September 8, 2018, breached her duty to maintain confidentiality by doing one or more of the following:

a. Removed the September 4, 2018 HUB Report Sheets, which contained patients' personal and medical information, from the Northern Lights Regional Hospital without justification or authorization; and

b. Disposed of the September 4, 2018 HUB Report Sheets, which contained patients' personal and medical information, in her personal garbage.

2. On or between September 4, 2018 and September 8, 2018, did one or more of the following:

a. Removed Dimenhydrinate (Gravol) injectable along with needles and syringes from the Northern Lights Regional Hospital without justification or authorization;

b. Self-administered injectable Dimenhydrinate (Gravol) without a prescription; and

c. Disposed of needles/syringes in her personal garbage without using a Biohazard Sharps Container."

(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. Burk 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 Statement of Allegations during the hearing.

Legal Counsel for the Complaints Director 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

(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.

(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. Burk'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. Burk.

Allegation 1

Erin Burk admitted on or between September 4, 2018 and September 8, 2018, she breached her duty to maintain confidentiality by doing one or more of the following:

a. Removed the September 4, 2018 HUB Report Sheets, which contained patients' personal and medical information, from the Northern Lights Regional Hospital without justification or authorization; and

b. Disposed of the September 4, 2018 HUB Report Sheets, which contained patients' personal and medical information, in her personal garbage.

Ms. Dale Flanders lives outside of Fort McMurray, Alberta, on an acreage. On September 8, 2018, Ms. Flanders observed that garbage from a neighboring house had been spread by wildlife onto the roadway and neighboring properties, including her own property.

After Ms. Flanders attempts to contact the owner of the home and to have the owner pick up the garbage were unsuccessful, Ms. Flanders and another neighbor, Ms. Nicole Wilson, along with Wilson's sons, picked up the garbage themselves as there was a risk that wildlife would come into the area.

Ms. Flanders picked up the garbage in her yard, which included papers. Ms. Flanders determined that the papers were medical documents containing personal and medical information of patients from the local hospital, Northern Lights Regional Hospital. The medical documents included HUB Report Sheets from a Medicine Unit of the hospital.

The HUB Report Sheets contain patients' medical and personal information. Staff at the hospital fill out the sheets at the beginning of their shift to track tasks and treatment for the patients, as well as other information throughout the shift including nurses' notes. The HUB Report Sheets are not a part of a patient's chart. After each shift, staff are required to shred the HUB Report Sheets and the HUB Report Sheets are not to be removed from the hospital.

The HUB Report Sheets found by Ms. Flanders on September 8, 2018, were dated September 4, 2018, and contained personal and medical information of twelve (12) patients from the Northern Lights Regional Hospital. Ms. Flanders was able to identify personal and medical information, including diagnoses, of the twelve (12) patients', as well as Ms. Burk's name on the HUB Report Sheets.

Ms. Flanders reviewed the HUB Report Sheets and recognized one of the patients on the document, DM, as being her aunt. Ms. Flanders was aware her aunt was a patient in the hospital but was not aware of the reasons for admission. After reading the HUB Report Sheets, Ms. Flanders was upset to learn that DM was diagnosed with throat cancer.

When asked, Ms. Burk admitted that she took the HUB Report Sheets home from the hospital on September 4, 2018. She then disposed of the documents in her personal garbage instead of returning it to the hospital to shred.

Ms. Burk removed the September 4, 2018, HUB Report Sheets which contained patients' personal and medical information for twelve (12) patients, from the Northern Lights Regional Hospital without justification or authorization. She inappropriately disposed of the HUB Report Sheets in her personal garbage.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Burk's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in 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**: The conduct of Ms. Burk in this allegation shows a clear lack of judgment on her part. Ms. Burk was not a new employee to Northern Lights Regional Hospital and understood she should not be removing her HUB Report Sheets from the hospital at the end of her shift. Ms. Burk was also aware of what the proper disposal method was of the HUB Report Sheets and that they were to be placed in a confidential

bin for shredding and not thrown into her personal garbage bin. Ms. Burk demonstrated a lack of judgement by removing the HUB Report Sheets and disposing of them in her personal garbage at her residence. This was a breach of confidentiality on the part of Ms. Burk. There was a total of twelve (12) patients' information on the HUB Report Sheets that Ms. Burk had removed from the hospital which resulted in those patients' personal and health information being disclosed to a member of the public;

ii. **Contravention of the Act, a code of ethics or standards of practice**: Ms. Burk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and as set out specifically below and that such breaches are sufficiently serious to constitute unprofessional conduct; and

iii. **Conduct that harms the integrity of the regulated profession**: Ms. Burk harmed the integrity of the profession by not doing by what another LPN would do in a similar situation. Once Ms. Burk realized that she removed her HUB Report Sheets from Northern Lights Regional Hospital she should have either shredded them herself at her residence or returned them back to the hospital on her next shift and disposed of them in a confidential shredding bin. She should never have placed the HUB Report Sheets in her own personal garbage.

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

Ms. Burk acknowledged that her conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada ("CLPNA Code of Ethics"), which states as follows:

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.

- 2.3.1 Safeguard health and personal information by collecting, sorting, using and disclosing it in compliance with relevant legislation and employer policies.

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 Practice in a manner that is consistent with the privilege and responsibility of self-regulation.

Ms. Burk acknowledged that her conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice"), which state as follows:

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.

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

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:

- 3.4 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.

- 3.6 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.

Allegation 2

Erin Burk admitted on or between September 4, 2018 and September 8, 2018, she did one or more of the following:

a. Removed Dimenhydrinate (Gravol) injectable along with needles and syringes from the Northern Lights Regional Hospital without justification or authorization;

b. Self-administered injectable Dimenhydrinate (Gravol) without a prescription; and

c. Disposed of needles/syringes in her personal garbage without using a Biohazard Sharps Container

Ms. Dale Flanders lives outside of Fort McMurray, Alberta, on an acreage. On September 8, 2018, Ms. Flanders observed that garbage from a neighboring house had been spread by wildlife onto the roadway and neighboring properties, including her own property.

After Ms. Flanders attempts to contact the owner of the home and to have the owner pick up the garbage were unsuccessful, Ms. Flanders and another neighbor, Ms. Nicole Wilson, along with Wilson's sons, picked up the garbage themselves as there was a risk that wildlife would come into the area.

One of Ms. Wilson's sons picked up garbage which contained a syringe with a needle.

Sometime between September 4, 2018 and September 8, 2018, Ms. Burk removed Dimenhydrinate (Gravol) injectable, along with a needle and syringe, from the Northern Lights Regional Hospital.

Ms. Burk prepared Dimenhydrinate (Gravol) for a patient who complained of nausea. However, the patient subsequently refused the medication. Ms. Burk put the Dimenhydrinate (Gravol) into her pocket instead of the Sharps Container at the hospital. Ms. Burk forgot about the medication and took it home.

Once at home, Ms. Burk found the Dimenhydrinate (Gravol) in her pocket. She then self-injected the medication at home when she felt nauseous. Ms. Burk does not have a prescription for Dimenhydrinate (Gravol).

After self-injecting the Dimenhydrinate (Gravol), sometime between September 4, 2018 and September 8, 2018, Ms. Burk disposed of the syringe and needle in personal garbage. She did not use a Biohazard Sharps Container.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Burk's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in 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**: Ms. Burk showed a clear lack of knowledge and judgment with respect to this allegation. Ms. Burk removed a syringe that contained Dimenhydrinate (Gravol) without justification or cause, whether it was intentional or not. The CLPNA takes the removal of all medication, without proper authorization, seriously. Ms. Burk should have disposed of the Dimenhydrinate (Gravol) syringe in a Biohazard Sharps Container once the patient refused the medication. Even if Ms. Burk was unaware if the syringe remained in her pocket, once she realized her mistake, she should have never self-administered the Dimenhydrinate (Gravol) to herself;

ii. **Contravention of the Act, a code of ethics or standards of practice**: Ms. Burk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct; and

iii. **Conduct that harms the integrity of the regulated profession**. Ms. Burk harmed the integrity of the profession by not doing by what another LPN would do in a similar situation. Once Ms. Burk realized that she had the syringe of Dimenhydrinate (Gravol) in her pocket, she should have placed it into the Biohazard Sharps Disposal immediately. Ms. Burk also self-administered the Dimenhydrinate (Gravol) when she was having nausea and this could have posed a serious medical risk to herself. Ms. Burk also disposed of the syringe with a needle into her own personal garbage at her residence which could have caused an injury to a member of the public.

Summary

In summary, the Hearing Tribunal considered the evidence put forth in Exhibit #2 and concluded that each of the Allegations against Ms. Burk were factually found. In addition, after considering the definition of unprofessional conduct found in section 1(1)(pp) of the Act, the CLPNA Code of Ethics and CLPNA Standards of Practice applicable to Ms. Burk as an LPN, the Hearing Tribunal found that for each allegation, unprofessional conduct had occurred.

(9) Partial Joint Submission on Penalty

The Complaints Director and Ms. Burk 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 decision (the "Decision") shall serve as a reprimand.

2. Ms. Burk shall pay 25% of the costs of the investigation and hearing in equal monthly installments over a period of thirty six (36) months from the date of service of the Decision, or over such other period of time as agreed to by the Complaints Director.

3. Ms. Burk shall read and reflect on how the following CLPNA documents, located on the CLPNA website at www.clpna.com under the "Governance" tab, will impact her nursing practice within thirty (30) days of service of the Decision:

    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 Competency Profile A1: Critical Thinking and Critical Inquiry;
    e. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
    f. CLPNA Competency Profile C: Professionalism and Leadership;
    g. CLPNA Interpretive Document: Privacy Legislation in Alberta; and
    h. CLPNA Practice Guideline: Confidentiality.

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

4. Ms. Burk shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses and provide a certificate confirming its successful completion to the Complaints Director within thirty (30) days of service of the Decision.

    If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Director.

5. Ms. Burk shall complete the **HIA Awareness Course** offered by Alberta Health Services and available online at https://www.albertahealthservices.ca/info/Page3962.aspx and provide a certificate confirming its successful completion to the Complaints Director within thirty (30) days of service of the Decision.

    If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Director.

6. Should Ms. Burk 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 Director.

7. Ms. Burk 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. Burk will keep her contact information current with the CLPNA on an ongoing basis.

8. Should Ms. Burk 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, the Complaints Director may do any or all of the following:

    (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

    (b) Treat Ms. Burk's non-compliance as information under s. 56 of the *Health Professions Act*; or

    (c) In the case of non-payment of the costs described in paragraph 3 above, suspend Ms. Burk's practice permit until such costs are paid in full or the Complaints Director is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Director.

Legal Counsel for the 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 partial 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 and partial joint submissions 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 carefully considered the Partial Joint Submission on Penalty by Ms. Burk and the Complaints Consultant.

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

(10) Additional Order sought by the Complaints Consultant

In addition to the Partial Joint Submission on Penalty, outlined above, the Complaints Consultant requested the Hearing Tribunal make the following order:

1. Ms. Burk will be required to pay a fine of $1,500.00. The fine 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, or over such other period as agreed to by the Complaints Consultant.

This request for an additional fine was requested due to the breach of confidentiality on the part of Ms. Burk. The Hearing Tribunal was presented with similar cases that had additional fines requested on behalf of the CLPNA.

The Hearing Tribunal heard submissions from the Complaints Consultant as to why this additional fine was merited in this case, and reviewed the similar cases where fines of this nature have been levied.

The Hearing Tribunal then heard submissions from Ms. Burk's representative. In those submissions, Ms. Burk's representative submitted that Ms. Burk does have some additional medical expenses which are not covered under her medical benefits through her employer and that Ms. Burk does have to pay out of pocket approximately $600/month for these medical expenses. Therefore, Ms. Burk objected to the additional fine on the basis that it would cause financial hardship for her.

In this case, the Hearing Tribunal felt that the additional fine requested was merited. The circumstances surrounding the allegations in this case were severe and amounted to a significant breach of private, personal information. In one instance, the breach resulted in a third party learning about the cancer diagnosis of her aunt, which should never have been disclosed. The one-time fine paid over thirty six (36) months was a reasonable request and, when paid over that time, does not expose Ms. Burk to severe financial hardship.

(11) 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. Burk 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

The nature and gravity of the proven allegations: This is a significant factor as the allegations that Ms. Burk has acknowledged deal with personal and confidential information as well as removing a medication from the Northern Lights Regional Hospital without justification or authorization. LPNs are an integral part of the medical team and the public needs to be assured that their personal information remains confidential. Ms. Burk also removed medications from her employer when she was not authorized to do so. Ms. Burk then self-administered that medication in which she exposed herself to the possibility of a reaction to the medication.

The age and experience of the investigated member: Ms. Burk had initially become registered with the CLPNA on March 17, 2014. Ms. Burk has worked at the Northern Lights Regional Hospital since 2014. The allegations that Ms. Burk acknowledged took place in 2018. Ms. Burk, at the time, was an LPN for approximately four years and should have been more than aware regarding the proper disposal of both her HUB Report Sheets, as well as, syringes that contain medications, regardless of the medication type.

The number of times the offending conduct was proven to have occurred: The Hearing Tribunal was presented with two (2) allegations with respect to Ms. Burk and were not made aware of any other allegations with respect to Ms. Burk. These allegations appear to be isolated incidents and there was no evidence of repeated conduct as both allegations that were presented happened between September 4, 2018 and September 8, 2018.

The role of the investigated member in acknowledging what occurred: Ms. Burk did acknowledge the allegations that were brought forward by her employer. Ms. Burk also did cooperate by working with both the CLPNA and her representative from AUPE by providing the Hearing Tribunal with an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Partial Joint Submission on Penalty.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Burk was placed on a three (3) day suspension without pay which was served on October 13, 14, and 15, 2018, as a result of the serious nature of both of the allegations by her employer of Alberta Health Services.

The impact of the incident(s) on the victim: This was an important factor for the Hearing Tribunal as the HUB Report Sheets contained the personal health information of twelve (12) patients, which resulted in a privacy breach of, not only Northern Lights Regional Hospital, but also Alberta Health Services. There was no direct impact on the patients whose information that was listed on the HUB Report Sheets; however, one of the patients who was listed on the HUB Report Sheet was the aunt of Ms. Flanders, who found the HUB Report Sheets. As a result of Ms. Flanders finding the HUB Report Sheets and knowing that her aunt was an inpatient at the Northern Lights Regional Hospital, Ms. Flanders discovered that her aunt's diagnosis, which Ms. Flanders' family did not, and should not, have known. Ms. Flanders would have never known of the diagnosis had she not been exposed to the improperly handled HUB Report Sheets.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was not made aware 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: Regarding specific deterrence, there is a need to impose sanctions with regards to Ms. Burk as she should be aware that her behavior is not acceptable and that it falls below the expectations of an LPN. Regarding general deterrence, the public should also be made aware that this type of behavior will not be tolerated by the CLPNA and such behavior will be dealt with in a serious manner. CLPNA does have a discipline process in place which helps to ensure that LPNs are competent and self-regulated professionals and the public needs to be reassured that this standard is upheld.

The need to maintain the public's confidence in the integrity of the profession: The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches in the Act, the CLPNA Code of Ethics and the CLPNA Standards of Practice which reflects the seriousness of the conduct which is expected of LPNs and for the purpose of protecting the public.

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.

In considering the additional Order regarding costs, submitted by the Complaints Consultant, the Hearing Tribunal does feel in the instance that costs should be levied against Ms. Burk.

Although Ms. Burk did provide an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, there was still a requirement for a hearing and costs incurred as a result of her conduct. As such, the Hearing Tribunal has decided that the fine in the amount of $1,500.00 will be awarded against Ms. Burk, to be paid in thirty six (36) monthly payments.

(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 decision (the "Decision") shall serve as a reprimand.

2. Ms. Burk will be required to pay an additional fine of $1,500.00. This fine will be payable in equal monthly installments over a period of thirty six (36) months from the date of service of the Decision, or over such other period as agreed to by the Complaints Consultant.

3. Ms. Burk shall pay 25% of the costs of the investigation and hearing in equal monthly installments over a period of thirty six (36) months from the date of service of the Decision, or over such other period of time as agreed to by the Complaints Director.

4. Ms. Burk shall read and reflect on how the following CLPNA documents, located on the CLPNA website at www.clpna.com under the "Governance" tab, will impact her nursing practice within thirty (30) days of service of the Decision:

    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 Competency Profile A1: Critical Thinking and Critical Inquiry;

    e. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

    f. CLPNA Competency Profile C: Professionalism and Leadership;

    g. CLPNA Interpretive Document: Privacy Legislation in Alberta; and

    h. CLPNA Practice Guideline: Confidentiality.

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

5. Ms. Burk shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses and provide a certificate confirming its

successful completion to the Complaints Director within thirty (30) days of service of the Decision.

If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Director.

6. Ms. Burk shall complete the **HIA Awareness Course** offered by Alberta Health Services and available online at https://www.albertahealthservices.ca/info/Page3962.aspx and provide a certificate confirming its successful completion to the Complaints Director within thirty (30) days of service of the Decision.

   If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Director.

7. Should Ms. Burk 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 Director.

8. Ms. Burk 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. Burk will keep her contact information current with the CLPNA on an ongoing basis.

9. Should Ms. Burk 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, the Complaints Director may do any or all of the following:

   (d) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

   (e) Treat Ms. Burk's non-compliance as information under s. 56 of the *Health Professions Act*; or

   (f) In the case of non-payment of the costs described in paragraph 3 above, suspend Ms. Burk's practice permit until such costs are paid in full or the Complaints Director is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Director.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 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 2nd DAY OF JANUARY, 2020 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal