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 REBECCA BEAULIEU

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 REBECCA BEAULIEU, LPN #26233, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted by videoconference using Zoom on September 15 and 16, 2020 with the following individuals present:

Hearing Tribunal:
Marg Hayne, Public Member, Chairperson
Verna Ruskowsky, Licensed Practical Nurse ("LPN")
Johanne Chicoine, LPN

Staff:
Jason Kully, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
No attendance

(2) Preliminary Matters

The hearing was open to the public and was conducted virtually by videoconference due to the ongoing COVID-19 pandemic.

Legal Counsel for the Complaints Director advised the Hearing Tribunal that the Investigated Member was not in attendance, and he made an application pursuant to section 79(6) of the *Health Professions Act*, RSA 2000, c H-7 ("HPA") for the hearing to proceed in the absence of the Investigated Member. In support of that application was submitted an affidavit of Ms. Bonnie McEwen, the CLPNA Hearings Director, which set out her office's efforts to serve the Notices of Hearing, Notices to Attend and Notices to Produce on the Investigated Member. That affidavit established that the notices referenced above were served on the Investigated Member's registered mailing address and email address, maintained pursuant to section 33(1) of the *Licensed Practical Nurses Profession Regulation*, Alta Reg 81/2003. Evidence of service on the Investigated Member was set out in the exhibits to Ms. McEwen's affidavit, and Ms. McEwen confirmed in her affidavit that the Investigated Member did not respond.

The Hearing Tribunal noted that a Registered Member has a positive obligation to provide updated contact information to the CLPNA pursuant to the HPA and the Regulation. It is clear that the Investigated Member had been aware of the fact of the complaints against her. Having

accepted evidence of good service pursuant to the HPA and noting the public-policy rationale in not allowing a non-responsive Member to frustrate a regulatory body's ability to undertake disciplinary proceedings, the Hearing Tribunal directed that the hearing proceed in the absence of the Member pursuant to section 79(6) of the HPA.

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.

(3) Background

The Investigated Member was an LPN within the meaning of the HPA at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaints. The Investigated Member was initially licensed as an LPN in Alberta on February 21, 2003 (affidavit of Ms. McEwen, para 7).

In accordance with s. 55(2)(d) of the Act, Ms. Sandy Davis, Complaints Director for CLPNA (the "Complaints Director") appointed Kerry Palyga, Investigator for CLPNA (the "Investigator") to investigate the complaints received about the Investigated Member. After reviewing the Investigation Report, the Complaints Director determined there was sufficient evidence the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the HPA.

(4) Allegations

The Allegations in the Statement of Allegations (the "Allegations") are set out as Schedule "A" to this decision. Legal Counsel for the Complaints Director indicated that allegations 13(b) and 17(b) were withdrawn, and the Hearing Tribunal accepted the withdrawal. Further, Legal Counsel for the Complaints Director applied to amend allegation 12(b) by removing "0036" and replacing it with "0056"; that application was a housekeeping matter and was granted by the Hearing Tribunal.

(5) Evidence

Legal Counsel for the Complaints Director called the evidence of four witnesses in support of the allegations. A list of exhibits entered in this hearing is attached to this decision as Schedule "B".

Rosemary Van Herk-Auger ("RV")

RV testified that she has been a Registered Nurse for 38 years, and currently works at the Queen Elizabeth II Hospital in Grande Prairie, Alberta. For five years (including 2017), she has been the Patient Care Director and oversees managers in various units. In her role, she was aware of the Investigated Member and was in a supervisory position in relation to her. She indicates that she

did not have much direct supervision of the Investigated Member but assisted the Investigated Member's manager. She states that she became aware of conduct concerns with the Investigated Member on July 21, 2017, through KD. These included concerns regarding a higher use of pain medication reflected in documents when the Investigated Member was working; a pattern that was out of the normal usage was brought to her attention. She involved the human resources department and also some coworkers. RV reviewed a number of records which were entered as exhibits and highlighted the discrepancies in the records made by the Investigated Member, including the use of "white out" by the Investigated Member which was not permitted for the nature of the legal records at issue. For a number of patients, there was not sufficient recordkeeping in relation to the need for the administration of pain medication and no follow-up charting to reflect the need for medication. This pattern of conduct followed for a number of patients over a number of days in July of 2017, including no documentation regarding the administration of pain medication, no progress notes to verify the need for the administration of pain medication. These facts were set out in exhibits 3-14.

RV also gave evidence that the Investigated Member did not sign for wastages, and the records from the emergency department from June 27 to July 26, 2017, showed that the Investigated Member had removed controlled drugs and did not record wastages (exhibits 15-17). RV testified that she met with colleagues and then with the Investigated Member, who indicated either that she "could not remember" or did not know why the records indicated these issues. She stated that she had learned of a death in the family at the start of a shift and that she felt "fogged over" at times. She was given a one-day suspension and indicated that she would do better in the future. RV indicated that the issue arising in March of 2018 was under the supervision of KD. In relation to how she concluded that there was excess usage of pain medication in relation to the Investigated Member, she indicated that the usage was compared to the usage arising with other nurses during the same time period. She states that when the Investigated Member was removed from medication duty for a period of time, usage went down.

Kristin Dirom ("KD")

KD testified that she has been a Registered Nurse since 2014 and that she was the clinical coordinator for the 4-South surgical unit. She worked directly with the Investigated Member until she resigned in 2019. At first, she was the charge nurse, and then she was the Investigated Member's manager. She testified that she would interact with the Investigated Member every day shift and that she had a good working relationship with her. She identified the complaint that she submitted to the CLPNA on August 16, 2017 (exhibit 18) and the letter of suspension given to the Investigated Member on the same date (exhibit 19).

She testified that she became aware of concerns from a Registered Nurse who had followed the shift worked by the Investigated Member, and she noted that there was excessive drug usage while the Investigated Member worked compared to other days. She reported the matter to RV, who conducted the investigation. She confirmed the evidence given by RV regarding the investigation, meeting with the Investigated Member, and the one-day suspension imposed, along with the decision to report the matter to the CLPNA. On March 8, 2018, the Investigated

Member's behavior resulted in her being sent home (exhibit 20). She testified about being notified of an issue on that date and attending at 4-South as a result of concerns communicated by Regina Dawe ("RD"). After attending at the hospital, she spoke with RD, Kimberley Ireland ("KI"), Brittany Klaassen ("BK") and Brittany Moulds ("BM"). RD told her that the Investigated Member was not able to keep her eyes open and was not oriented to time and place and was apparently suffering from dry mouth. RD stated that the Investigated Member had been sent home. She identified an email that was sent by RD with respect to these issues (exhibit 21). In speaking with her colleagues, she learned that BK noticed that there were drugs missing form the cart being used by the Investigated Member. She stated that the Investigated Member's blood sugar was tested given that she was known to be diabetic and that it was normal. She identified her notes in relation to these issues (exhibits 22 and 23). She stated that the Investigated Member could not remember what medications she had given to patients, and that it appeared that patients had been given incorrect medications by the Investigated Member.

KD reviewed records relating to the medication carts (exhibits 24-28) and testified that there were a number of errors, including records showing that morphine had been removed by the Investigated Member without corresponding documentation showing use. Her conclusion based on the review of the records was that the Investigated Member made many medication errors, that patients had been put at risk, and that she was unfit to practice based on the reported concerns by staff members and reflected by the errors. KD stated that she attempted multiple times to get in touch with the Investigated Member without success, and that she then received a letter of resignation from the Investigated Member, which was accepted on March 29, 2018 (exhibit 29).

<u>Kimberley Ireland ("KI")</u>

KI testified that she has been a Registered Nurse since 2015 and that she worked with the Investigated Member from 2015-2018 on the 4-South surgical unit. She stated that she worked the night shift on March 7, 2018, from 1900h to 0715h on March 8, 2018, and that the Investigated Member worked the same shift. She was on team 1 and the Investigated Member was on team 3, and that each team had 10 patients for two nurses. She and the Investigated Member were team leading and were responsible for administering medication from the carts. She stated that at approximately 0110h, the Investigated Member was giving out medications to team 2, which had been the responsibility of BK. She stated that the Investigated Member stated, "I don't know what I am doing". She stated that they reviewed the narcotics sheet and that the Investigated Member seemed a little "off". She stated that she then found another medication error and that the Investigated Member didn't want to talk about it. She told the Investigated Member that there were numerous medication errors, and that she was told that she either needed to get checked out in emergency, or she needed to go home. She states that the Investigated Member was quiet, had slurred speech and a distant demeanor. She called her son to pick her up. It appeared that she had been giving out medication however she wanted, and that there were multiple errors in timing, incorrect drugs and incorrect amounts ordered. The Investigated Member did not provide any answers when questioned about the errors. KI said that it was very alarming and very unsafe given the amount of errors found on one shift. She testified

that she called her manager to determine what should be done. She identified an email that she sent to KD about the matter (exhibit 30). She testified that she and the Investigated Member would have done a shift report together, and that she didn't notice anything was wrong until about 0100h.

Brittany Moulds ("BM")

BM testified that she has been a Registered Nurse since 2015 and that she worked with the Investigated Member on the 4-South surgical unit with the Investigated Member around twice each week. She was on the same shift with the Investigated Member on March 7-8, and that she was the charge nurse at the time. The Investigated Member was the team lead on team 3. She states that it was a busy night, that she went on her first break at 2400h, and that the Investigated Member went on her smoke break. She asked the Investigated Member if she was tired. She noted that after the break, the Investigated Member was on the team 2 medication cart, and when she asked about it the Investigated Member responded that she was "always on T2". Shortly thereafter, BK came to see her about the Investigated Member and that they consulted with KI about whether there was a blood sugar issue but that it was okay. BK advised her that the team 2 narcotics count was off and when they asked a patient whether she had received her pain medication, the patient responded by indicating that she had not received anything all night. She called the supervisor to inform her of what was going on. She testified about a patient who told her that a nurse (who was not her patient) had forced him to take some pills, and that the patient was allergic to Tylenol 3's. BM testified that the Investigated Member originally said that she would go to emergency, but then she refused to go so decided to go home. When the medical charts were reviewed, it was discovered that there was inaccurate charting, wrong dates, or an absence of charting. Her manager then requested that the nurses involved write everything down (exhibit 31). Her observation was that the Investigated Member could not answer questions about what happened and could barely keep her eyes open at the time. Finally, she identified an incorrect date of August 27, which should have been March 7, 2018 (exhibit 32).

Brittany Klaassen ("BK")

BK testified that she has been a Registered Nurse since 2015 and worked as a casual employee at the Queen Elizabeth II Hospital starting in 2016, and that she frequently worked with the Investigated Member on the 4-South surgical unit. She stated that she worked well with the Investigated Member and that she thought that she was a team player. She worked on the night shift on March 7-8 and was on team 2. Following the completion of her regular duties, she checked charts, and was asked by the Investigated Member to write an order from the OR because the Investigated Member could not remember it. After her break, she came back and realized that the Investigated Member was giving medication off of the wrong cart. She testified that she and others tried to confront the Investigated Member, that she was "not all there" and was not oriented to date and time. This included the fact that she was not recording times accurately on the patient records. She and others then investigated with patients to determine whether any medication had been distributed incorrectly; the Investigated Member did not participate and was just quiet. They decided to call the manager. She reviewed narcotics records

and indicated that the record showed that the recording was removed by the Investigated Member and that some of the entries had been crossed out and changed (exhibits 33 and 34). She also reviewed documentation which showed that hydromorphone had been administered, but that had not been ordered for the particular patient (exhibit 35). She and her coworkers had to check all of the patient charts given that medication had not been ordered or not given. BK followed-up with a patient who had been given medication that the patient was allergic to, although the symptoms resolved. She wrote down a summary of what occurred that night so that she would not forget what happened (exhibit 36). She noted that the entry on exhibit 32 (which had the date changed by the Investigated Member) related to morphine, and the actual record related to hydromorphone, which is much stronger than morphine. She testified that she met with management about the issue to discuss what had occurred.

The Hearing Tribunal acknowledges that some of the evidence presented is hearsay evidence. The Hearing Tribunal concludes that hearsay evidence can be admissible when it is determined the central issues have been established or where there is additional evidence to support the Allegations. All issues of guilt or innocence are considered on a balance of probabilities. The onus is on the Complaints Director to establish on a balance of probabilities the facts as alleged in the Statement of Allegations occurred and that it rises to the level of unprofessional conduct as defined in the HPA.

(6) Decision of the Hearing Tribunal and Reasons

In considering this matter, the Hearing Tribunal must first make factual findings as to whether the alleged conduct set out in the Statement of Allegations actually 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 Complaints Director bears the onus to establish that the allegations are factually proven and that the conduct is unprofessional as defined in the HPA.

Given that the nature of many allegations were similar, the Hearing Tribunal first considers the factual basis for the allegations, and then considers the issue related to unprofessional conduct together.

Allegation 1

> On or about July 19 and 20, 2017, used correction fluid to correct documentation errors on the Daily Narcotic and Controlled Drug Record.

The evidence of RV was clear that the entries in Exhibit 3 had been covered with correction fluid, and specifically with respect to the entry for July 19, 2017. She was clear that correction fluid had been used on the record and that this was improper given the nature of the document, and that the correct process was to cross-out an error and make it clear that the correction had been made. The evidence indicates that it is more likely than not that the Investigated Member was the person who applied the correction fluid. This allegation is factually proven.

Allegation 2

Failed to document on the Interprofessional Progress Notes the reason for administering Hydromorphone 2 mg SC to patient SL on one or more of the following occasions:

a. 2000 hours on July 19, 2017;

b. 2300 hours on July 19, 2017;

c. 0200 hours on July 20, 2017;

d. 0550 hours on July 20, 2017;

e. 2030 hours on July 20, 2017;

f. 0125 hours on July 21, 2017;

g. 0620 hours on July 21, 2017.

Allegation 3

Failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment after administering Hydromorphone 2 mg SC to patient SL on one or more of the following occasions:

a. 2030 hours on July 20, 2017;

b. 0125 hours on July 21, 2017;

c. 0620 hours on July 21, 2017.

The contents of exhibits 4 and 5 show that there were eight doses for the patient; seven of which were administered by the Investigated Member. RV testified that there was no documentation on the progress notes to justify the increased use of the medication, and that there were no records for the seven specific times set out in the allegations. The records are clear that there is no documentation relating to those dates and times. The evidence also demonstrates a failure to document a post-assessment in the PRN record after the doses were administered. There was no documentation to justify the need for increased pain medication during that time. Further, the failure to conduct the post assessment makes it impossible to monitor the impact of the medication, or to follow warning signs or potential issues in the records. There is no way to determine whether the medication (if it was needed) was helping with a legitimate need. The evidence is clear that there was a failure to document the administration of medication and follow-up on the dates and times set out in the allegations 2 and 3 for patient SL.

Allegation 4

Failed to document on the Interprofessional Progress Notes the reason for administering Morphine 10 mg SC to patient GM on one or more of the following occasions:

a. 2025 hours on July 20, 2017;

b. 0100 hours on July 21, 2017;

c. 0559 hours on July 21, 2017.

Allegation 5

On or about July 20, 2017, failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment after administering Morphine 10 mg SC to patient GM at 0559 hours.

Allegations 4 and 5 relate to similar conduct for another patient, GM (exhibits 6 and 7). It is clear that the medication was administered by the Investigated Member. There was a failure to document the need for pain medication in the progress notes, and a failure to conduct or document a post assessment. This creates the same problems with tracking the need for medication, any justification for the increased use, whether the medication assisted, and does not permit subsequent caregivers to understand the continuity of care. There was a failure by the Investigated Member to document the administration of medication and follow-up on the dates and times set out in allegations 4 and 5 for patient GM.

Allegation 6

On or about July 20, 2017, failed to document the administration and/or disposal of Tylenol #3 (acetaminophen 325 mg + codeine 15 mg) removed at 2200 hours for patient GM.

RV testified that the documents showed that the Investigated Member signed out two tablets of Tylenol 3 for GM (exhibit 3, page 6) and that she did not document the administration of the medication in any of the patient records (exhibits 6 and 7). She testified that there was no record of the disposal of that medication. As a result of the failure to document, it was impossible to know what happened to the medication that was signed-out by the Investigated Member. This creates uncertainty about what medication the patient actually received. This allegation is factually proven based on the evidence of RV and the records entered as exhibits in relation to patient GM.

Allegation 7

Failed to document on the Interprofessional Progress Notes the reason for administering Hydromorphone 2 mg SC to patient AY on one or more of the following occasions:

a. 2200 hours on July 19, 2017;

b. 0330 hours on July 20, 2017;

c. 0620 hours on July 20, 2017;

d. 2205 hours on July 20, 2017.

Allegation 8

Failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment after administering Hydromorphone 2 mg SC to patient AY on one or more of the following occasions:

a. 0620 hours on July 20, 2017;

b. 0215 hours on July 21, 2017;

c. 0542 hours on July 21, 2017.

Allegations 7 and 8 relate to patient AY, and they follow a similar pattern to the other allegations. The progress notes demonstrate a failure to document the need for the administration of increased hydromorphone, and a failure to document an assessment of the patient after the medication was administered (exhibits 8 and 9) on the dates and times identified. RV noted that there was no documentation at all in relation to these matters. KD testified that there was an expectation that there would have been at least one post-assessment documented in the patient records; here there were none done by the Investigated Member. The same concerns arise with respect to the need for medication, the impact of the medication, and the difficulties regarding the continuity of care for patient AY. The allegations with respect to patient AY have been proven.

Allegation 9

Failed to document on the Interprofessional Progress Notes the reason for administering Morphine 10 mg SC to patient LE on one or more of the following occasions:

a. 0200 hours on July 20, 2017;

b. 0630 hours on July 21, 2017.

Allegation 10

On or about July 20, 2017, failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment after administering Morphine 10 mg SC to patient LE at 0200 hours.

Allegations 9 and 10 relate to patient LE and give rise to similar concerns. The evidence of RV and exhibits 10 and 11 demonstrate a failure to document the reason for administering morphine to

LE and failed to document an assessment following the administration of that medication on the date identified in the progress notes. The allegations with respect to patient LE are proven.

Allegation 11

Failed to document on the Interprofessional Progress Notes the reason for administering Lorazepam 2 mg to patient BC on one or more of the following occasions:

a. 1930 hours on July 21, 2017;

b. 2230 hours on July 22, 2017;

c. 0045 hours on July 23, 2017;

d. 0650 hours on July 23, 2017;

e. 2157 hours on July 23, 2017;

f. 0050 hours on July 24, 2017.

Allegation 11 is also proven. The contents of exhibits 12-14, and the evidence of RV, demonstrate that the Investigated Member failed to properly document in the progress notes the administration of Lorazepam to patient BC. There was no justification in the records for the increase in the amount of Lorazepam during the time that the Investigated Member was involved in the administration of that medication. There was some documentation by the Investigated Member for certain doses, but out of the total of 10 occasions when the drug was administered, only three doses were justified through documentation. No documentation was created by the Investigated Member for the doses set out in allegation 11, and the Hearing Tribunal finds that the allegation is proven.

Allegation 12

On or between July 21, 2017 and July 24, 2017, failed to document the narcotic wastage on one or more of the following occasions:

a. Morphine 10 mg/1 ml removed at 2108 hours on July 21, 2017 for patient BC;

b. Morphine 10 mg/1 ml removed at 0056 [as amended] hours on July 22, 2017 for patient KW;

c. Morphine 10 mg/1 ml removed at 1938 hours on July 22, 2017 for patient BC;

d. Morphine 10 mg/1 ml removed at 2243 hours on July 22, 2017 for patient KW;

e. Morphine 10 mg/1 ml removed at 0044 hours on July 23, 2017 for patient BC;

f. Morphine 10 mg/1 ml removed at 1949 hours on July 23, 2017 for patient BC;

g. Morphine 10 mg/1 ml removed at 2201 hours on July 23, 2017 for patient KW;

h. Morphine 10 mg/1 ml removed at 0417 hours on July 24, 2017 for patient KW.

Exhibit 15 sets out the narcotics that had been removed by the Investigated Member, including the patient for whom the narcotics were to be used. RV identified eight occasions where the Investigated Member obtained more morphine for patients than had been prescribed for them, and that his would have necessitated the wastage of 5mg for each of these patients. RV testified that she had reviewed the patient orders and confirmed that they were less than the amounts taken by the Investigated Member. Further, the wastage report (exhibit 16) had a record of all wastages for the Investigated Member for the relevant time period, but there were no wastages recorded. This demonstrates a failure on the part of the Investigated Member to properly document wastages in accordance with the relevant policy (exhibit 17). The factual basis for this allegation has been proven.

Allegation 13

On or about March 7, 2018, failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment on one or more of the following occasions:

a. after administering Morphine 10 mg SC to patient TM at 2115 hours;

b. [withdrawn]

KD testified that on the PRN record (exhibit 28) it indicates that there was an administration of morphine, but that the Investigated Member failed to document an assessment after the administration. She stated that there should have been at least one post-administration assessment to demonstrate that the medication was, in fact, achieving the goal of pain management. The Investigated Member failed to document any post-administration assessment, and the allegation is factually proven.

Allegation 14

On or about March 7 and March 8, 2018, attended work while unfit to practice nursing as an LPN, particulars of which include one or more of the following:

a. Being disorientated and confused;

b. Being exhausted and unable to keep eyes open;

c. Having slurred speech.

The evidence in support of this allegation was offered by multiple witnesses who gave evidence at the hearing. KD, the unit manager, testified and referred to her contemporaneous complaint letter (exhibit 20), which states that the Investigated Member was unfit to work, was not able to keep her eyes open, and had slurred speech. She testified that she relied on statements from other staff members and a physician, who stated that the Investigated Member was "out of her mind". Her evidence, although hearsay, was reliable, based on identified evidence from others, and was consistent with the evidence from others (see eg exhibit 21). All the evidence from that timeframe was consistent relating to this issue. BM's evidence was that the Investigated Member was confused and disoriented at the time and that something was "off" about the Investigated Member. She identified multiple errors made by the Investigated Member. KI confirmed this evidence and addressed her notes (exhibit 23), which confirmed that the Investigated Member was tired and groggy. BK's evidence was consistent with these observations, and that the Investigated Member was not oriented to the date and time. BK's conclusion was that there were a number of errors made by the Investigated Member, that medication had been given to the wrong patients, and the documentation was not completed. KD believed, based on all of the information that she gathered, that the Investigated Member was not fit to practice and that she put patients at risk. The changes in the Investigated Member's behavior on that date were so pronounced that they checked her blood sugar, and that the normal reading indicated that this was not an explanation for the change in behavior. Finally, the evidence indicates that the Investigated Member was attempting to give out medication from the wrong medication cart.

The preponderance of the evidence from all of the witnesses, consistent with the documentation made at the time, establishes on a balance of probabilities that the Investigated Member attended work on March 7-8, 2018, when she was not fit to practice.

Allegation 15

> On or about March 7 and 8, 2018, attempted to administer medications to one or more patients without checking the Medication Administration Record.

The evidence on this point is clear: BK testified that she personally saw the Investigated Member attempt to administer medication on the medication cart that had been assigned to BK and that the Investigated Member did not check the corresponding MAR when she attempted to do so. This is consistent with BK's written account of these events (exhibit 36). This is a serious issue which put patients at risk, and the Hearing Tribunal finds that the allegation is proven.

Allegation 16

> On or about March 7 and 8, 2018, did one or more of the following with respect to patient JK:
>
> a. Documented the incorrect date of "2018-03-27" instead of March 7, 2018 when recording the administration of 7.5 mg of Morphine IV on the Parenteral Opioid Administration PRN Record;

b. Failed to document the administration and/or disposal of Hydromorphone 2 mg/ml inj, 2 ml removed at 0255 hours.

BK and BM both gave evidence about this matter and confirmed that the Investigated Member recorded the wrong date for the administration of the medication. Although there was uncertainty about what the date was, there was no doubt that it should have been March 7. In relation to allegation 16(b), the record made by the Investigated Member was unclear and that there was no documentation made by the Investigated Member about the administration or disposal of the hydromorphone (exhibit 32; see also exhibits 34-35). They testified about why it is important that documentation relating to medication is accurate. The factual basis for this allegation has been proven.

Allegation 17

On or about March 7 and 8, 2018, did one or more of the following with respect to patient SA:

a. Failed to document the administration and/or disposal of Morphine SR 30 mg cap removed at 1940 hours;

b. [withdrawn].

Similarly, the evidence is clear that the Investigated Member failed to appropriately document the administration and disposal of morphine for patient SA. KD testified that she reviewed the narcotics records relating to that patient (exhibit 25) and that it demonstrated that the Investigated Member removed the drug, but that the MAR for the patient does not reflect that it was administered (or wasted). This was a concern because it was not possible to conclude whether the drug had actually been received by the patient. The factual basis for this allegation has been proven.

Unprofessional Conduct

Having concluded that the factual basis for each of the allegations have been proven on a balance of probabilities, the Hearing Tribunal turns to consider whether the proven conduct amounts to unprofessional conduct as set out in the HPA.

The relevant provisions for the purposes of the Hearing Tribunal's consideration here are set out in section 1(1)(pp) of the HPA:

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.

In relation to the allegations relating to the failure to document and record the administration or disposal of medication, including the failure to document post-administration assessment and wastage, the failure to document the need for increased medication, and the use of corrective fluid (allegations 1-13, 16-17), these all relate to similar concerns.

Documentation, particularly in relation to medication, is one of the central, essential tasks for Licensed Practical Nurses. This is central to patient care and is a fundamental aspect of ethical nursing practice. Without appropriate documentation, it was not possible for other caregivers to understand the need for medication (or increased medication), the impact of the medication, or whether there were underlying issues that were not being addressed. A failure to document creates risks to patients and to the institution providing care.

The Hearing Tribunal also notes that the medication at issue relates largely to narcotics, and it is particularly important to ensure that such medication is accurately tracked to avoid overdoses and protects against diversion of such medication. It is well-known to all Licensed Practical Nurses that the documentation of narcotics is particularly important.

The failures by the Investigated Member to properly document patient care reflects a lack of knowledge, skill or judgment in the provision of nursing services. This is not a situation were a typo or slip is excusable or is explained by a particular circumstance. The nature of the deficient record-keeping deals with a core function of a Licensed Practical Nurse and relates to circumstances involving controlled drugs with serious consequences for patient care. This is also conduct that harms the integrity of the profession; if coworkers, patients, and members of the public are not able to trust that Licensed Practical Nurses will accurately, carefully and diligently record the use of narcotics, the profession's reputation and integrity will be significantly harmed.

The Hearing Tribunal also finds that the proven conduct represents breaches of the following sections of the *Code of Ethics for Licensed Practical Nurses in Canada* ("Code of Ethics"):

> 1.5 Provide care directed toward the health and well-being of the person, family, and community.
>
> 2.9 Identify and minimize risks to clients.
>
> 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.

The conduct of the Investigated Member does not reflect practice that was directed towards the health and wellbeing of the patients, nor that minimized risks to clients. On the contrary, her failure to document matters relating to the administration of narcotics was a serious breach of these obligations and presented real risks to patient safety for the reasons set out above. Her conduct was not consistent with the privilege and responsibility of self-regulation.

Further, the Hearing Tribunal finds that the proven conduct represents breaches of the following *Standards of Practice for Licensed Practical Nurses in Canada* ("Standards"):

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 [see also 4.1.].

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

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

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

The evidence was clear that the Investigated Member had policies with respect to documentation that were not followed by her regarding medication administration. Further, for the reasons set out above, the Investigated Member's actions put patients at risk. There was a clear and repeated lack of appropriate documentation, and this had a negative impact on the communication of important patient information to co-workers involved in patient care. For the reasons set out above, the Investigated Member's practice was not consistent with the Code of Ethics. These breaches are not trivial or inconsequential.

For all of those reasons, the Hearing Tribunal is satisfied that the Investigated Member's conduct, set out in allegations 1-13 and 16-17, are unprofessional conduct as defined in the HPA.

In relation to allegation 14, the evidence overwhelmingly suggests that the Investigated Member was unfit to practice nursing on March 7-8, 2018. Regardless of the specific reason for the lack of fitness to practice, it is clear that the Investigated Member's state of mind created risks to patient safety. She was not able to effectively communicate, record information, or understand what her assigned tasks were. She was confused about which team she was on and purported to use a medication cart not assigned to her. The evidence from the witnesses working that day is clear that her unfitness to practice resulted in multiple errors in records, the administration of medication to patients in error, and that the problems caused by the Investigated Member took her colleagues several hours to resolve. Simply stated, practicing while unfit puts patients at risk and is unprofessional conduct.

As a regulated professional, each Licensed Practical Nurse has a positive obligation to ensure that he or she is fit and able to competently practice; a failure to do so (as reflected by the proven facts in this case) reflects both a lack of knowledge, skill or judgment, and represents conduct that harms the integrity of the profession.

The Hearing Tribunal also finds that the proven conduct represents breaches of the following sections of the Code of Ethics:

1.1 Maintain standards of practice, professional competence and conduct.

2.9 Identify and minimize risks to clients.

3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.

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

5.2 Recognize their capabilities and limitations and perform only the nursing functions that fall within their scope of practice and for which they possess the required knowledge, skills and judgement.

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

5.8 Maintain the required mental and physical wellness to meet the responsibilities of their role.

The Investigated Member failed to maintain professional conduct during the March 7-8 shift, and she failed to minimize risks to clients. Her conduct on that day was not consistent with the privilege of self-regulation and she did not maintain the required mental wellness necessary to discharge her responsibilities. The evidence indicates that her misconduct could not be explained by a blood sugar issue, and the Hearing Tribunal agrees that it is not necessary for the Complaints Director to lead evidence demonstrating the specific cause of the unfitness to practice. The fact of the unfitness, the corresponding errors, risks to patient safety, and the impact on the integrity of the profession leaves the Hearing Tribunal with no doubt that the Investigated Member's conduct was unprofessional as contemplated in the HPA. This is a serious matter which could have had tragic consequences.

Further, the Hearing Tribunal finds that the proven conduct represents breaches of the following Standards:

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

1.4. Recognize their own practice limitations and consult as necessary.

1.5. Identify and report any circumstances that potentially impede professional, ethical or legal practice.

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.

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

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

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

It is not necessary to repeat the findings set out above in relation to the Standards. Several of them relate to compliance with the Code of Ethics, and others deal with fitness to practice and a member's responsibilities to patients/clients for safe and competent practice. The Investigated Member's conduct was materially inconsistent with the above-noted sections of the Standards, and therefore amount to unprofessional conduct.

Similarly, the Investigated Member's proven conduct set out in allegation 15 is unprofessional conduct. The Member administered medication with the MAR, which represents a significant departure from acceptable conduct. It reflects a lack of knowledge, skill or judgment, particularly given the importance of the MAR in ensuring that medication is appropriately administered. It was fundamentally impossible for the Investigated Member to know whether or not she was administering the right medication to the right patients, in the right dosage and at the right time. The serious and well-known patient risk that arise from such conduct make this a core function of a Licensed Practice Nurse, and a failure to abide by this requirement is conduct that harms the integrity of the profession.

The Investigated Member's conduct is also inconsistent with the following sections of both the Code of Ethics and the Standards:

Code of Ethics:

1.1 Maintain standards of practice, professional competence and conduct.

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

2.8 Use evidence and judgement to guide nursing decisions.

2.9 Identify and minimize risks to clients.

3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.

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

Standards

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.

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

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

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

For all of those reasons, the Hearing Tribunal finds that the proven conduct in each of the allegations amounts to unprofessional conduct as defined in s. 1(1)(pp) of the HPA. The breaches of the Code of Ethics and Standards are sufficiently serious to constitute unprofessional conduct.

The Hearing Tribunal therefore makes findings of unprofessional conduct for all of the allegations against the Investigated Member.

SANCTION

Having made the determinations noted above, the Hearing Tribunal invited written submissions from Legal Counsel for the Complaints Director in relation to appropriate orders arising under section 82 of the HPA. Written submissions were received from Legal Counsel for the Complaints Director, but not from the Investigated Member given her failure or refusal to participate in the hearing. Legal Counsel indicated that the Complaints Director sought the following orders:

a) Ms. Beaulieu shall pay 50% of the costs of the investigation and hearing to be paid over a period of 24 months from service of the Hearing Tribunal's written decision (the "Decision").

b) Ms. Beaulieu shall receive a reprimand with the Decision serving as the reprimand.

c) Ms. Beaulieu's practice permit will remain suspended and she shall not be eligible to apply for reinstatement of her practice permit until she complies with the following requirements:

i. Ms. Beaulieu shall undergo, at her own cost, a Fitness to Work Assessment & Substance Abuse Assessment (Combined) provided by Homewood Health Inc., subject to the following terms and conditions:

i. The assessor will be provided with a copy of the Decision;

ii. The assessor will conduct an assessment to determine whether Ms. Beaulieu is currently fit to practice as an LPN;

iii. The assessor will indicate whether they are making any recommendations for ongoing counselling or treatment and, if ongoing counselling or treatment is recommended, Ms. Beaulieu shall complete the ongoing counselling or treatment in its entirety;

iv. An assessment report will be provided to Ms. Beaulieu and to the Complaints Director and it shall validate that Ms. Beaulieu is fit to practice according to CLPNA's Interpretive Document: Incapacity pursuant to the HPA.

ii. Ms. Beaulieu shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance". Ms. Beaulieu shall provide a signed written declaration to the Complaints Director attesting she has reviewed CLPNA's documents:

i. Code of Ethics for Licensed Practical Nurses in Canada;
ii. Standards of Practice for Licensed Practical Nurses in Canada;
iii. CLPNA Practice Policy: Professional Responsibility & Accountability;
iv. CLPNA Practice Policy: Documentation;
v. CLPNA Practice Guideline: Medication Management; and
vi. CLPNA's Interpretive Document: Incapacity Under the HPA.

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

iii. Ms. Beaulieu shall complete the following remedial education and provide the Complaints Director with a certificate confirming successful completion of each of the following courses:

i. Health Assessment Self-Study Course, available online at https://studywithclpna.com/healthassessment/;

ii. Nursing Documentation 101, available online at https://studywithclpna.com/nursingdocumentation101/ ;

iii. LPN Ethics Course, available online at http://www.learninglpn.ca/index.php/courses.

If a course becomes unavailable, Ms. Beaulieu shall request in writing to be assigned an alternative course. The Complaints Director shall, in her sole discretion, reassign a course. Ms. Beaulieu will be notified by the Complaints Director, in writing, advising of the new course required.

d) The orders set out above at paragraphs a) and c) will appear as conditions on Ms. Beaulieu's practice permit and the Public Registry subject to the following:

i. The requirement to complete the remedial education and readings/reflection paper will appear as "CLPNA Monitoring Orders (Conduct)" on Ms. Beaulieu's practice permit and the Public Registry until the following sanctions have been satisfactorily completed:

i. CLPNA Reading
ii. Health Assessment Self-Study Course
iii. Nursing Documentation 101
iv. LPN Ethics Course

ii. The requirement to pay costs will appear as "Conduct Cost/Fines" on Ms. Beaulieu's practice permit and the Public Registry until all costs have been paid as set out above at paragraph a).

iii. The conditions on Ms. Beaulieu's practice permit and on the Public Registry will be removed upon completion of each of the requirements.

In considering the proposed sanction, the Hearing Tribunal considers the primary need to protect the public, the maintenance of public confidence in the nursing profession, the principles of proportionality, and both general and specific deterrence. The Hearing Tribunal agrees with Legal Counsel for the Complaints Director that the decision in *Jaswal v. Newfoundland (Medical Board)*, 1996 CanLII 11630 provides a useful framework for the Hearing Tribunal to consider the proposed sanctions in professional regulatory context. The Hearing Tribunal therefore considers the following:

The nature and gravity of the proven allegations: This factor indicates that a more serious penalty is required given the very serious nature of the unprofessional conduct at issue. As noted above, documentation is a central part of the practice of nursing, and failures to abide by professional standards in relation to documentation, particularly having regard to the

administration of medication, can result in devastating consequences. The medications at issue involved narcotics, and the potential for adverse effects, overdose and allergic reactions was significant. Further, in relation to finding 14, nurses must ensure that they are fit and able to practice at all times, and the failure by the Investigated Member to do so is also serious.

The age and experience of the Member: The evidence indicates that the Investigated Member was in her mid-40s at the relevant time and was an experienced member of the profession. The facts here do not indicate that the unprofessional conduct could be explained through immaturity due to age or a lack of on-the-job experience. The Investigated Member had at least 14 years of experience at the relevant time, and ought to have known that her conduct was serious and that it created significant risks for patients. This factor tends towards a more serious sanction.

Prior complaints or convictions: There is no evidence of any prior complaints or findings of unprofessional conduct, and this is a mitigating factor. There is no evidence that the Investigated Member engaged in similar conduct in the past, or that this was a more recent incident of previous failures to abide by applicable standards for documentation or fitness for practice.

Vulnerability of the affected patients: Other than establishing that the unit upon which the Investigated Member worked was for surgical patients, no evidence was led about any particular vulnerability of patients. However, the Hearing Tribunal agrees that all in-patients in a hospital setting are somewhat vulnerable to the care provided by doctors and nurses, and that a high standard (as reflected in the Standards and Code) must apply given that vulnerability. This is a mildly aggravating factor.

The number of times the offence occurred: The proven allegations here relate to conduct that occurred over two short time periods, but that involved a number of discrete errors which were established as unprofessional conduct. The Hearing Tribunal finds that this is a largely neutral factor, although it accepts that the Investigated Member ought to have learned from the July 2017 experiences and ought to have taken steps to prevent similar occurrences thereafter.

Acknowledgment by the Member: There was no acknowledgement here and the Investigated Member did not participate in the hearing. The Hearing Tribunal does not treat this as an aggravating factor in this case.

Other consequences: The evidence on this issue is limited to the fact that the Investigated Member had imposed upon her a one-day suspension arising from the 2017 misconduct. The Complaints Director acknowledged in written submissions that the Investigated Member has also been subject to an interim suspension since March 8, 2018, as a result of these matters. The Hearing Tribunal considers this factor as a mitigating factor insofar as the Investigated Member has been unable to practice nursing for more than three years. It is an important factor in the Hearing Tribunal's ultimate decision that any further suspension will be pending the successful accomplishment of orders that are focused on rehabilitation and ensuring public safety prior to the Investigated Member being able to practice in the future.

Impact of the incidents on patients: The Complaints Director led no evidence about adverse impacts on the affected patients. However, the absence of evidence about negative impacts does not significantly mitigate the sanctions here. The nature of the unprofessional conduct could very easily have led to significant, and potentially devastating, impacts on patients given the medication issues and lack of documentation. The Investigated Member ought not to receive a benefit from the fact that no adverse consequence happened to follow from the misconduct.

Deterrence and Public Confidence: The Hearing Tribunal finds that there are significant factors in this case. First, the Investigated Member must clearly understand that similar conduct will not be tolerated, and the sanctions proposed are sufficiently serious to communicate this to the Investigated Member. Further, the sanctions will communicate to the members in general that similar conduct by others will not be tolerated, and will result in similar consequences, including costs and further education. Public confidence will be maintained because the proposed sanctions focus on ensuring that the Investigated Member is not put in a position where similar conduct could occur until the Investigated Member undergoes remedial work, refamiliarizes herself with the applicable standards and is able to practice without risks relating to fitness. The proposed sanctions accomplish these objectives, while contemplating that the Investigated Member is able to eventually return to safe practice.

Degree to which the misconduct fell outside the range of permitted conduct: For the reasons already articulated, the conduct at issue here fell markedly outside of the range of permitted conduct. The centrality of documentation, particularly relating to medication matters, and the Member's failure to abide by applicable standards are significant.

Similar cases: While Legal Counsel for the Complaints Director provided a case for consideration, the Hearing Tribunal notes that there was no specific evidence here about any personal use of the medication that was inappropriately documented or administered. This is a significant difference. However, the fitness to practice finding in this case warrants the imposition of sanctions which ensure that the Investigated Member is fully fit to practice prior to the lifting of the suspension.

The Hearing Tribunal carefully considered the seriousness of the misconduct and whether or not cancellation of registration was required for the purposes of the protection of the public and deterrence, but ultimately concluded that the existing three-year suspension, coupled with the reprimand, the fitness assessment and the documentation review accomplish the objectives of sentencing here. The reprimand denounces the misconduct and the fitness assessment ensures the protection of the public. Further, the requirement that the Investigated Member pay 50 percent of the costs of the investigation and hearing ensures that she is required to accept a significant financial responsibility for her misconduct while not creating an insurmountable burden; the time period within which she must pay the amount provides some assurance that payment will not be crippling for the Investigated Member.

For all of those reasons, the Hearing Tribunal finds that the proposed sanctions accomplish all of the objectives set out above, and it hereby imposes the orders set out on pages 20-21 pursuant to section 82 of the HPA. The Hearing Tribunal directs the Hearings Director to provide a copy of this decision to the Investigated Member.

DATED THE 24th of JUNE 2021 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Marg Hayne, Public Member
Chair, Hearing Tribunal

Schedule "A": Statement of Allegations

"It is alleged that REBECCA BEAULIEU, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about July 19 and 20, 2017, used correction fluid to correct documentation errors on the Daily Narcotic and Controlled Drug Record.

2. Failed to document on the Interprofessional Progress Notes the reason for administering Hydromorphone 2 mg SC to patient SL on one or more of the following occasions:

    a. 2000 hours on July 19, 2017;

    b. 2300 hours on July 19, 2017;

    c. 0200 hours on July 20, 2017;

    d. 0550 hours on July 20, 2017;

    e. 2030 hours on July 20, 2017;

    f. 0125 hours on July 21, 2017;

    g. 0620 hours on July 21, 2017.

3. Failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment after administering Hydromorphone 2 mg SC to patient SL on one or more of the following occasions:

    a. 2030 hours on July 20, 2017;

    b. 0125 hours on July 21, 2017;

    c. 0620 hours on July 21, 2017.

4. Failed to document on the Interprofessional Progress Notes the reason for administering Morphine 10 mg SC to patient GM on one or more of the following occasions:

    a. 2025 hours on July 20, 2017;

    b. 0100 hours on July 21, 2017;

    c. 0559 hours on July 21, 2017.

5. On or about July 20, 2017, failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment after administering Morphine 10 mg SC to patient GM at 0559 hours.

6. On or about July 20, 2017, failed to document the administration and/or disposal of Tylenol #3 (acetaminophen 325 mg + codeine 15 mg) removed at 2200 hours for patient GM.

7. Failed to document on the Interprofessional Progress Notes the reason for administering Hydromorphone 2 mg SC to patient AY on one or more of the following occasions:

    a. 2200 hours on July 19, 2017;

    b. 0330 hours on July 20, 2017;

    c. 0620 hours on July 20, 2017;

    d. 2205 hours on July 20, 2017.

8. Failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment after administering Hydromorphone 2 mg SC to patient AY on one or more of the following occasions:

    a. 0620 hours on July 20, 2017;

    b. 0215 hours on July 21, 2017;

    c. 0542 hours on July 21, 2017.

9. Failed to document on the Interprofessional Progress Notes the reason for administering Morphine 10 mg SC to patient LE on one or more of the following occasions:

    a. 0200 hours on July 20, 2017;

    b. 0630 hours on July 21, 2017.

10. On or about July 20, 2017, failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment after administering Morphine 10 mg SC to patient LE at 0200 hours.

11. Failed to document on the Interprofessional Progress Notes the reason for administering Lorazepam 2 mg to patient BC on one or more of the following occasions:

    a. 1930 hours on July 21, 2017;

    b. 2230 hours on July 22, 2017;

    c. 0045 hours on July 23, 2017;

    d. 0650 hours on July 23, 2017;

    e. 2157 hours on July 23, 2017;

    f. 0050 hours on July 24, 2017.

12. On or between July 21, 2017 and July 24, 2017, failed to document the narcotic wastage on one or more of the following occasions:

    a. Morphine 10 mg/1 ml removed at 2108 hours on July 21, 2017 for patient BC;

    b. Morphine 10 mg/1 ml removed at 0036 hours on July 22, 2017 for patient KW;

c. Morphine 10 mg/1 ml removed at 1938 hours on July 22, 2017 for patient BC;

d. Morphine 10 mg/1 ml removed at 2243 hours on July 22, 2017 for patient KW;

e. Morphine 10 mg/1 ml removed at 0044 hours on July 23, 2017 for patient BC;

f. Morphine 10 mg/1 ml removed at 1949 hours on July 23, 2017 for patient BC;

g. Morphine 10 mg/1 ml removed at 2201 hours on July 23, 2017 for patient KW;

h. Morphine 10 mg/1 ml removed at 0417 hours on July 24, 2017 for patient KW.

13. On or about March 7, 2018, failed to conduct and/or document on the Parenteral Opioid Administration – PRN Record any post assessment on one or more of the following occasions:

    a. after administering Morphine 10 mg SC to patient TM at 2115 hours;

    b. [withdrawn].

14. On or about March 7 and March 8, 2018, attended work while unfit to practice nursing as an LPN, particulars of which include one or more of the following:

    a. Being disorientated and confused;

    b. Being exhausted and unable to keep eyes open;

    c. Having slurred speech.

15. On or about March 7 and 8, 2018, attempted to administer medications to one or more patients without checking the Medication Administration Record.

16. On or about March 7 and 8, 2018, did one or more of the following with respect to patient JK:

    a. Documented the incorrect date of “2018-03-27” instead of March 7, 2018 when recording the administration of 7.5 mg of Morphine IV on the Parenteral Opioid Administration PRN Record;

    b. [withdrawn].

17. On or about March 7 and 8, 2018, did one or more of the following with respect to patient SA:

    a. Failed to document the administration and/or disposal of Morphine SR 30 mg cap removed at 1940 hours;

Failed to document the administration and/or disposal of Morphine 5 mg tab removed at 2315 hours.”

Schedule “B”: List of Exhibits

Exhibit 1 – Statement of Allegations
Exhibit 2 – Affidavit of Bonnie McEwen, sworn, September 10, 2020
Exhibit 3 - Daily Narcotic and Controlled Drug Record, 4 South, July 19-20, 2017
Exhibit 4 - Parenteral Opioid Administration PRN Record (SOL), July 19-21, 2017
Exhibit 5 - Inter-Professional Progress Notes, July 17-20, 2017
Exhibit 6 - Parenteral Opioid Administration PRN Record (GFM), July 20, 2017; Non-Recurring PRN MR, July 20-21, 2017 and MAR, July 20-21, 2017
Exhibit 7 - Inter-Professional Progress Notes (GFM), July 20-22, 2017 and Surgical Inpatient Assessment, July 20-23, 2017
Exhibit 8 - Parenteral Opioid Administration PRN Record (AJY), July 15-21, 2017
Exhibit 9 - Inter-Professional Progress Notes (AJY) July 19-20, 2017
Exhibit 10 - Admission, Ambulatory Patient Care Record and Emergency Nursing Parameter Record (BMC), July 20-21, 2017
Exhibit 11 - Parenteral Opiod Administration PRN Record and MAR (LEE), July 20-21, 2017
Exhibit 12 - Non-Recurring PRN Medication Record (BMC) July 21-24, 2017
Exhibit 13 - Emergency Room Nursing Parameter Record, Inter-Professional Progress Notes, Physician's Orders (BMC), July 20-26, 2017
Exhibit 14 - Physician Order Set - Alcohol Withdrawal Protocol and CIWA (BMC), July 21-25, 2017
Exhibit 15 - PYXIS Report, All Station Events, User Rebecca Beaulieu, June 27 - July 26, 2017
Exhibit 16 - PYXIS Report, Returns and Waste, User Rebecca Beaulieu, July 3 - August 2, 2017
Exhibit 17 - Policy, Peace Country Health, Narcotics Administration and Control, February 11, 2003
Exhibit 18 - Letter from K. Dirom to S. Davis, August 16, 2017
Exhibit 19 - Letter of Suspension from R. Van Herk-Auger to K. Palyga, August 16, 2017
Exhibit 20 - Letter from K. Dirom to S. Davis, March 8, 2018
Exhibit 21 - Email from R. Dawe to K. Dirom, March 8, 2018
Exhibit 22 - Handwritten Notes of B. Elden, K. Dirom, undated
Exhibit 23 - Handwritten Notes of K. Ireland to K. Dirom, March 8, 2018
Exhibit 24 - Handwritten Notes of K. Dirom, undated
Exhibit 25 - Daily Narcotic and Controlled Drug Record, 4 South #3, March 7, 2018
Exhibit 26 - Medication Administration Record (SA), February - March, 2018
Exhibit 27 - Non-Recurring PRN Medication Record (SA), March 5-7, 2018
Exhibit 28 - Parenteral Opiod Administration PRN Record (TM), March 7, 2018
Exhibit 29 - Letter from K. Dirom to R. Beaulieu, March 29, 2018
Exhibit 30 - Email from K. Ireland to K. Dirom, March 8, 2018
Exhibit 31 - Emails from B. Elden to K. Dirom, March 8, 2018
Exhibit 32 - Parenteral Opioid Administration PRN Record, (JK), March 7, 2018
Exhibit 33 - Daily Narcotic and Controlled Drug Record, 4 South #2, March 7, 2018
Exhibit 34 - Non-Recurring PRN Medication Record (JK), March 7, 2018
Exhibit 35 - Medication Administration Record (JK), March, 2018
Exhibit 36 - Handwritten Notes of B. Klaassen, April 5, 2018