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 KATHY BOYCHUK

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 KATHY BOYCHUK, LPN #23452, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The Hearing was conducted via Teleconference on October 26, 2023 with the following individuals present:

Hearing Tribunal:
Kunal Sharma, LPN, Chairperson
Nicole Searle, LPN
Terry Engen, Public Member
Don Wilson, Public Member

Staff:
Caitlyn Field, Legal Counsel for the Complaints Director, CLPNA
Sanah Sidhu, Complaints Director, CLPNA

(2) Preliminary Matters

The hearing was open to the public.

The Complaints Director's Legal Counsel made an application to the Hearing Tribunal to proceed with the Hearing without Ms. Boychuk's presence. Ms. Boychuk had been provided repeated and significant notice of the proceedings and she had chosen not to attend. Under the Act, the Hearing Tribunal does have the statutory authority to proceed in Ms. Boychuk's absence. As per section 79(6) of the *Health Professions Act* (the "Act"), despite having been given notice, if the investigated person does not appear at the hearing and there is proof they have been given notice to attend the hearing, the Hearing Tribunal may proceed with the hearing in the absence of the member and may act or decide on the matter being heard in the absence of the investigated person.

This hearing was originally scheduled to proceed on April 14, 2023. Ms. Boychuk had been given notice of that hearing, as well as all the materials including the Statement of Allegations and the Investigation Report with attachments. When the Complaints Officer attended the hearing in April, Ms. Boychuk did not attend. The member's union representative, Carol Drennan, attended the hearing. Mrs. Drennan advised that Ms. Boychuk was aware of the proceedings but would not be in attendance. The hearing was adjourned to a later date.

On June 21, 2023, a letter was sent to Ms. Boychuk by registered mail which provided further notice of the hearing, as well as notice explicitly that if Ms. Boychuk was not in attendance at the next scheduled hearing, the hearing would proceed in her absence.

The Complaints Officer received a telephone call from Ms. Boychuk on July 13, 2023 and Ms. Boychuk was verbally advised by the Complaints Officer that the matter would be rescheduled for October 26, 2023. She also notified Ms. Boychuk would need to advise whether she would attend and how she wished to proceed. Ms. Boychuk did not indicate how she would attend at that time.

On August 9, 2023, a Notice of Hearing and a summary of the witnesses being called was sent to Ms. Boychuk advising of the hearing scheduled for October 26, 2023.

In considering whether the hearing would proceed, the Hearing Tribunal weighed two main considerations – procedural fairness to the member and the public interest in having this matter proceed. The Complaints Director's Legal Counsel noted that the member had been advised of the hearing on several occasions and Ms. Boychuk had been provided fulsome disclosure of the Investigation Report and attachments which form the documentary basis of the case. The Investigation Report also included summaries of the anticipated witness testimony so Ms. Boychuk would be aware of what the witnesses would be able to testify to. It was submitted that the Complaints Director had met her obligations to be procedurally fair to Ms. Boychuk and ensuring Ms. Boychuk had been given the ability to exercise her rights to be heard and know the case against her. Ms. Boychuk is fully aware of the proceedings and their significance, and she has chosen not to participate.

Counsel further argued that on the balance of public interest in having the matter heard it was submitted that the public interest clearly satisfied the need to proceed today. The complaints are from 2021 and relate to significant practice concerns in key areas of competency of Ms. Boychuk. Ms. Boychuk's refusal to participate in the proceedings cannot mean that the case is never heard nor that her conduct is not considered by a tribunal to determine whether it is proven and whether it amounts to unprofessional conduct. It was also submitted that a further adjournment of this matter could have potentially negative consequences on the hearing by potentially impacting witness memories if this is prolonged. Further adjournment could also potentially have a negative impact on the public perception of the College by not fulfilling its mandate in regulating the conduct of its members.

The Hearing Tribunal determined that Ms. Boychuk was notified of the hearing verbally and via email by CLPNA on numerous occasions. Mrs. Boychuk decided not to participate in both the hearings. The Hearing Tribunal decided to proceed with the hearing in Ms. Boychuk's absence.

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

Ms. Boychuk was an LPN within the meaning of the Act at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Boychuk was initially licensed as an LPN in Alberta on January 1, 2000.

By letter dated June 16, 2021, the CLPNA received a complaint (the "Complaint") from Steve Tetz, Manager, Rehabilitation ("Unit 35"), Red Deer Regional Hospital, Alberta Health Services ("AHS") in Red Deer, Alberta pursuant to s. 57 of the Act. The Complaint stated that Ms. Kathy Boychuk, LPN, was suspended for one day because of multiple medication administration and documentation errors as well as being unfit for duty.

In accordance with s. 55(2)(d) and s. 20(1) of the Act, Ms. Sandy Davis, Complaints Director at that time (the "Complaints Director") appointed Kerry Palyga (the "Investigator") to investigate the Complaint.

Ms. Boychuk received notice of the Complaint and the Investigation by letter dated June 22, 2021.

By letter dated October 19, 2021, the CLPNA received a second complaint (the "Second Complaint") from Steve Tetz pursuant to s. 57 of the Act. The Second Complaint stated that Ms. Boychuk was suspended for three days because of multiple medication administration and documentation errors, failing to provide care to clients, and failing to wear necessary personal protective equipment, among other concerns.

Ms. Boychuk received notice of the Second Complaint and the Investigation by letter dated June 22, 2021.

On October 25, 2021, Kevin Oudith, CLPNA Complaints Officer at the time (the "Complaints Officer"), wrote to Carrie Waggot, Executive Officer at the CLPNA (the "Executive Officer") requesting a condition be placed on Ms. Boychuk's practice permit for supervised practice. Ms. Boychuk was provided an opportunity to provide a response to the Complaints Officer's request. Mrs. Boychuk did not respond to this request.

On November 5, 2021, the Executive Officer issued her decision regarding the Complaints Officer's request and ordered that Ms. Boychuk's practice permit was subject to a condition for directly supervised practice.

On January 19, 2022, the Investigator concluded the investigation.

Following the conclusion of the Investigation, the Complaints Director determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Boychuk received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report under cover of letter dated March 31, 2022.

On June 6, 2022, Ms. Boychuk provided medical documentation to the CLPNA indicating that she was unable to participate in the disciplinary process. Subsequently, on June 29, 2022, Ms. Boychuk's union representative requested an extension of the time to schedule a disciplinary hearing. Accordingly, Kevin Oudith, Complaints Officer at the time, agreed to delay the scheduling of the disciplinary hearing until Ms. Boychuk was able to participate.

On September 28, 2022, Ms. Boychuk, by way of her union representative, requested a further extension prior to scheduling the disciplinary hearing dates.

A Hearing was scheduled for April 14, 2023, and A Notice of Hearing, Notice to Attend and Notice to Produce respecting the Complaint were served upon Ms. Boychuk under cover of letter dated January 24, 2023.

On April 14, 2023, Ms. Boychuk's union representative advised she had spoken to Ms. Boychuk on April 13, 2023, and confirmed her attendance; however, after delaying the hearing for 15 minutes, Ms. Boychuk did not attend the hearing. An application was jointly put forward to the Hearing Tribunal by Ms. Boychuk's representative and CLPNA's Legal Counsel to adjourn the hearing and reschedule at a later date.

A subsequent hearing was scheduled for October 26, 2023. A Notice of Hearing, Notice to Attend and Notice to Produce were served upon Ms. Boychuk under cover of letter dated August 16, 2023.

(4) Allegations

The Allegations in the Statement of Allegations are:

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

1. On or about May 17, 2021, failed to follow proper medication administration practices with regards to client FJ by doing one or more of the following:
    a. Documented on the Medication Administration Record the administration of Bisoprolol 1.25mg at 0800 hours when Bisoprolol 1.25mg was not administered to client FJ;

b. Documented on the Medication Administration Record the administration of Symbicort 200mcg inhaler at 0800 hours when Symbicort 200 mcg inhaler was not administered to client FJ;

c. Administered Ciprofloxacin 500 mg to client FJ at or about 0800 hours instead of 2000 hours, as ordered.

2. On or about May 17, 2021, failed to follow proper medication practices with regards to client AM by doing one or more of the following:

    a. Administered Perindopril 2 mg at 1120 hours instead of 0800 hours as ordered;

    b. Failed to ensure client AM consumed Perindopril 2mg tablet;

    c. Left AM's dose of Perindopril 2 mg unattended in client AM's room.

3. On or about May 18, 2021, failed to document on client TL's Medication Administration Record the time and/or site of administration of Lispro Insulin 6 units.

4. On or about June 19, 2021, did one or more of the following with regards to client EH:

    a. Failed to follow proper medication administration practices by administering Morphine 5 mg instead of Hydromorphone 1 mg, as ordered;

    b. Incorrectly documented the administration of Hydromorphone 1 mg on the Medication Administration Record.

5. On or about September 3, 2021, failed to follow proper medication administration practices with regards to client MH, by doing one or more of the following:

    a. Documented on the Medication Administration Record the administration of Hydromorphone SR 18 mg at 0800 hours, when the medication was not administered;

    b. Failed to administer Hydromorphone SR 18 at 0800 hours, as ordered;

    c. Incorrectly documented on the Oral Narcotic Inventory Record the removal of Hydromorphone 5 mg at 0912 hours, instead of Hydromorphone SR 18 mg as ordered.

6. On or about September 26, 2021, failed to provide basic Activities of Daily Living (ADLs) to client JW, particulars of which are:

    a. Failed to assist JW put on a brassiere;

    b. Failed to provide peri-care when requested by client JW.

7. On or about September 26, 2021, failed to accurately document her interaction with JW on the 24 Hour Systems Assessment.

8. On or about September 27, 2021, failed to follow proper medication administration practices with regards to client DC by doing one or more of the following:
    a. Failed to administer Telmisartan 40 mg at 0800 hours, as ordered;
    b. Documented on client DC's Medication Administration Record the administration of Telmisartan 40 mg at 0800 hours when the medication was not administered.
9. On or about September 27, 2021, failed to don Personal Protective Equipment (PPE) prior to entering client DC's room, who was on contact/sporicidal precautions, as required.
10. On or about September 30, 2021, failed to follow proper medication administration practices with regards to client RD by failing to administer Lispro insulin 3 units at 1145 hours as per the Basal Bolus Insulin Therapy (BBIT) order.
11. On or about September 30, 2021, failed to follow proper medication administration practices with regards to client JE by administering Percocet 2 tablets at 0815 hours instead of Percocet 1 tablet, as ordered.
12. On or about October 4, 2021, failed to follow proper medication administration practices by administering Percocet 2 tablets to client JE at 1936 hours instead of Percocet 1 tablet as ordered.
13. On or about October 9, 2021, failed to follow proper medication administration practices by administering Percocet 2 tablets to client JE at 1540 hours instead of the ordered dose of Percocet 1 tablet.
14. On or about October 10, 2021, failed to follow proper medication administration practices by administering Percocet 2 tablets to client JE at 1420 hours instead of the ordered dose of Percocet 1 tablet."

(5) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Statement of Allegations
Exhibit #2: Boychuk Exhibit Book of the Complaints Director

The following are the documents included in Exhibit #2:

Tab 1: Complaint to CLPNA June 16, 2021
Tab 2: Letter of Warning March 19, 2021
Tab 3: Learning Plan April 13, 2021

Tab 4: Suspension Letter June 15, 2021
Tab 5: RLS Report May 20, 2021
Tab 6: FJ Short Profile
Tab 7: FJ Medication Administration Record
Tab 8: FJ Physician Orders
Tab 9: AM Medication Administration Record
Tab 10: LT Basal Bolus Insulin Therapy
Tab 11: LT Medication Administration Record
Tab 12: LT Blood Glucose and Subcutaneous Insulin Record
Tab 13: Email from S. Reimer December 20, 2021
Tab 14: Second Complaint October 19, 2021
Tab 15: Second Suspension Letter October 19, 2021
Tab 16: RLS Report June 19, 2021
Tab 17: EH Short Profile
Tab 18: EH Medication Administration Record
Tab 19: EH 24 Hour Systems Assessment
Tab 20: RLS Report September 3, 2021
Tab 21: MH Medication Administration Record
Tab 22: MH Short Profile
Tab 23: Oral Narcotic Inventory Record September 3, 2021
Tab 24: Email from S. Masyk September 26 - October 18, 2021
Tab 25: Handwritten Notes October 18, 2021
Tab 26: JW 24 Hr. Systems Assessment
Tab 27: RLS Report September 27, 2021
Tab 28: DC Medication Administration Record
Tab 29: DC 24 Hr. Systems Assessment
Tab 30: Second RLS Report September 27, 2021
Tab 31: Contact and Droplet Precautions
Tab 32: RLS Report September 30, 2021
Tab 33: RD Medication Administration Record
Tab 34: RD Basal Bolus Insulin Therapy
Tab 35: RD Blood Glucose and Subcutaneous Insulin Record
Tab 36: RLS Report October 1, 2021
Tab 37: JE Medication Administration Record
Tab 38: Oral Narcotic Inventory Record September 30, 2021
Tab 39: Oral Narcotic Inventory Record, October 4, 2021
Tab 40: RLS Report October 12, 2021
Tab 41: JE Medication Administration Record October 9-10, 2021
Tab 42: Oral Narcotic Inventory Record October 9, 2021
Tab 43: AHS Policy - Glycemic Management
Tab 44: AHS Policy - Treatment of Hypoglycemia
Tab 45: AHS Policy - Treatment of Hyperglycemia
Tab 46: AHS Policy - Medication Administration

Tab 47: AHS Policy - Management of High Alert Medications
Tab 48: AHS Clinical Knowledge Basal Bolus Insulin Therapy
Tab 49: CLPNA Standards of Practice
Tab 50: CLPNA Code of Ethics

(6) Witnesses

The following individuals were called as witnesses in the hearing:

Steve Tetz
Carrie Osiki
Anya Knebel
Samantha Masyk
Lisa Elford-Milley
Shanyn Reimer
Sara Jackson

The following is a summary of the evidence given by each witness:

Steve Tetz testified that he has been working as an Occupational Therapist since 2001. He joined Red Deer Regional Hospital in 2018, as a manager on unit 35. This is a sub-acute unit with 38 beds providing care to stroke and post amputation patients. There are RNs, LPNs, HCAs and OTs that provide 24-hour care to patients. When Mr. Tetz joined unit 35, Ms. Boychuk was already working there as an LPN. Ms. Boychuk was the most senior LPN on the unit. According to Mr. Tetz, Ms. Boychuk was very slow at work, she made medication errors regularly. Ms. Boychuk's competence in working with patients and families was average to below average of what is expected from an LPN. Mr. Tetz also said that Ms. Boychuk was not the most capable LPN they had on the unit. Mr. Tetz was concerned with Ms. Boychuk's medication errors that led to discipline and suspension.

Carrie Osicki testified that she has been working as a Physiotherapist for 20 years. She worked with Ms. Boychuk on unit 35. Ms. Osicki testified that Ms. Boychuk was not the easiest LPN and was difficult to work with. Ms. Boychuk would not absorb all the information provided to her. On May 17, 2021, Ms. Osicki witnessed that Ms. Boychuk had left medications on the side table of patient AM who was cognitively impaired. Ms. Osicki informed the charge nurse about this. Ms. Osicki filed a Reporting and Learning System (RLS) report.

On September 27, 2021, Ms. Osicki witnessed Ms. Boychuk administering medications to patient DC, who was in isolation, without wearing appropriate PPE including that she was not wearing a gown as required. There were signs posted and equipment outside the patient's room advising that DC was on contact and droplet precautions. According to Ms. Osicki, Ms. Boychuk could have spread infection to other patients affecting their health and recovery. Ms. Osicki again informed the charge nurse and filed an RLS report.

Anya Knebel testified that she has been working as an LPN since November 2013. She sometimes worked with Ms. Boychuk but mostly saw her during shift change. On September 27, 2021, between 1600 to 2000 hours, Ms. Knebel found Telmisartan 40 mg that was due to be administered to patient DC at 0800 hours. Ms. Boychuk had signed the medication administration record (MAR) that Telmisartan was administered to DC at 0800 hours. Ms. Knebel said that Telmisartan is a blood pressure medication and missing a dose can elevate blood pressure and result in a risk of stroke. Ms. Knebel assessed DC's blood pressure and it was stable; there was no harm done to DC. Ms. Knebel notified patient DC and filed an RLS report.

Samantha Masyk testified that she has been working as a Health Care Aide since 2016. She worked with Ms. Boychuk on unit 35. Ms. Masyk said that Ms. Boychuk was not 100% during her work. Ms. Masyk stated that Ms. Boychuk was disgusting in front of patients and their families. Ms. Masyk gave some examples that Ms. Boychuk would sleep in patients' beds when there were family and patients present in the room. She also observed Ms. Boychuk cursing at patients and telling a patient to "shut the fuck up" while providing care. Ms. Boychuk told patients that she was "just there to do the job" and "did not care". On September 26, 2021, Ms. Masyk and Ms. Boychuk were providing care to patient JW. JW wanted her Depends changed, and brassiere and shirt put on. Ms. Boychuk refused to do this and said it was too much work for us. Ms. Masyk said she went back to JW and did peri-care and put JW's clothes on.

Lisa Elford-Milley testified that she has been working as a Registered Nurse for 28 years. In 2021 she worked as a charge nurse on Unit 35 in a supervisory role. Her job duties included listening to patient complaints and staff could approach her for education. She worked with Ms. Boychuk and there were consistent issues with Ms. Boychuk. She provided a description of the layout of the unit where one LPN, one RN and one HCA worked on each side providing care to 15 patients.

On May 17, 2021, Ms. Osicki notified Ms. Elford-Milley that medications were left on patient AM's bedside table. When Ms. Elford-Milley checked AM's MAR she found that Ms. Boychuk had signed that Perindopril 2 mg was administered. When she spoke with Ms. Boychuk, she admitted leaving medications on AM's bedside table.

On June 19, 2021, Ms. Boychuk was working a night shift. Ms. Boychuk notified Ms. Elford-Milley that she had made a medication error by administering Morphine 5 mg to patient EH instead of Hydromorphone 1 mg. Ms. Boychuk also documented on the MAR that she administered Hydromorphone 1 mg. Ms. Elford-Milley notified the attending Physician and advised Ms. Boychuk to fill out an RLS report.

Patient MH was ordered to receive Hydromorphone 18 mg SR at 0800 and 2000 hours. On September 3, 2021, Ms. Boychuk signed on the MAR that Hydromorphone 18 mg SR was administered at 0800 hours. Ms. Elford-Milley discovered that the narcotic count was wrong and this dose was not administered to MH until 1517 hours. It took three days for patient MH's pain to be controlled and affected his healing. Ms. Boychuk also incorrectly documented on the oral

narcotic inventory record the removal of Hydromorphone 5 mg at 0912 hours instead of Hydromorphone 18 mg.

Ms. Elford-Milley also spoke about how Ms. Osicki reported to her that Ms. Boychuk was seen going into a patients' room without wearing appropriate PPE when there were signs posted outside of that patient's room advising that patient was on contact and droplet precautions.

On September 30, 2021, at 1145 hours patient RD's blood sugar was 13.8 and RD should have received 3 units of Lispro insulin at 1145 hours. Ms. Boychuk failed to administer this insulin dose to RD. At 1450 hours RD's blood sugar was 12.7. This medication error was discovered by Amanda Scott and reported to Ms. Elford-Milley. Ms. Scott also submitted an RLS report. Ms. Elford-Milley reported that missing a dose of insulin could cause significant harm to the patient's blood sugar level and they can crash.

Shanyn Reimer testified that she started working as a Registered Nurse on Unit 35 in August 2020. She often worked with Ms. Boychuk. Ms. Reimer reported that it was stressful working with Ms. Boychuk as she would not do her job and often Ms. Boychuk would have to be told what to do. Ms. Boychuk made medication errors and was slow in documentation. On May 18, 2021, Ms. Boychuk signed on the MAR that she had administered Bisoprolol 1.25 mg and Symbicort 200 mcg inhaler to patient FJ when these medications had not even arrived from the pharmacy. Patient FJ was ordered to receive Ciprofloxacin 500 mg at 2000 hours. However, Ms. Boychuk administered Ciprofloxacin 500 mg to FJ at 0900 hours. This did not cause any adverse effects to FJ, but the antibiotic dose had to be moved to morning.

On May 18, 2021, Ms. Reimer asked Ms. Boychuk to administer 6 units of Lispro insulin to patient TL. Ms. Reimer then went on break. When she returned from break, she noticed that Ms. Boychuk had not administered insulin to TL. Ms. Boychuk was about to give medications to the wrong patient. Ms. Boychuk was looking at a different patient's MAR and another patient's blister pack medications. Ms. Reimer stopped Ms. Boychuk from administering medications to the wrong patient.

Sara Jackson testified that she has worked as a Registered Nurse on Unit 35 for 11 years. She also worked there as a charge nurse. One of her job duties is to deal with complaints from staff and patients and, if needed, to escalate the complaint to the manager. Ms. Jackson said that she enjoyed working with Ms. Boychuk on a personal level and found her to be a fun person. According to Ms. Jackson, when she worked with Ms. Boychuk, she had to stay late to finish charting as she found Ms. Boychuk was slow. However, she did not run into this issue when she worked with other staff.

On September 30, 2021, Amanda Scott reported a medication error to Ms. Jackson. Patient RD's blood sugar was 13.8 at 1145 hours and RD should have received 3 units of Lispro insulin. However, Ms. Boychuk had not administered the insulin to RD. Ms. Jackson showed RD's BBIT record to Ms. Boychuk and Ms. Boychuk agreed that she had missed giving insulin to RD. Ms.

Jackson said that Ms. Boychuk responded by saying "whatever" and shrugged her shoulders. Ms. Jackson requested that Ms. Boychuk check RD's blood sugar and it was 12.7 at 1456 hours. Ms. Jackson testified that missing a dose of insulin would mean that a patient's blood sugar would be higher than normal. Doctors do not check the MAR whether insulin was given or not and could have ordered more insulin to be administered. Also, missing a dose of insulin can result in kidney damage and delay wound healing.

Ms. Jackson also testified how Ms. Boychuk administered two tablets of Percocet to patient JE on four different occasions when the ordered dose was one tablet of Percocet. Administering a double dose of narcotic medications to patients can result in loss of consciousness, it can cause falls, and lower patient's blood pressure. No impacts to patient JE were noted.

The Hearing Tribunal recognizes some of the evidence it is being asked to accept and consider in this matter may be 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 CLPNA 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 Act.

(6) Hearing Tribunal Decisions and Reasons

The Hearing Tribunal is aware that 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.

Allegation 1

On or about May 17, 2021, Ms. Boychuk failed to follow proper medication administration practices with regards to client FJ by doing one or more of the following:

a. Documented on the Medication Administration Record the administration of Bisoprolol 1.25mg at 0800 hours when Bisoprolol 1.25mg was not administered to client FJ;

b. Documented on the Medication Administration Record the administration of Symbicort 200mcg inhaler at 0800 hours when Symbicort 200 mcg inhaler was not administered to client FJ;

c. Administered Ciprofloxacin 500 mg to client FJ at or about 0800 hours instead of 2000 hours, as ordered.

The Hearing Tribunal reviewed the RLS reports and MAR for patient FJ. The Hearing Tribunal also heard from Ms. Reimer how Ms. Boychuk documented on the MAR that she had administered Bisoprolol 1.25 mg and Symbicort 200 mcg to patient FJ when these medications had not even arrived from the pharmacy. Ms. Reimer decided to review the MAR for FJ and noticed that Ms. Boychuk had administered Ciprofloxacin 500 mg to FJ at 0800 hours instead of 2000 hours as ordered by the Doctor. Ms. Reimer filed RLS reports for both incidents which the Hearing Tribunal reviewed.

The Hearing Tribunal considered and found that the oral evidence and documents included in Exhibit #2 prove that the conduct for Allegation 1 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she documented on the MAR that she had administered Bisoprolol and Symbicort to patient FJ when these medications had not even arrived from the pharmacy. LPNs are expected to faithfully record medication administration, recording a false entry in this manner is below the expectation of an LPN. Ms. Boychuk again demonstrated a lack of skill and judgement by administering Ciprofloxacin 500 mg to FJ at 0800 hours instead of 2000 hours. Just as LPNs are required to record medication administration properly, they are also required to administer the medication as ordered. Significant harm can result where a patient receives their medication late.

The LPN profession and its integrity as trusted caregivers must be maintained in the public's confidence. Thousands of people every day leave their loved ones in the care of responsible, skilled, and compassionate LPNs. They trust and expect that the care given to their loved ones is safe. Conduct such as that of Ms. Boychuk undermines this trust. If a member of the public was made aware of Ms. Boychuk's conduct, it would be understandable if they had a diminished view of LPNs and their profession.

The conduct also 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. Licensed Practical Nurses, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public.

- 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.

Principle 2: Responsibility to Clients. Licensed Practical Nurses, provide safe and competent care for their clients.

- 2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities.
- 2.8 Use evidence and judgement to guide nursing decisions.
- 2.9 Identify and minimize risks to clients.

Principle 3: Responsibility to the Profession. Licensed Practical Nurses, have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public.

- 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.
- 3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws, and regulations under which they are accountable.

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

- 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.

Licensed Practical Nurses are accountable for their practice and responsible for ensuring that their practice and conduct meets both the standards of the profession and legislative requirements.

- 1.1 Practice to their full range of competence within applicable legislation, regulations and employer policies.
- 1.2 Engage in ongoing self-assessment of their professional practice and competence, and seek opportunities for continuous learning.
- 1.4. Recognize their own practice limitations and consult as necessary.
- 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.
- 1.9. 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.

Licensed Practical Nurses 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.

- 3.2. Collaborate with clients and co-workers in the analysis, development, implementation and evaluation of LPN practice and policy that guide client-focused care delivery.
- 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.
- 3.8. Practice within the relevant laws governing privacy and confidentiality of personal health information.

Standard 4: Ethical Practice.

Licensed Practical Nurses uphold, promote and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics.

- 4.1. Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.
- 4.5. Advocate for the protection and promotion of clients' right to autonomy, respect, privacy, confidentiality, dignity and access to information.
- 4.10. Practice with honesty and integrity to maintain the values and reputation of the profession.

LPNs are required to reflect and recognize when they need to improve their practices and ensure they are not harming patients. Doing so is an integral aspect of self-regulation which requires that all regulated members participate in ensuring they are providing safe and effective care. Failing to do so undermines their ability to practice for the good of their clients which then impacts the ability of the whole health care team to provide safe care. When medications are not administered as required, patients can face negative impacts to their mental and physical health. Inaccurate patient records may later be relied on for the purposes of making health care decisions which are then grounded in incorrect information. Ms. Boychuk's actions introduced risk to patient FJ and thereby breached the trust FJ had placed in Ms. Boychuk. For these reasons, the Hearing Tribunal concluded Ms. Boychuk breached the CLPNA Code of Ethics and Standards of Practice.

Allegation 2

On or about May 17, 2021, Ms. Boychuk failed to follow proper medication practices with regards to client AM by doing one or more of the following:

a. Administered Perindopril 2 mg at 1120 hours instead of 0800 hours as ordered;
b. Failed to ensure client AM consumed Perindopril 2mg tablet;
c. Left AM's dose of Perindopril 2 mg unattended in client AM's room.

The Hearing Tribunal reviewed the MAR for patient AM and heard from Ms. Osicki how she found Perindopril 2 mg at the bedside of patient AM when she entered the patient's room. Ms. Osicki reported this to Ms. Elford-Milley and filed an RLS report. Ms. Elford-Milley also testified that she spoke with Ms. Boychuk and Ms. Boychuk admitted that she did not administer Perindopril to AM. However, Ms. Boychuk signed on the MAR that the medication was administered. Perindopril was administered to patient AM 3 hours and 20 minutes later at 1120 hours.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 2 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she administered Perindopril 2 mg 3 hours and 20 minutes late to patient AM. Ms. Boychuk also failed when she left the medication unattended in patient AM's room and did not ensure that AM took the medication.

LPNs must be able to correctly administer medications following all the medication rights. Correct medication administration is a core competence for an LPN. When Ms. Boychuk failed to administer medication properly to AM, she failed to demonstrate the basic skills required of an LPN. Ms. Boychuk should also have ensured that all care provided to AM was properly documented. In this case, the MAR was not filled in and did not reflect the medication AM had received and when AM received it. Ms. Boychuk left medication unattended in AM's room. When the medication was finally administered to AM it was done over three hours late. The problem with this is that any member of the care team must be able to review and rely on the records kept for any patient to make informed decisions about their care. When information is missing or incorrect, a decision could be made that causes harm to a patient. It is critical for an LPN to make accurate notes and keep accurate records because of the role they play in a patient's care. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons discussed above, this conduct also does harm to the integrity of the profession. Finally, the Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal concluded that this conduct was unprofessional for these reasons.

Allegation 3

On or about May 18, 2021, Ms. Boychuk failed to document on client TL's Medication Administration Record the time and/or site of administration of Lispro Insulin 6 units.

The Hearing Tribunal reviewed the MAR, BBIT record of patient TL and the investigation report submitted by Ms. Reimer. The Hearing Tribunal heard from Ms. Reimer that she had asked Ms. Boychuk to administer 6 units of Lispro insulin to patient TL. Ms. Reimer then went on her lunch break. When she returned from her break, she found the insulin pen was full and no insulin had been administered to TL. TL did receive the insulin but the time and/or the site of administration

was not documented on patient TL's MAR. In a written e-mail Ms. Reimer wrote to Mr. Palyga, she mentioned that the insulin was given to patient TL after the patient had finished their meal.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 3 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement by not administering 6 units of Lispro Insulin to patient TL as ordered. Ms. Boychuk also further failed by not documenting the time and site of administration on TL's MAR.

Ms. Boychuk should have administered Lispro Insulin as ordered and documented it properly on TL's Mar. LPNs must be able to correctly administer medications following all the medication rights. Correct medication administration is a core competence for an LPN. When Ms. Boychuk failed to administer Insulin to TL, she failed to demonstrate the basic skills required of an LPN. Ms. Boychuk should also have ensured that all care provided to AM is properly documented. In this case, TL's MAR was not filled out properly and did not reflect the time and site of insulin administration. When the Insulin was finally administered to TL, it was after TL had finished their meal. This insulin dose should have been administered prior to TL consuming their meal. When information is missing or incorrect, a decision could be made that causes harm to a patient. It is critical for an LPN to make accurate notes and keep accurate records because of the role they play in a patient's care. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

This conduct tends to harm the integrity of the profession as it undermines the trust the public places in LPNs when it is proven to have been misplaced.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 4

On or about June 19, 2021, Ms. Boychuk did one or more of the following with regard to client EH:

a. Failed to follow proper medication administration practices by administering Morphine 5 mg instead of Hydromorphone 1 mg, as ordered;

b. Incorrectly documented the administration of Hydromorphone 1 mg on the Medication Administration Record.

The Hearing Tribunal reviewed the RLS report, MAR and 24 Hours Systems Assessment for patient EH. The Hearing Tribunal heard from Ms. Elford-Milley in which she testified that on June 19, 2021, Ms. Boychuk worked a night shift. Patient EH was ordered to receive Hydromorphone 1 mg but Ms. Boychuk had administered 5 mg of Morphine. Ms. Boychuk also signed on the patient's MAR that she had administered Hydromorphone 1 mg which was incorrect. Ms. Boychuk reported the medication error to Ms. Elford-Milley and admitted to administering the wrong medication. Ms. Elford-Milley advised Ms. Boychuk to complete a RLS report.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 4 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement by administering and documenting Morphine 5 mg instead of Hydromorphone 1 mg to patient EH.

Ms. Boychuk should have administered and documented Hydromorphone 1 mg as ordered to patient EH. However, Ms. Boychuk administered Morphine 5 mg to EH. Ms. Boychuk also incorrectly documented on the MAR that she administered Hydromorphone 1 mg to EH. LPNs must be able to correctly administer and document medications following all the medication rights. Correct medication administration is a core competence for an LPN. When Ms. Boychuk failed to follow proper medication administration to EH, she failed to demonstrate the basic skills required of an LPN. Ms. Boychuk should also have ensured that medications administered to EH are properly documented. When there is incorrect information present, a decision could be made that causes harm to a patient. It is critical for an LPN to make accurate notes and keep accurate records because of the role they play in a patient's care. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 5

On or about September 3, 2021, Ms. Boychuk failed to follow proper medication administration practices with regards to client MH, by doing one or more of the following:

a. Documented on the Medication Administration Record the administration of Hydromorphone SR 18 mg at 0800 hours, when the medication was not administered;

b. Failed to administer Hydromorphone SR 18 at 0800 hours, as ordered;

c. Incorrectly documented on the Oral Narcotic Inventory Record the removal of Hydromorphone 5 mg at 0912 hours, instead of Hydromorphone SR 18 mg as ordered

The Hearing Tribunal reviewed the RLS report, MAR, and oral narcotic inventory record. The Hearing Tribunal heard from Ms. Elford-Milley that patient MH was ordered to receive Hydromorphone 18 mg at 0800 and 2000 hours. On September 3, 2021, Ms. Boychuk documented on patient MH's MAR that she administered Hydromorphone 18 mg at 0800 hours. While doing the narcotic count Ms. Elford-Milley discovered that Hydromorphone 18 mg was never administered to patient MH. This medication was finally administered to MH at 1517 hours.

The error led to MH being in pain for three days. This affected his healing and prevented him from participating in physiotherapy. Mr. Tetz also testified that he heard patient MH calling out in pain around September 3, 2021. On September 3, 2021, Ms. Boychuk incorrectly documented on the oral narcotic inventory record that she removed Hydromorphone 5 mg at 0912 hours, instead of Hydromorphone 18 mg SR. This medication error was discovered by Ms. Elford- Milley while she was doing the narcotic count on September 3, 2021. Ms. Elford-Milley submitted an RLS report.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 5 did in fact occur.

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

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;

iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement by not administering and documenting the administration of Hydromorphone 18 mg SR to patient MH at 0800 hours as ordered. Ms. Boychuk failed when she documented on the oral narcotic inventory record the removal of Hydromorphone 5 mg instead of Hydromorphone 18 mg SR as ordered.

As an LPN Ms. Boychuk should have been able to correctly administer and document medications following all the medication rights. Correct medication administration is a core competence for an LPN. Ms. Boychuk failed to follow proper medication administration by not administering and documenting the administration of Hydromorphone 18 mg SR at 0800 hours as ordered to patient MH. Ms. Boychuk did not administer Hydromorphone; instead she documented on the MAR that she had administered this medication to patient MH. Ms. Boychuk further failed when she documented on the oral narcotic inventory record the removal of Hydromorphone 5 mg instead of Hydromorphone 18 mg SR. Hydromorphone 18 mg SR was finally administered to MH at 1517 hours instead of 0800 hours. It caused three days of unnecessary pain to patient MH. Ms. Boychuk failed to demonstrate the basic medication administration skills required of an LPN. Ms. Boychuk should also have ensured that medications administered to MH were properly documented. When there is incorrect information present, a decision could be made that causes harm to a patient. It is critical for an LPN to make accurate notes and keep accurate records because of the role they play in a patient's care. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 6

On or about September 26, 2021, Ms. Boychuk failed to provide basic Activities of Daily Living (ADLs) to client JW, particulars of which are:

a. Failed to assist JW put on a brassiere;
b. Failed to provide peri-care when requested by client JW.

The Hearing Tribunal reviewed the e-mails sent from Ms. Masyk to Mr. Tetz and the handwritten notes of Mr. Tetz's interview of patient HW. The Hearing Tribunal heard from Ms. Masyk that on September 26, 2021, she and Ms. Boychuk were providing care to patient JW. JW requested to have her depends changed, and her brassiere and pants put on. Ms. Boychuk refused to change JW's depends. Ms. Boychuk also refused to put on JW's brassiere and pants and stated it was

"too much work for us". Ms. Masyk went back to patient JW to change her depends; she also put JW's pants and brassiere on.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 6 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she refused to assist patient JW to put on her brassiere and to provide peri-care.

LPNs play an important role in providing basic activities of daily living care to patients as required. Ms. Boychuk should have been able to provide this very basic care to patient JW. However, Ms. Boychuk failed to do so when she refused to assist patient JW to put on her brassiere and to provide peri care. This is a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 7

On or about September 26, 2021, Ms. Boychuk failed to accurately document her interaction with JW on the 24 Hour Systems Assessment.

The Hearing Tribunal reviewed the 24 Hour System Assessment for patient JW. On September 26, 2021, Ms. Boychuk wrote "1150 hr. Total am care given with x 2 staff up into w/c with breakfast and ate well with assist by Terry. Resting in bed at present with call bell in reach". In her testimony Ms. Masyk testified that it was she who went back and provided care to JW and not Ms. Boychuk. Ms. Boychuk had refused to change JW's depends, she also refused to put JW's shirt and brassiere on.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 7 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she failed to accurately document her interactions with JW on the 24 hour system assessment.

Proper documentation of patient interactions is a core competence skill required by LPNs. Ms. Boychuk failed to demonstrate this skill when she incorrectly documented her interactions with patient JW. Ms. Boychuk should also have ensured that all care provided to JW is properly documented. In this case, Ms. Boychuk wrote how she provided care to patient JW. However, the care was provided by Ms. Masyk. Any member of the care team must be able to review and rely on the records kept for any patient to make an informed decision about their care. When information is incorrect, a decision could be made that causes harm to a patient. It is critical for an LPN to make accurate notes and keep accurate records because of the role they play in a patient's care. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk. The Hearing Tribunal has concluded that this conduct is unprofessional for these reasons.

LPNs play an important role in providing care to patients as required. Ms. Boychuk should have been able to provide basic care to patient JW. However, Ms. Boychuk failed to do so when she refused to assist patient JW to put on her brassiere and to provide peri care. This is a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 8

On or about September 27, 2021, Ms. Boychuk failed to follow proper medication administration practices with regards to client DC by doing one or more of the following:

a. Failed to administer Telmisartan 40 mg at 0800 hours, as ordered;

b. Documented on client DC's Medication Administration Record the administration of Telmisartan 40 mg at 0800 hours when the medication was not administered.

The Hearing Tribunal reviewed the MAR, the 24 Hours Systems Assessment and the RLS report for patient DC. On September 27, 2021, Ms. Boychuk documented on patient DC's MAR that she had administered Telmisartan 40 mg at 0800 hours. However, Ms. Knebel found this medication in the drawer of the medication cart around 1935 hours, and she disclosed the missed dose of Telmisartan to DC. DC's vital signs were taken, they were stable. Ms. Knebel filed an RLS report.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 8 did in fact occur.

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

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;

iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement by not administering and documenting the administration of Telmisartan 40 mg at 0800 hours to patient DC.

Proper medication administration and documentation is a core competence of an LPN. As an LPN Ms. Boychuk should have been able to follow this competence. Ms. Boychuk failed to follow proper medication administration by not administering and by documenting the administration of Telmisartan 40 mg at 0800 hours as ordered. Ms. Boychuk did not administer Telmisartan 40 mg; instead, she documented on the MAR that she had administered this medication to patient DC at 0800 hours. Ms. Boychuk failed to demonstrate the basic medication administration skills required of an LPN. Ms. Boychuk should also have ensured that medications administered to DC were properly documented. When there is missing or incorrect information present, a decision could be made that causes harm to a patient. It is critical for an LPN to make accurate notes and keep accurate records because of the role they play in a patient's care. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 9

On or about September 27, 2021, Ms. Boychuk failed to don Personal Protective Equipment (PPE) prior to entering client DC's room, who was on contact/sporicidal precautions, as required.

The Hearing Tribunal reviewed the RLS report Ms. Osicki filed on September 27, 2021. In this RLS report, Ms. Osicki wrote "Writer observed the LPN in a contact/sporicidal room without appropriate PPE donned. No gown. LPN was spooning medication into patient's mouth. The LPN was doing the morning meds and at least 2 other patients would receive meds after this patient encounter. LPN was using the med cart outside the room as well". There were contact and droplet precaution signs posted outside of the patient's room. Ms. Elford-Milley also testified that she spoke with Ms. Boychuk about not wearing appropriate PPE and Ms. Boychuk admitted that she did not wear the appropriate PPE.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 9 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she entered the room and provided care to patient DC without wearing a gown. DC was on contact/sporicidal isolation.

It is a core competence of LPNs to wear proper personal protective equipment when required to provide care to patients. PPE is required to safely provide care to patients and it also protects staff. Ms. Boychuk should have donned a gown when she was providing care to DC. However, Ms. Boychuk failed to follow proper PPE by not wearing a gown when DC was on contact/sporicidal isolation. By not wearing proper PPE Ms. Boychuk could have passed the infection to other patients and staff. It is critical for an LPN to follow proper PPE guidelines. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 10

On or about September 30, 2021, Ms. Boychuk failed to follow proper medication administration practices with regards to client RD by failing to administer Lispro insulin 3 units at 1145 hours as per the Basal Bolus Insulin Therapy (BBIT) order.

The Hearing Tribunal reviewed the MAR, the BBIT record and RLS Amanda Scott filed on September 30, 2021, for patient RD. In the RLS report, Ms. Scott wrote "Writer was doing a double check for coworker, to ensure that all meds were signed for/given for day shift. Writer observed that no insulin was written on the diabetic record for patient for lunch. Writer checked current BBIT orders and discovered that patient should have received insulin at lunch. Writer asked coworker if they gave patient any insulin at lunch. Coworker stated they did not give any insulin to the patient at lunch". Ms. Scott notified charge nurse, Ms. Elford-Milley, about the missed insulin. At 1145 hours RD's blood sugar was 13.8, at 1450 hours RD's blood sugar was checked again, and it was 12.7. Ms. Elford-Milley also testified that missing a dose of insulin could have significant harm on the patient as they can crash.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 10 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement by not administering 3 units of Lispro Insulin to patient RD at 1145 hours.

Correct medication administration is a core competence for LPNs. LPNs must be able to correctly administer medications following all the medication rights. Ms. Boychuk should have administered 3 units of Lispro Insulin to patient RD. When Ms. Boychuk failed to administer Insulin to RD, she failed to demonstrate the basic skills required of an LPN. When information is

missing or incorrect, a decision could be made that can cause harm to a patient. It is critical for an LPN to make accurate notes and keep accurate records because of the role they play in a patient's care. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 11

On or about September 30, 2021, Ms. Boychuk failed to follow proper medication administration practices with regards to client JE by administering Percocet 2 tablets at 0815 hours instead of Percocet 1 tablet, as ordered.

The Hearing Tribunal reviewed the oral narcotic inventory record, MAR and the RLS report Ms. Jackson filed on September 30, 2021. In the RLS report, Ms. Jackson wrote "Patient's PRN order for Percocet is one tablet three times a day. Found on evening shift that patient received two tablets twice on day shift instead of just one tablet. Patient notified. Vitals stable. No excessive drowsiness noted". The Hearing Tribunal found that Ms. Boychuck administered two tablets of Percocet to JE on September 30, 2021, at 0815 hours when JE was only ordered to receive one tablet of Percocet.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 11 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she administered 2 tablets of Percocet to JE at 0815 instead of 1 tablet of Percocet as ordered.

Proper medication administration is a core competence of LPNs. As an LPN, Ms. Boychuk should have been able to follow this competence. Ms. Boychuk failed to follow proper medication

administration when she administered 2 tablets of Percocet to JE at 0815 hours instead of 1 tablet as ordered. Ms. Boychuk failed to demonstrate the basic medication administration skills required of an LPN. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

<u>Allegation 12</u>

On or about October 4, 2021, Ms. Boychuk failed to follow proper medication administration practices by administering Percocet 2 tablets to client JE at 1936 hours instead of Percocet 1 tablet as ordered.

The Hearing Tribunal reviewed the oral narcotic inventory record and MAR for patient JE for October 4, 2021. JE was ordered to receive one tablet of Percocet PRN three times a day. Ms. Boychuk administered two tablets of Percocet to JE on October 4, 2021, at 1936 hours and signed in the MAR.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 12 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she administered 2 tablets of Percocet to JE at 1936 hours instead of 1 tablet of Percocet as ordered.

Proper medication administration is a core competence of LPNs. As an LPN, Ms. Boychuk should have been able to follow this competence. Ms. Boychuk failed to follow proper medication administration when she administered 2 tablets of Percocet to JE at 1936 hours instead of 1 tablet as ordered. Ms. Boychuk failed to demonstrate the basic medication administration skills required of an LPN. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 13

On or about October 9, 2021, Ms. Boychuk failed to follow proper medication administration practices by administering Percocet 2 tablets to client JE at 1540 hours instead of the ordered dose of Percocet 1 tablet.

The Hearing Tribunal reviewed the oral narcotic inventory record, MAR and the RLS report Ms. Jackson filed on October 12, 2021. In the RLS report, Ms. Jackson wrote “PRN Percocet ordered 1 tablet three times per day. While writer giving PRN dose today noted 2 tablets given at 1420 on October 10th and 2 tablets given at 1540 on October 9th. No apparent harm to patient”. The Hearing Tribunal finds that Ms. Boychuck administered two tablets of Percocet to JE on October 9, 2021, at 1540 hours when JE was only ordered to receive one tablet of Percocet.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 13 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she administered 2 tablets of Percocet to JE at 1540 hours instead of 1 tablet of Percocet as ordered.

LPNs are required to follow proper medication administration and it is a core competence of LPNs. As an LPN, Ms. Boychuk should have been able to follow this competence. Ms. Boychuk failed to follow proper medication administration when she administered 2 tablets of Percocet to JE at 1540 hours instead of 1 tablet as ordered. Ms. Boychuk failed to demonstrate the basic medication administration skills required of an LPN. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

Allegation 14

On or about October 10, 2021, Ms. Boychuk failed to follow proper medication administration practices by administering Percocet 2 tablets to client JE at 1420 hours instead of the ordered dose of Percocet 1 tablet.

The Hearing Tribunal reviewed the oral narcotic inventory record, MAR and the RLS report Ms. Jackson filed on October 12, 2021. In the RLS report, Ms. Jackson wrote "PRN Percocet ordered 1 tablet three times per day. While writer giving PRN dose today noted 2 tablets given at 1420 on October 10th and 2 tablets given at 1540 on October 9th. No apparent harm to patient". The Hearing Tribunal finds that Ms. Boychuck administered two tablets of Percocet to JE on October 10, 2021 at 1420 hours when JE was only ordered to receive one tablet of Percocet.

The Hearing Tribunal considered and found that the oral evidence and documents prove that the conduct for Allegation 14 did in fact occur.

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

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;
iii. Conduct that harms the integrity of the regulated profession.

Ms. Boychuk displayed a serious lack of skill or judgement when she administered 2 tablets of Percocet to JE at 1420 hours instead of 1 tablet of Percocet as ordered.

LPNs are required to follow proper medication administration and it is considered a core competence skill for all LPNs. As an LPN, Ms. Boychuk should have been able to follow this competence. Ms. Boychuk failed to follow proper medication administration when she administered 2 tablets of Percocet to JE at 1420 hours instead of 1 tablet as ordered. Ms. Boychuk failed to demonstrate the basic medication administration skills required of an LPN. This is also a skill that all LPNs must be able to carry out and a failure to do so in this case demonstrates a lack of skill on the part of Ms. Boychuk.

For the reasons already given in the prior allegations, this conduct also harms the integrity of the profession.

The Hearing Tribunal has also determined that for substantially the same reasons given at Allegation #1, Ms. Boychuk has also breached the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above.

The Hearing Tribunal has concluded that this conduct was unprofessional for these reasons.

As the Hearing Tribunal has made findings of unprofessional conduct, it will be necessary to determine the appropriate sanction response to this unprofessional conduct. This decision shall be distributed to the parties and a further hearing date scheduled for the purposes of addressing sanction.

DATED THE 21st DAY OF FEBRUARY 2024 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kunal Sharma, LPN
Chair, Hearing Tribunal