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 RHONDA MELNYK

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 RHONDA MELNYK, LPN #24117, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Videoconference on July 14, 2021 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Jennifer Martin, LPN
Nancy Brook, Public Member
Anita Warnick, Public Member

Staff:
Jason Kully, Legal Counsel for the Complaints Officer, CLPNA
Susan Blatz, Complaints Officer, CLPNA

Investigated Member:
Rhonda Melnyk, LPN ("Ms. Melnyk" or "Investigated Member")
Kathie Milne, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Melnyk was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Melnyk was initially licensed as an LPN in Alberta on October 10, 1997.

The CLPNA received a complaint dated November 3, 2020 (the "Complaint") from Christie Schmelzle, Care Manager for Athabasca and Boyle Healthcare Centres, pursuant to s. 57 of the Act. The Complaint advised Ms. Melnyk, LPN, had been suspended from her employment at the Boyle Healthcare Centre ("BHC") for concerns related to documenting and administering narcotics.

By way of letter dated November 6, 2020, the Director of Professional Conduct/Complaints Director of the CLPNA, Sandy Davis ("Complaints Director"), provided Ms. Melnyk with notice of the Complaint and notified Ms. Melnyk that she was delegating her powers under Part 4 of the Act to Kevin Oudith, Complaints Officer (the "Complaints Officer") pursuant to s. 20 of the Act. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Ms. Melnyk that she had appointed Katie Emter, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint. Additionally, the Complaints Director informed Ms. Melnyk that due to the nature of the alleged conduct, she was recommending to Jeanne Weis, Chief Executive Officer for the CLPNA, that Ms. Melnyk's practice permit be immediately suspended under s. 65(1)(b) of the Act.

The Complaints Director requested that Ms. Weis impose an immediate suspension of Ms. Melnyk's practice permit under s. 65(1)(b) of the Act by letter on November 6, 2020. Ms. Melnyk received a copy of this letter and its corresponding attachments.

By letter dated November 16, 2020, Ms. Weis declined the request for an interim suspension of Ms. Melnyk's practice permit. Instead, Ms. Weis imposed a condition on Ms. Melnyk's practice permit requiring her to practice under supervision of one regulated care provider when receiving and transcribing medication orders and when administering narcotics and notified Ms. Melnyk accordingly.

On February 22, 2021, the Investigator concluded the investigation into the Complaint.

The Complaints Officer determined there was sufficient evidence that the issues raised in the Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Melnyk received notice the matters were referred to a hearing, as well as a copy of the Statement of Allegations and the Investigation Report, on April 14, 2021.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Melnyk under cover of letter dated May 27, 2021.

(4) Allegations

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

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

1. On or about July 10, 2020 did one or more of the following with regards to client PB:

    a) Failed to document on the Multidisciplinary Notes the reason for the administration of Codeine 60 mg at 0800 hours and 1200 hours;

    b) Failed to document on the MAR or Multidisciplinary Notes the reason for the removal of Codeine 60 mg removed at 1600 hours;

    c) Failed to document on the Multidisciplinary Notes the effectiveness of the Codeine 60 mg administered at 0800 hours, 1200 hours and 1600 hours;

    d) Documented on the MAR the administration of Hydromorphone 2 mg at 0800 hours but failed to document the removal of Hydromorphone 2 mg on the Narcotic and Controlled Drug Administration Record.

2. On or about July 12, 2020 did one or more of the following with regards to client AS:

    a) Failed to properly transcribe a verbal physician's order on the Ambulatory Client Care Record for one tablet of Tylenol #3 to go;

    b) Removed 12 tablets of Tylenol #3 to go without a physician's order;

    c) Failed to document on the Ambulatory Client Care Record or Emergency Department Nursing Assessment and Treatment Record the reason for the removal of 12 tablets of Tylenol #3.

3. On or about August 2, 2020 did one or more of the following with regards to client DP:

    a) Failed to properly transcribe a verbal physician's order on the Ambulatory Client Care Record for two tablets of Percocet now and two tablets of Percocet to go;

    b) Removed 14 tablets of Percocet at 0300 hours without a physician's order;

    c) Failed to document on the Ambulatory Client Care Record or Emergency Department Nursing Assessment and Treatment Record the reason for the removal of 14 tablets of Percocet.

4. On or about July 10, 2020 did one or more of the following with regards to client PS:

    a) Removed 2 tablets of Tylenol #3 at 0800 hours without a physician's order;

    b) Failed to document on the MAR or Multidisciplinary Notes the reason for the removal of 2 tablets of Tylenol #3 at 0800 hours;

    c) Failed to document on the Multidisciplinary Notes the reason for the administration of Tylenol extra strength at 0800 hours and 1200 hours.

5. On or about April 14, 2020 documented on client DS' MAR the administration of Oxycodone 20 mg at 0800 hours but failed to document the removal of Oxycodone 20 mg on the Narcotic and Controlled Drug Administration Record.

6. On or about July 31, 2020 did one or more of the following with regards to client CC:

    a) Documented the removal of Hydromorphone 2mg tablet at 2100 hours but documented on the MAR the administration of PRN Hydromorphone 1 mg tablet at 2100 hours;

    b) Failed to document on the Multidisciplinary Notes the reason for the removal of Hydromorphone 2 mg tablet at 2100 hours;

    c) Documented on the MAR the administration of Hydromorphone 1 mg tablet at 2359 but failed to document the removal of Hydromorphone 1 mg tablet on the Narcotic and Controlled Drug Administration Record at 2359 hours.

7. On or about August 1, 2020 did one or more of the following with regards to client CC:

    a) Documented the removal of Hydromorphone 2 mg tablet at 0600 hours but documented on the MAR the administration of Hydromorphone 1 mg tablet at 0600 hours;

    b) Removed Hydromorphone 2 mg tablet at 2000 hours for PRN administration without a physician's order;

    c) Failed to document on the MAR or Multidisciplinary Notes the reason for the removal of Hydromorphone 2 mg tablets at 2000 hours;

    d) [Withdrawn].

(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. Melnyk 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 Officer 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: 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. Melnyk'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. Melnyk.

Allegation 1

Ms. Melnyk admitted that on or about July 10, 2020, she did one or more of the following with regards to client PB:

a) Failed to document on the Multidisciplinary Notes the reason for the administration of Codeine 60 mg at 0800 hours and 1200 hours;

b) Failed to document on the MAR or Multidisciplinary Notes the reason for the removal of Codeine 60 mg removed at 1600 hours;

c) Failed to document on the Multidisciplinary Notes the effectiveness of the Codeine 60 mg administered at 0800 hours, 1200 hours and 1600 hours;

d) Documented on the MAR the administration of Hydromorphone 2 mg at 0800 hours but failed to document the removal of Hydromorphone 2 mg on the Narcotic and Controlled Drug Administration Record.

Client PB was ordered to receive Codeine 60mg as needed (PRN) in the form of four 15mg tablets.

When a PRN medication is administered, health professionals are required to include a pain assessment describing the reason for administering the medication. Another pain assessment should be completed in the next 30 to 60 minutes to assess the effectiveness of the PRN medication.

On July 10, 2020, Ms. Melnyk documented the removal of Codeine 60mg (4 tabs) for PB on the Narcotic and Controlled Drug Administration Record at 0800 hours, 1200 hours, and 1600 hours.

Ms. Melnyk did not document on the Multidisciplinary Notes a pain assessment or any reason for the administration of Codeine 60mg at 0800 hours and 1200 hours.

Ms. Melnyk also failed to document on the MAR or the Multidisciplinary notes the reason for removing Codeine 60mg for PB at 1600 hours.

Ms. Melnyk did not document any assessment of the effectiveness of the Codeine 60mg administered to PB at 0800 hours, 1200 hours, or 1600 hours.

Ms. Melnyk also documented on PB's MAR the administration of Hydromorphone 2mg at 0800 hours. However, Ms. Melnyk did not document the removal of Hydromorphone 2mg on the Narcotic and Controlled Drug Administration Record.

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

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

Ms. Melnyk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services. Ms. Melnyk did not adhere to what is expected of an LPN. It is expected that LPNs have the knowledge of what is expected when it comes to medication administration and documentation.

Ms. Melnyk's conduct harms the integrity of the regulated profession in that Ms. Melnyk did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to understand which documentation is expected of them with regards to clients who are receiving medications and that such would be properly documented as medication administration and documentation are core competencies of an LPN. When LPNs do not

document the appropriate reactions with respect to medication administration it could have an effect on the care which the client receives, as it is not known by the other health care providers who are providing care to the client of what the outcome to administering the medication was.

Ms. Melnyk did not abide by the provisions of the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Melnyk in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as set out below. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice in that it created a situation of risk for a client under her care, did not make information available to the whole health care team on which to make evidence-based decisions, and did not demonstrate the competence expected of an LPN. Ms. Melnyk breached both the CLPNA Code of Ethics and the CLPNA Standards of Practice by failing to adhere to the physician's order as well as failing to follow the "Rights of Medication Administration".

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics ("CLPNA Code of Ethics") and CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice"):

CLPNA Code of Ethics:

Principle 1: Responsibility to the Public – LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically states 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 states that LPNs:

- 2.9 Identify and minimize risks to clients.

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 states 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.

Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 specifically provides that LPNs:

- 5.1 Demonstrate honesty, integrity and trustworthiness in all interactions.

- 5. 3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.

CLPNA Standards of Practice:

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

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

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

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

- 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.

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

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

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

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

- 4.9 Support and contribute to healthy and positive practice environments.

Allegation 2

Ms. Melnyk admitted that on or about July 12, 2020, she did one or more of the following with regards to client AS:

a) Failed to properly transcribe a verbal physician's order on the Ambulatory Client Care Record for one tablet of Tylenol #3 to go;

b) Removed 12 tablets of Tylenol #3 to go without a physician's order;

c) Failed to document on the Ambulatory Client Care Record or Emergency Department Nursing Assessment and Treatment Record the reason for the removal of 12 tablets of Tylenol #3.

On July 12, 2020, Dr. Jan Fourie gave a verbal order to Ms. Melnyk that client AS was to be given one tablet of Tylenol #3 to go at the time of AS's discharge.

Ms. Melnyk did not transcribe Dr. Fourie's verbal order for one tablet of Tylenol #3 to go for AS on the Ambulatory Client Care Record. Instead, Ms. Melnyk wrote on a COVID Swab Instruction Sheet an order for "12 to go" of Tylenol #3 for AS.

Ms. Melnyk removed 12 tablets of Tylenol #3 to go for AS without a physician's order for this number of tablets.

Ms. Melnyk did not document on the Ambulatory Client Care Record or Emergency Department Nursing Assessment and Treatment Record the reason for the removal of 12 tablets of Tylenol #3.

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

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

Ms. Melnyk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to transcribe Dr. Fourie's verbal order for the administration of Tylenol #3 for client AS. Ms. Melnyk did not adhere to Dr. Fourie's verbal order by removing 12 tablets of Tylenol #3 for AS. Ms. Melnyk did not document on the Ambulatory Client Care Record or Emergency Department Nursing Assessment and Treatment Record the reason for the removal of 12 tablets of Tylenol #3. Medication administration is a core competency which is expected of an LPN. When an LPN receives a verbal order from a physician the expectation is that they will document the medication order verbatim as to which the physician had instructed, and

that the LPN will then administer the medication in both the manner which the physician has instructed and in the manner which the medication should be taken. Ms. Melnyk did not adhere to the "Rights of Medication Administration" in which it is an expectation of an LPN to follow these "Rights".

Ms. Melnyk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Melnyk in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as set out in Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. Ms. Melnyk did not properly transcribe a verbal physician's order, removed 12 tablets of Tylenol #3 without a physician's order as the order was for one Tylenol #3 tablet, and Ms. Melnyk failed to document the removal of the tablets of Tylenol #3 on the client's record. By not doing these steps, other members of AS's Health Care team were not aware of why the medication was taken out, if it was administered and what the outcome effects were for client AS. It is the expectation that LPNs have a comprehensive understanding of medication administration as this is a core competency regardless of the experience of the LPN. LPNs are expected to know the types of medications that they are giving to their clients, as well as the effects of this medication. It is also an expectation of LPNs to be able to take and transcribe verbal orders from a physician regardless of their experience as this is also a core competency for an LPN.

Ms. Melnyk's conduct harms the integrity of the regulated profession in that Ms. Melnyk did not act in a manner which would be expected by another LPN in a similar situation. LPNs are expected to document physician's orders properly and to understand which documentation is expected of them with regards to clients who are receiving medications and that such would be properly documented as medication administration and documentation are core competencies of an LPN.

<u>Allegation 3</u>

Ms. Melnyk admitted that on or about August 2, 2020, she did one or more of the following with regards to client DP:

a) Failed to properly transcribe a verbal physician's order on the Ambulatory Client Care Record for two tablets of Percocet now and two tablets of Percocet to go;

b) Removed 14 tablets of Percocet at 0300 hours without a physician's order;

c) Failed to document on the Ambulatory Client Care Record or Emergency Department Nursing Assessment and Treatment Record the reason for the removal of 14 tablets of Percocet.

On August 1, 2020, Dr. Marthinus Doman gave a verbal order to Ms. Melnyk that client DP was to be given two Percocet at that time and then two tablets of Percocet to go.

Ms. Melnyk did not transcribe Dr. Doman's verbal order for two tablets of Percocet and two tablets of Percocet to go for DP on the Ambulatory Client Care Record. Instead, Ms. Melnyk wrote an order stating "give 12 to go" of Percocet for DP on the Ambulatory Client Care Record.

At approximately 0300 hours on August 2, 2020, Ms. Melnyk removed 14 tablets of Percocet, being 12 to go and 2 now, for DP without a physician's order for this number of tablets.

Ms. Melnyk did not document on the Ambulatory Client Care Record or Emergency Department Nursing Assessment and Treatment Record the reason for the removal of 14 tablets of Percocet.

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

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

Ms. Melnyk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to document on the Multidisciplinary Notes the reason for the administration of medication and the removal of medications that Client DP required. Ms. Melnyk also failed to document a pain assessment or a reason for the administration of the medications that DP required. By not doing this, Ms. Melnyk also failed to follow the physician's orders with respect to the medications. Medication administration is a core competency which is expected of an LPN. When an LPN receives a verbal order from a physician the expectation is that they will document the medication order verbatim and that the LPN will then administer the medication in both the manner which the physician has instructed and in the manner which the medication should be taken. Ms. Melnyk did not adhere to the "Rights of Medication Administration" in which it is an expectation of an LPN to follow these "Rights of Medication Administration".

Ms. Melnyk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Melnyk in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as set out in Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. Ms. Melnyk breached both the CLPNA Code of Ethics and the CLPNA Standards of Practice. Ms. Melnyk did not properly transcribe a verbal physician's order. It is an expectation that an LPN, regardless of their experience, have the knowledge of how to document a physician's verbal order. Ms. Melnyk removed 14 tablets of Percocet without a physician's order. Ms. Melnyk failed to document the removal of the tablets of Percocet on the client's record. By not doing these steps, other members of DP's health care team were not aware of why the medication was taken out, if it was administered, and what the outcome effects were for client DP. It is an expectation that an LPN will not remove any type of medication that they are not instructed to remove and if there is any

removal of medications that it will be documented on the Medication Administration Record as well as in the client's record and what the expected outcome effect of the medication is.

Ms. Melnyk's conduct harms the integrity of the regulated profession in that Ms. Melnyk did not act in a manner which would be expected by another LPN in a similar situation. LPNs are expected to understand which documentation is expected of them with regards to clients who are receiving medications and that such would be properly documented, as medication administration and documentation are core competencies of an LPN. This conduct does not promote the "Rights of Medication Administration" which is a core competency of LPNs regardless of their experience.

Allegation 4

Ms. Melnyk admitted that on or about July 10, 2020, she did one or more of the following with regards to client PS:

a) Removed 2 tablets of Tylenol #3 at 0800 hours without a physician's order;

b) Failed to document on the MAR or Multidisciplinary Notes the reason for the removal of 2 tablets of Tylenol #3 at 0800 hours;

c) Failed to document on the Multidisciplinary Notes the reason for the administration of Tylenol extra strength at 0800 hours and 1200 hours.

On July 9, 2020, Dr. Fournie discontinued an order for client PS to receive Tylenol #3 PRN.

On July 10, 2020, at 0800 hours, Ms. Melnyk removed two tablets of Tylenol #3 for PS. The order had been discontinued the day before; there was no physician's order for Tylenol #3 PRN for PS.

Ms. Melnyk failed to document on the MAR or the Multidisciplinary notes any pain assessment or reason for the removal of Tylenol #3 at 0800 hours.

On July 10, 2020, Ms. Melnyk administered Tylenol extra strength to PS at 0800 hours and 1200 hours. However, Ms. Melnyk did not document in the Multidisciplinary Notes any reason why the Tylenol extra strength was given at 0800 hours and 1200 hours.

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

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

Ms. Melnyk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to follow physician's orders and adequately documenting them.

By not doing this, Ms. Melnyk also failed to follow the physician's orders with respect to the medications. Medication administration is a core competency which is expected of an LPN. It is the expectation that LPNs will not remove medications from the worksite as those medications are for the clients of the facility. Ms. Melnyk did not have a physician's order to remove 2 tablets of Tylenol #3 for client PS. Ms. Melnyk did not adhere to the "Rights of Medication Administration" in which it is an expectation of an LPN to follow these "Rights of Medication Administration". Ms. Melnyk did not document on the Multidisciplinary Notes the reason or the outcome of the Tylenol administration with respect to the client.

Ms. Melnyk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Melnyk in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as set in Allegation 1 in detail. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. Ms. Melnyk breached both the CLPNA Code of Ethics and the CLPNA Standards of Practice. Ms. Melnyk removed 2 tablets of Tylenol #3 without a physician's order. Ms. Melnyk failed to document the removal of the tablets of Tylenol #3 on the client's record. By not doing these steps, other members of PS's health care team were not aware of why the medication was removed and if it was administered to PS and what the outcome effects were for client PS. Ms. Melnyk failed to document the "Rights of Medication Administration" by removing the tablets of Tylenol #3 on client PS's Medication Administration Record or the outcome of the Tylenol #3 administration with respect to client PS.

Ms. Melnyk's conduct harms the integrity of the regulated profession in that Ms. Melnyk did not act in a manner which would be expected by another LPN in a similar situation. LPNs are expected to understand which documentation is expected of them with regards to clients who are receiving medications and that such would be properly documented as medication administration and documentation are core competencies of an LPN. This conduct does not promote the "Rights of Medication Administration" which is a core competency of LPNs regardless of their experience.

<u>Allegation 5</u>

Ms. Melnyk admitted that on or about April 14, 2020, she documented on client DS' MAR the administration of Oxycodone 20 mg at 0800 hours but failed to document the removal of Oxycodone 20 mg on the Narcotic and Controlled Drug Administration Record.

On April 14, 2020, Ms. Melnyk documented on the MAR the administration of Oxycodone 20mg to client DS at 0800 hours.

Ms. Melnyk did not document the removal of the Oxycodone 20mg for DS on the Narcotic and Controlled Drug Administration Record.

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

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

Ms. Melnyk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to follow physician's orders and adequately document the administration of a Narcotic and Controlled Medication. Medication administration is a core competency which is expected of an LPN. It is the expectation that LPNs will document medications that have been administered to a client. Ms. Melnyk did not document the removal of the Oxycodone 20mg on the Narcotic and Controlled Drug Administration Record which is an expectation of an LPN as this is a core competency for LPNs.

Ms. Melnyk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Melnyk in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. Ms. Melnyk failed to document that she had removed Oxycodone 20mg on the Narcotic and Controlled Drug Administration Record. This would then result in the narcotic count for the nursing unit to be incorrect and, as narcotics are controlled substances on the unit, this also had the potential to expose other members of the health care team to unnecessary risks with the incorrect count. LPNs are expected to do all the proper documentation in respect to narcotic administration. Narcotics are a controlled substance and are regulated under both federal and provincial legislation. By Ms. Melnyk not properly documenting the removal of Oxycodone 20mg on the Narcotic and Controlled Drug Administration Record she was in violation of this legislation as well as the "Rights of Medication Administration" that, regardless of experience, are a core competency of LPNs.

Ms. Melnyk's conduct harms the integrity of the regulated profession in that Ms. Melnyk did not act in a manner which would be expected by another LPN in a similar situation. LPNs are expected to understand which documentation is expected of them with regards to clients who are receiving medications and that such would be properly documented, as medication administration and documentation are core competencies of an LPN. Performing narcotic counts is a nursing task that is expected to be done at least once a shift by two nursing staff members. These counts are expected to be done as per federal regulations. Ms. Melnyk, by not documenting the removal of the Oxycodone, caused for the count to be incorrect and then her co-workers would have to file a narcotic count discrepancy. This is a core competency of an LPN regardless of their experience.

<u>Allegation 6</u>

Ms. Melnyk admitted that on or about July 31, 2020, she did one or more of the following with regards to client CC:

a) Documented the removal of Hydromorphone 2mg tablet at 2100 hours but documented on the MAR the administration of PRN Hydromorphone 1 mg tablet at 2100 hours;

b) Failed to document on the Multidisciplinary Notes the reason for the removal of Hydromorphone 2 mg tablet at 2100 hours;

c) Documented on the MAR the administration of Hydromorphone 1 mg tablet at 2359 but failed to document the removal of Hydromorphone 1 mg tablet on the Narcotic and Controlled Drug Administration Record at 2359 hours.

On July 31, 2020, client CC had an order for Hydromorphone 1mg every 6 hours PRN.

At 2100 hours on July 31, 2020, Ms. Melnyk documented the removal of Hydromorphone 2mg tablet for CC on the Narcotic and Controlled Drug Administration Record. Ms. Melnyk then documented on CC's MAR the administration of PRH Hydromorphone 1mg tablet to CC at 2100 hours.

Ms. Melnyk did not document on the Multidisciplinary Notes a pain assessment or any reason for the removal of the Hydromorphone 2mg tablet at 2100 hours.

At 2359 hours on July 31, 2020, Ms. Melnyk documented on the MAR the administration of Hydromorphone 1mg tablet to CC. Ms. Melnyk did not document the removal of the Hydromorphone 1mg tablet for CC on the Narcotic and Controlled Drug Administration Record.

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

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

Ms. Melnyk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services. Ms. Melnyk did not adhere to what is expected of an LPN. It is expected that LPNs have the knowledge of what is expected when it comes to medication administration and documentation.

Ms. Melnyk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Melnyk in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. LPNs are expected to do all the proper documentation in respect to narcotic administration. Narcotics are a controlled substance and are regulated under both federal and provincial legislation. By Ms. Melnyk not properly documenting the removal of Hydromorphone 2mg on the Narcotic and Controlled Drug Administration Record, she was in violation of this legislation as well as the "Rights of Medication Administration" that regardless of experience are a core competency of LPNs. Ms. Melnyk failed to document the removal of Hydromorphone 2mg and instead documented removal of Hydromorphone 1mg but these are

not the same medication strengths and could have different effects on the client. The documentation of the incorrect medication being removed also would affect the Narcotic Count Record for both medications involved. Ms. Melnyk also failed to document on the Multidisciplinary Notes the removal reason which is a core competency of LPNs in that there should be a recorded reason for medication especially narcotic removal.

Ms. Melnyk's conduct harms the integrity of the regulated profession in that Ms. Melnyk did not act in a manner which would be expected by another LPN in a similar situation. LPNs are expected to understand which documentation is expected of them with regards to clients who are receiving medications and that such would be properly documented as Medication administration and documentation are core competencies of an LPN Ms. Melnyk failed to adhere to the "Rights of Medication Administration" in that she did not confirm that she was removing the proper medication that was ordered for the client. Both the failure to adhering to the "Rights of Medication Administration" and the lack of documentation are expectations of an LPN regardless of their experience.

Allegation 7

Ms. Melnyk admitted that on or about August 1, 2020, she did one or more of the following with regards to client CC:

a) Documented the removal of Hydromorphone 2 mg tablet at 0600 hours but documented on the MAR the administration of Hydromorphone 1 mg tablet at 0600 hours;

b) Removed Hydromorphone 2 mg tablet at 2000 hours for PRN administration without a physician's order;

c) Failed to document on the MAR or Multidisciplinary Notes the reason for the removal of Hydromorphone 2 mg tablets at 2000 hours;

d) [Withdrawn].

At 0600 hours on August 1, 2020, Ms. Melnyk documented on the MAR the administration of Hydromorphone 1mg tablet to CC. However, at 0600 hours, Ms. Melnyk documented the removal of a Hydromorphone 2mg tablet.

Dr. Doman discontinued an order for client CC to receive Hydromorphone 1mg PRN at approximately 1200 hours on August 1, 2020.

On August 1, 2020, at 2000 hours, Ms. Melnyk removed a Hydromorphone 2mg tablet for CC. As the order had been discontinued, there was no physician's order for Hydromorphone 1mg PRN or Hydromorphone 2mg PRN for CC.

Ms. Melnyk failed to document on the MAR or the Multidisciplinary notes any pain assessment or reason for the removal of Hydromorphone 2mg tablet at 2000 hours.

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

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

Ms. Melnyk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services. Ms. Melnyk did not adhere to what is expected of an LPN. It is expected that LPNs have the knowledge of what is expected when it comes to medication administration and documentation.

Ms. Melnyk's conduct harms the integrity of the regulated profession in that Ms. Melnyk did not act in a manner which would be expected by another LPN in a similar situation. LPNs are expected to understand which documentation is expected of them with regards to clients who are receiving medications and that such would be properly documented as Medication administration and documentation are core competencies of an LPN. Ms. Melnyk failed to document the removal of Hydromorphone 2mg and instead documented removal of Hydromorphone 1mg. These are not the same medication strengths and could have different effects on the client. The documentation of the incorrect medication being removed also would affect the Narcotic Count Record for both medications involved. Ms. Melnyk also failed to document on the Multidisciplinary Notes the removal reason which is a core competency of LPNs in that there should be a recorded reason for medication especially narcotic removal. Documentation of narcotics is a competency that, regardless of experience, an LPN should possess and by not doing this Ms. Melnyk was in violation of the "Rights of Medication Administration" which is also a core competency of an LPN.

Ms. Melnyk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above in Allegation 1 and that such breaches are sufficiently serious to constitute unprofessional conduct for the same reasons given above. Ms. Melnyk failed to adhere to the "Rights of Medication Administration" in that she did not confirm that she was removing the proper medication that was ordered for the client. Both the failure to adhering to the "Rights of Medication Administration" and the lack of documentation are expectations of an LPN regardless of their experience.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Melnyk jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #3. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

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

2. Ms. Melnyk shall pay 25% of the costs of the investigation and hearing to be paid over a period of **24 months** from service of the Decision.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Melnyk shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Melnyk shall provide a signed written declaration to the Complaints Officer attesting that she has reviewed the CLPNA documents within **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 Practice Policy: Documentation;

    e. CLPNA Practice Guideline: Medication Management;

    f. CLPNA Competency Profile A1: Critical Thinking;

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

    h. CLPNA Competency Profile A3: Time Management; and

    i. CLPNA Competency Profile U: Medication Management.

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

4. Ms. Melnyk shall complete the **NURS 0161: Medication Management** course offered online at www.macewan.ca. Ms. Melnyk shall provide the Complaints Officer with a certificate confirming successful completion of the course within **9 months** of service of the Decision.

5. Ms. Melnyk shall complete the **CLPNA Nursing Documentation 101** course offered on line at https://studywithclpna.com/nursingdocumentation101/. Ms. Melnyk shall provide the Complaints Officer with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

6. Ms. Melnyk shall complete the **LPN Ethics Course** offered online at www.learningnurse.org. Ms. Melnyk shall provide the Complaints Officer with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

7. The sanctions set out above at paragraphs 2-6 will appear as conditions on Ms. Melynk's practice permit and the Public Registry subject to the following:

    (a) The requirement to complete the remedial education and readings outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)" on Ms. Melnyk's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings;

        ii. NURS 0161: Medication Management;

        iii. CLPNA Nursing Documentation 101;

        iv. LPN Ethics Course;

    (b) The requirement to pay the costs outlined at paragraph 2 will appear as "Conduct Cost/Fines" on Ms. Melnyk's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

8. The conditions on Ms. Melnyk's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 7.

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

10. Should Ms. Melnyk 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 Officer.

11. Should Ms. Melnyk 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 Officer 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. Melnyk's non-compliance as information for a complaint under s. 56 of the Act; or

    (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Melnyk's practice permit until such costs are paid in full or the Complaints

Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

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

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

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Melnyk 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: The allegations are serious in nature as they deal with the administration of medications such as Tylenol #3, Percocet, Hydromorphone, and Oxycodone which are all narcotics. The allegations also deal with lack of documentation of the effects of these medications with respect to clients and their care. There is also deliberate conduct with respect to removing these medications without a physician's order or by documenting the incorrect physician's order as well as documentation errors. This is significant in that it deals with core competencies with respect to medication administration and documentation. There also was a risk to the clients as there were controlled substances which need to be accounted for and properly handled. All of these factors combine to make these allegations serious in nature.

The age and experience of the investigated member: Ms. Melnyk was initially registered with the CLPNA in 1997 and began working at the Boyle Healthcare Center at that time. At the time of the allegations, Ms. Melnyk had been an LPN for approximately 23 years.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The Hearing Tribunal was not presented with any information regarding this factor.

The age and mental condition of the victim, if any: The Hearing Tribunal was not made aware of any impact on the clients who were in Ms. Melnyk's care.

The number of times the offending conduct was proven to have occurred: There were multiple instances with multiple clients over the time period of April 14, 2020 to August 2, 2020.

The role of the investigated member in acknowledging what occurred: Ms. Melnyk acknowledged the conduct that was brought forward which does demonstrate accountability and Ms. Melnyk's willingness to take accountability for her actions.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Melnyk was suspended from her employment on October 26, 27, 30, 31 and November 1, 2020, for a time period of five shifts. Ms. Melnyk also did lose hours because of the condition of supervised practice that was placed on her practice permit.

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: Specific deterrence is required to keep Ms. Melnyk from repeating the same conduct in the future. General deterrence is required to ensure that other members of the LPN profession do not engage in similar conduct as well as to make sure that it is known that this type of conduct will not be tolerated by the CLPNA. LPNs are recognized as independent and capable members of the healthcare team and follow self-regulation 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 CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct 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.

(11) Orders of the Hearing Tribunal

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

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

2. Ms. Melnyk shall pay 25% of the costs of the investigation and hearing to be paid over a period of **24 months** from service of the Decision.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Melnyk shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Melnyk shall provide

a signed written declaration to the Complaints Officer attesting that she has reviewed the CLPNA documents within **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 Practice Policy: Documentation;

e. CLPNA Practice Guideline: Medication Management;

f. CLPNA Competency Profile A1: Critical Thinking;

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

h. CLPNA Competency Profile A3: Time Management; and

i. CLPNA Competency Profile U: Medication Management.

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

4. Ms. Melnyk shall complete the **NURS 0161: Medication Management** course offered online at www.macewan.ca. Ms. Melnyk shall provide the Complaints Officer with a certificate confirming successful completion of the course within **9 months** of service of the Decision.

5. Ms. Melnyk shall complete the **CLPNA Nursing Documentation 101** course offered on line at https://studywithclpna.com/nursingdocumentation101/. Ms. Melnyk shall provide the Complaints Officer with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

6. Ms. Melnyk shall complete the **LPN Ethics Course** offered online at www.learningnurse.org. Ms. Melnyk shall provide the Complaints Officer with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

7. The sanctions set out above at paragraphs 2-6 will appear as conditions on Ms. Melynk's practice permit and the Public Registry subject to the following:

    (a) The requirement to complete the remedial education and readings outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)" on Ms. Melnyk's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings;

        ii. NURS 0161: Medication Management;

iii. CLPNA Nursing Documentation 101;

iv. LPN Ethics Course;

(b) The requirement to pay the costs outlined at paragraph 2 will appear as "Conduct Cost/Fines" on Ms. Melnyk's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

8. The conditions on Ms. Melnyk's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 7.

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

10. Should Ms. Melnyk 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 Officer.

11. Should Ms. Melnyk 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 Officer 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. Melnyk's non-compliance as information for a complaint under s. 56 of the Act; or

(f) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Melnyk's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

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

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that

(a) identifies the appealed decision, and

(b) states the reasons for the appeal.

(2) A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 4th DAY OF OCTOBER 2021 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal