

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/sporidical 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/sporidical 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/sporidical 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/sporidical 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.

Allegation 12

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. Boychuk 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

**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 ON SANCTION OF THE HEARING TRIBUNAL

(1) Submissions

The submissions of the Complaints Officer were submitted to the Hearing Tribunal in writing. Ms. Boychuk did not reply to the Hearing Tribunal's direction to provide written submissions on sanction.

Hearing Tribunal

Kunal Sharma, LPN, Chairperson

Nicole Searle, LPN

Terry Engen, Public Member

Don Wilson, Public Member

Staff:

Caitlyn M. Field, Legal Counsel for the Complaints Officer

Investigated Member:

Kathy Boychuk, LPN ("Ms. Boychuk", "Investigated Member")

(2) Preliminary Matters

The Hearing Tribunal considered the following:

1. Written submissions from Counsel for the Complaints Officer dated 15 April 2024.

(3) Findings of Unprofessional Conduct

Upon consideration of the evidence presented before it at the Hearing as well as the submissions of the Parties, the Hearing Tribunal determined Ms. Boychuk had engaged in the following conduct that was also determined to rise to the level of unprofessional conduct:

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.

(4) Submissions on the Factors to be Considered in Sanction

Counsel for the Complaints Officer referred to the leading case of *Jaswal v Newfoundland (Medical Board)*, 1996 CANLII 11630 at para 35 (NL SCTD)(“*Jaswal*”) in which the Court identified a list of factors to take into account when deciding the appropriate sanction in cases such as this. The list of factors offered in *Jaswal* includes:

- 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;
- 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 degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct; and
- The range of sentence in other similar cases.

The Complaints Officer also addressed that regarding sanction orders the emphasis must be on the public interest. Further that the public interest is protected by:

- 1) ensuring the public are not at risk of harm as a result of continuing conduct by the member,
- 2) ensuring that the public has confidence in the profession, and
- 3) sending an appropriate message to other members of the profession through the College's response to conduct that is found to be unacceptable.

The Complaints Officer submitted that sanction orders must make clear to each of the registrants, the profession and the public that the unprofessional conduct is not acceptable thereby demonstrating that the College is fulfilling its duty to protect the public.

The Nature and Gravity of the proven Allegations:

The Complaints Officer noted that Allegations 1-5, 8 and 1-14 all related to medication administration and documentation errors. Further, that such errors create a risk of overdosing or underdosing patients, putting them at risk. The Complaints Officer also noted the Hearing Tribunal's discussion of how documentation errors can cause harm to patients as other members of the health care team rely on accurate information to make decisions in respect of the patient.

The Complaints Officer noted that Allegation #6 related to the failure to provide basic Activities of Daily Living in which LPNs play an important role. Allegation #9 related to a failure to wear appropriate Person Protective Equipment ("PPE") which put herself, other patients and staff at risk.

Overall, the Complaint Officer argued that Ms. Boychuk failed to demonstrate fundamental skills, meet the minimum standards for her profession and failed as care provider demonstrating the need for significant penalties.

The age and experience of the investigated member:

The Complaints Officer notes that at the time of the hearing, Ms. Boychuk was a 29-year veteran of the profession. Arguing that Ms. Boychuk should have realized her conduct was unacceptable and her failure to do so is an aggravating factor.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:

The Complaints Officer notes that Ms. Boychuk did have two prior complaints. One in January 2013 which was resolved by agreement and an undertaking which specifically allows future Hearing Tribunals to consider it a factor in any future penalty determination. There were not, however, any prior findings by a Hearing Tribunal in respect of Ms. Boychuk and the previous complaints related to conduct differed than the subject of this hearing. As such, the Complaints Officer suggests this factor is only moderately aggravating.

The age and mental condition of the victim, if any:

The Complaints Officer notes that a number of witnesses gave evidence that Ms. Boychuk worked with individuals recovering from major medical events. While there was no direct evidence of specific vulnerability of these patients, the Complaints Officer suggests it was clear they were vulnerable given they were recovering from surgery or other major medical events and therefore this is an aggravating factor.

The number of times the offending conduct was proven to have occurred:

The Complaints Officer notes the conduct in this hearing occurred between May 2021 and October 2021. This was not a matter of a single instance but of a pattern of behavior including concerns brought to her attention multiple times.

The Complaints Officer notes that this is not a one-off but multiple errors, on multiple occasions, with multiple individuals. Despite having an opportunity to correct her course, Ms. Boychuk failed to do so. All of this, it is argued, makes this an aggravating factor.

The role of the investigated member in acknowledging what occurred:

The Complaints Officer cautions that the Hearing Tribunal cannot take a failure to admit conduct or responsibility as an aggravating factor. It can, however, be mitigating where such things do occur. In this case, no admission was made, and this is a neutral factor.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:

The Complaints Officer was not aware of any financial impact on Ms. Boychuk.

The impact of the incident on the victim(s):

The Complaints Officer argues it is clear Ms. Boychuk's conduct had an impact on clients and colleagues alike.

The failure to administer a long-acting pain killer for MH left him in pain. His pain was only managed normally again a few days later. This means MH was in pain for three days unnecessarily.

Client JW who Ms. Boychuk had refused to assist with dressing or peri-care was upset when this care was refused dismissively and caused pain as the care related to alleviate pain she would otherwise have.

Other clients missed insulin doses which the evidence indicated could lead to higher blood glucose levels and negatively impact wound healing.

Numerous patients would have been impacted by Ms. Boychuk's pattern of failing to administer medications as ordered and when ordered.

Numerous colleagues were also impacted by her conduct as working with her caused stress, anxiety, and impeded them from completing their work.

The Complaints Officer submits this is also an aggravating factor.

The presence or absence of any mitigating circumstances:

The Complaints Officer did not offer comments in respect of this factor.

The need to promote specific and general deterrence and, thereby protect the public and ensure the safe and proper practice:

In light of the need for specific deterrence of Ms. Boychuk, the Complaints Officer states that her conduct shows how patient wellbeing and care was not a priority for her. She had the opportunity to reflect and correct herself but chose not to and remained willfully blind to the impact her conduct was having on those around her.

In regard of general deterrence, all LPNs need to know this conduct will not be tolerated and will be met with appropriate sanction if it does.

The need to maintain the public's confidence in the integrity of the profession:

The Complaints Officer noted that it is necessary for the public to see the CLPNA holding members to their standards and obligations and to addressing that when they fail to do so.

This is required to show the public it can maintain confidence in the profession. The Complaints Officer suggests the orders proposed will maintain this public confidence in the integrity of the profession.

The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct

The Complaints Officer states only that it is clear Ms. Boychuk's conduct is a departure from the conduct expected of an LPN.

The range of sentences in other similar cases

The Complaints Officer provided three cases which it suggested the Hearing Tribunal could reference in respect of the range of sentences in similar cases.

In the first case, the College of Licensed Practical Nurses of Alberta and Edward Nde, the member had admitted to eleven allegations of failing to administer medication, failure of medication pass audits and failure to assess clients. The resulting sanction, which the parties jointly presented, was for the member to pay 25% of costs, to do CLPNA document review, and to undertake certain courses.

In the College of Licensed Practical Nurses of Alberta and Kinawa Sevanthavesouk, the member admitted to allegations for failing to document or reassess blood sugar levels, failing to document holding of insulin, failing to properly document medication administration, and medication administration errors. Further, a joint submission on sanction resulted in the member being required to pay 25% of costs, to undertake CLPNA document review, and certain education.

In the College of Licensed Practical Nurses of Alberta and Sandra Robles, the member admitted to several allegations relating to failing to follow medication administration practices, failing to administer medications, failing to perform assessments and failure to properly document. Again, by joint submission, the member was ordered to pay \$4000 in costs, undertake document review and to undertake certain education.

The Complaints Officer notes that each of these cases involved the mitigating factors of agreement to the conduct and joint submissions. However, the cases involved similar types of conduct as this one and in those cases the sanction focused on remedial education and an order for costs.

(5) Submissions of the Complaints Officer on Sanction

The Complaints Officer requested the following orders pursuant to section 82 of the *HPA*:

- a) The Hearing Tribunal's written reasons for the Decision shall serve as a reprimand.
- b) Ms. Boychuk shall pay 50% of the costs of the investigation and hearing to be paid over a period of 24 months from service of the Hearing Tribunal's written decision addressing sanction (the "Sanction Decision").
- c) Ms. Boychuk will not be eligible to apply for registration or reinstatement until she has complied with the following:
- i. Ms. Boychuk 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". Ms. Boychuk shall provide a signed written declaration to the Complaints Officer attesting she has reviewed the documents:
 - i. Code of Ethics for Licensed Practical Nurses in Canada;
 - ii. Standards of Practice for Licensed Practical Nurses in Canada;
 - iii. CLPNA Practice Policy: Professional Responsibility & Accountability;
 - iv. CLPNA Practice Guideline: Medication Management;
 - v. CLPNA Practice Guideline: Infection Prevention and Control;

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

- ii. Ms. Boychuk shall complete the following remedial education, at her own cost. Ms. Boychuk shall provide the Complaints Officer with a certificate confirming successful completion of the remedial education.
 - i. LPN Code of Ethics Learning Module available online at <https://www.clpna.com/members/continuing-education/study-with-clpna/>
 - ii. Medication Administration Course available online at <https://studywithclpna.com/medicationadministration/>
 - iii. Reducing Medication Errors: A Focus on the Med Pass Course available online at [https://pedagogyeducation.com/Courses/Reducing-Medication-Errors-A-Focus-on-the-Med-\(1\)](https://pedagogyeducation.com/Courses/Reducing-Medication-Errors-A-Focus-on-the-Med-(1))

Should any of the above courses become unavailable, then Ms. Boychuk shall request in writing to be assigned an alternative course prior to the deadline. The Complaints Officer shall, in her sole discretion, reassign a course. Ms. Boychuk will be notified by the Complaints Officer, in writing, advising of the new course required.

d) Once Ms. Boychuk has completed the requirements set out in paragraph (c) and provided that she is not in default of the requirement for payment of costs as set out in paragraph (b), she will be eligible to apply for reinstatement.

e) If, upon receiving her application for registration, the Registrar determines that Ms. Boychuk meets the CLPNA's requirements for reinstatement, Ms. Boychuk's practice permit shall be reinstated.

f) Ms. Boychuk 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. Boychuk will keep her contact information current with the CLPNA on an ongoing basis.

g) Should Ms. Boychuk 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:

- i. Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;
- ii. Treat Ms. Boychuk non-compliance as information for a complaint under s. 56 of the Act; or
- iii. In the case of non-payment of the costs described in paragraph 8(b) above, suspend Ms. Boychuk'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 Complaints Officer submits the requested orders are appropriate and reflect an appropriate consideration of the *Jaswal* factors. The orders sought, according to the Complaints Officer, will deter Ms. Boychuk from similar conduct in the future and re-educate her on her obligations and the standards required of LPNs. In this way the proposed orders will protect the public and are necessary to maintain the integrity of the profession.

The Complaints Officer argues the reprimand shows the conduct was not acceptable and is punitive in nature. The documents to be reviewed and education are to provide remedial education and ensures public protection. Finally, the history of errors, number of times the conduct was repeated and the failure to demonstrate core competencies makes the course work and remedial education appropriate.

The Complaints Officer suggests Ms. Boychuk be ordered to pay all or some of the costs of the investigation and hearing in this matter. The Complaints Officer provided records demonstrating the costs at the time of submissions were approximately \$39,085.72. The costs were significant due to the number of allegations and the number of witnesses that had to be called (7 in total) even though the hearing only took one day.

The Complaints Officer references the decision in *Jinnah v Alberta Dental Association and College*, 2022 ABCA 336 (“*Jinnah*”) of the Alberta Court of Appeal (“ABCA”), which held that it would not be appropriate to impose a significant costs order unless there is a compelling reason to do so.

Compelling reasons include the following:

- 1) engaged in serious unprofessional conduct;
- 2) was found to have engaged in unprofessional conduct on two or more occasions;
- 3) failed to cooperate with the investigation and forced the College to expend more resources than otherwise necessary; or
- 4) engaged in hearing misconduct.

The Complaints Officer asks that Ms. Boychuk be ordered to pay 50% of the costs of the investigation and hearing arguing there are compelling reasons to make such order. The Complaints Officer suggests Ms. Boychuk engaged in serious conduct which the ABCA indicated could be a “compelling reason”. There are a number of factors which the ABCA identified as helping to determine whether conduct was serious conduct, the Complaints Officer argues these factors favour the order sought.

Seriousness of the Charges

The Complaints Officer argues Ms. Boychuk’s conduct caused the proceedings to be necessary and that serious and significant findings of unprofessional conduct resulted. As such, the expense of the investigation and hearing was justified. The proven allegations showed breaches of core competencies, impacted vulnerable clients, resulted in patient neglect and significantly impacted colleagues and the work environment. Overall, the conduct Ms. Boychuk was found to have engaged in was egregious unprofessional conduct and the conduct was engaged in multiple times with multiple individuals.

Degree of Success in Resisting the Charges

The Complaints Officer notes Ms. Boychuk did not successfully resist any allegation made.

Necessity of calling all of the witnesses who gave evidence or for incurring other expenses associated with the hearing.

The Complaints Officer argues the hearing could not have proceeded without all of the witnesses called – no witness was unnecessary. Further that no unreasonable expenses were incurred, and the hearing was completed by videoconference meaning no travel or accommodation expenses were incurred. Also, the Complaints Officer took steps to limit the

number of allegations pursued by the witnesses needed effectively managing the costs of the hearing.

Whether Ms. Boychuk cooperated with respect to the investigation and offered to facilitate proof by admissions

Ms. Boychuk did not participate in the hearing at all. It had initially been scheduled to proceed on April 14, 2023, but it was adjourned due to Ms. Boychuk's non-attendance. This adjournment unnecessarily increased the expense of the hearing.

Financial Circumstances of Ms. Boychuk and the degree to which her financial position has already been affected by other aspects of any penalty that has been imposed

As already noted, no information was provided with respect to Ms. Boychuk's financial circumstances.

In sum, the Complaints Officer argues that the conduct in this matter meets the case in which the ABCA stated that where a member knowingly commits serious unprofessional misconduct it is not unfair or unprincipled to ask them to bear substantial costs of all of the costs of the regulator in prosecuting the matter. In this case, the Complaints Officer submits, the offensive conduct was brought to Ms. Boychuk's attention more than once and she was aware of the concerns relating to her conduct. Rather than to reflect and correct course, Ms. Boychuk was defensive and made no adjustments. She took no accountability for her conduct.

As such, the Complaints Officer argues that given the serious nature of the unprofessional conduct an order for costs is appropriate and that 50% of the anticipated costs strikes the right balance in considering the factors set out in *Jinnah*.

Finally, the Complaints Officer notes that it would be acceptable for Ms. Boychuk to be given 24 months in which to pay the amount sought to ensure the costs order is not a crushing financial blow for Ms. Boychuk.

(6) Decision of the Hearing Tribunal on Sanction

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 Mrs. Boychuk has engaged in. In making its decision on penalty, the Hearing Tribunal considered the number of factors identified in *Jaswal* as follows:

The Nature and Gravity of the proven Allegations:

The Hearing Tribunal considers the nature and gravity of Ms. Boychuk's actions as being very serious and shocking. LPNs are expected to follow proper medication administration and documentation requirements. As an LPN, Ms. Boychuk occupied a position of trust in caring for patients that were highly vulnerable. These people were dependent upon the integrity of LPNs who cared for them. LPNs play a very important role in protecting patients' health and well being. However, Ms. Boychuk failed in protecting that responsibility when she failed to provide safe and competent nursing care to patients. The Hearing Tribunal considers this as a failure to meet the minimum obligations of the profession.

Allegations 1-5, 8, and 10-14 are all medication administration and documentation errors. These errors create a risk of overdosing or underdosing vulnerable patients and put patients at risk. The Hearing Tribunal noted that significant harm can result where a patient receives their medication late, and that Ms. Boychuk's conduct could cause a diminished view of Licensed Practical Nurses and their profession. In specific reference to Ms. Boychuk's documentation errors, the Hearing Tribunal noted that other members of the care team must be able to review and rely on records to make informed decision for care, and when documentation is inaccurate it can cause harm to patients.

Accordingly, the conduct in issue is significant and serious because it demonstrates a failure to adhere to basic nursing practice and pertains to basic, core competencies of an LPN. The gravity of the proven allegations is an important consideration as the failure to properly carry out these competencies has the potential to cause harm to patients under an LPN's care.

Allegation 6 relates to a failure to provide basic Activities of Daily Living to client JW, including a failure to assist JW to put on a brassiere and provide requested peri-care. The Hearing Tribunal held that LPNs play an important role in providing basic Activities of Daily Life, and that this conduct harmed the integrity of the profession.

Allegation 9 relates to a failure to don Personal Protective Equipment ("PPE") prior to entering a client's room when that client was on contact/sporicidal precautions. The Hearing Tribunal noted that by failing to wear PPE, Ms. Boychuk could have passed on an infection to other patients and staff, and that it is critical that LPNs follow proper PPE guidelines.

Ms. Boychuk failed to demonstrate fundamental nursing skills, failed to meet the minimum obligations of the profession, and failed to respect her position as a care provider. This demonstrates a need for significant penalties to address these failures.

The age and experience of the investigated member:

Ms. Boychuk was initially registered as a member of the CLPNA on January 1, 1994. At the time of the hearing, she had been an LPN for 29 years. As such, this is not a case where allegations have been made against a young or new member of the profession who is

unaware of the importance of medication administration and documentation practices. Based on Ms. Boychuk's knowledge and experience, she should have realized her conduct was unacceptable. This is therefore an aggravating factor and demonstrates the need for significant sanctions, particularly sanctions with a remedial focus.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:

Ms. Boychuk does have a disciplinary history as she has two prior complaints dating from January 2013 and May 2015. The Complaint from January 2013 was resolved by agreement and undertaking, which specifically indicated that the conduct in issue could be considered by a future Hearing Tribunal for the purpose of determining penalty. There are no prior findings of unprofessional conduct by a Hearing Tribunal, and that the prior complaints against Ms. Boychuk do not involve similar conduct as the proven allegations before this Tribunal. As Ms. Boychuk has previously received complaints regarding her conduct, but since they do not relate to similar conduct and has no previous findings of unprofessional conduct, this is a moderately aggravating factor.

The age and mental condition of the victim, if any:

The Hearing Tribunal heard evidence from several witnesses that the unit Ms. Boychuk worked on served individuals recovering from major medical events, often strokes but also limb amputations or other medical events that required an interdisciplinary team. While there was not specific evidence in relation to the vulnerability of each client, the patients that Ms. Boychuk was caring for were in a vulnerable position as they were recovering from surgery or major medical events. In either situation, they were dependent on Ms. Boychuk for safe and effective care. This is therefore an aggravating factor.

The number of times the offending conduct was proven to have occurred:

The conduct took place over a period of six months, between May 2021 and October 2021. Ms. Boychuk's conduct was not a matter of a single instance, but a pattern of behavior which persisted despite having concerns brought to her attention on more than one occasion by her employer. Ms. Boychuk repeated her conduct on multiple occasions and on multiple dates. Ms. Boychuk engaged in numerous instances of unprofessional conduct, many of which were repeated. Ms. Boychuk's conduct not only impacted patients, but also her colleagues who testified to the additional work and stress caused by working with Ms. Boychuk. Ms. Boychuk's unprofessional conduct had the consequence of compromising the care of patients, with impact on patients' pain management, receipt of correct dosages, and overall treatment plans. The number of individuals affected and the number of times the conduct occurred, in various forms, points to the need for serious penalties. The conduct was not a single anomalous incident but rather represents errors in Ms. Boychuk's conduct over a period of time, on multiple different occasions, and with multiple individuals. The concerns were brought to Ms. Boychuk's attention, and she had ample opportunity to address her

practice concerns but still failed to do so. The Hearing Tribunal further notes that the proven allegations before stemmed from two separate complaints filed by Mr. Tetz. This is an aggravating factor.

The role of the investigated member in acknowledging what occurred:

The Hearing Tribunal must be careful not to treat a failure to admit conduct or take responsibility as an aggravating factor in sentencing. Members are innocent until proven guilty; a decision to not admit guilt is not an aggravating factor. However, this factor may be considered a mitigating one only if the member has acknowledged their conduct and taken responsibility. Ms. Boychuk did not cooperate with the hearing process. The Hearing was initially scheduled to proceed on April 14, 2023. While the Hearing Tribunal, counsel for the Complaints Officer, and Ms. Boychuk's representative attended, the hearing was adjourned due to Ms. Boychuk's non-attendance. The adjournment of the hearing due to Ms. Boychuk's absence increased the CLPNA's expenditures unnecessarily. Ms. Boychuk decided not to attend the second hearing on October 26, 2023, even though she was provided ample notice. Ms. Boychuk did not make admissions regarding the allegations made against her. This factor should therefore not be treated as mitigating. It is a neutral factor.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:

The Hearing Tribunal is not aware of any financial impact on Ms. Boychuk.

The impact of the incident on the victim(s):

The Hearing Tribunal finds that Ms. Boychuk's conduct clearly had an impact on both clients and colleagues on her unit. With regards to client MH, the Tribunal heard evidence that Ms. Boychuk had failed to administer his long-acting pain killer. Mr. Tetz testified that client MH was uncomfortable, called out that he was in pain, and that it took a few days for his pain management levels to return to normal. Ms. Elford-Milley testified that as client MH had been on a higher dose of long-acting pain medication, not receiving his ordered dose would have had a significant pain impact. The Hearing Tribunal found that Ms. Boychuk's error led to MH being in "unnecessary" pain for three days.

The Tribunal further heard evidence that client JW, who had requested assistance with activities of daily living, was emotionally upset by Ms. Boychuk's dismissive response and refusal to assist her dress or provide peri-care when requested. Ms. Masyk testified that client JW's left hemiplegia caused her arm to compress her left breast, causing pain, and that wearing a brassiere helped to alleviate that pain. The Hearing Tribunal also heard evidence from Ms. Jackson that missed doses of insulin could lead to higher blood glucose levels, which has an impact on wound healing. The Hearing Tribunal further found that missed doses of insulin can cause harm to patients.

The Hearing Tribunal heard evidence from Ms. Osicki that client DC was on contact precautions, and that by going into client DC's room without appropriate personal protective equipment there was a risk of transmission to other clients that could cause delay to their access of rehabilitation therapy. As previously noted, the Hearing Tribunal held that by failing to wear PPE, Ms. Boychuk could have passed on an infection to other patients. Outside of these specific clients, the Hearing Tribunal heard evidence that Ms. Boychuk's failure to administer medications as ordered, incorrect/delayed administration, and pattern of conduct would have impacted her clients. Clients on Unit 35 worked with an interdisciplinary team of health care providers, and interruptions to their pain management or other medications could interfere with their ability to participate in rehabilitation.

Further, the Tribunal heard evidence that Ms. Boychuk's colleagues were impacted by her conduct:

- 1) Ms. Reimer testified that, when working with Ms. Boychuk, she felt stressed, had to do extra work, and would double-check Ms. Boychuk's medication administration and charting due to her concerns over patient care.
- 2) Ms. Knebel testified that she felt anxious working with Ms. Boychuk, that Ms. Boychuk was not a fair team member, and would double check to ensure all medications had been given.
- 3) Ms. Osicki testified that Ms. Boychuk did not seem to be aware of patients' needs and often received complaints from patients regarding Ms. Boychuk.
- 4) Ms. Jackson testified that while she liked Ms. Boychuk as a person, she found that when she worked with Ms. Boychuk it was difficult to complete the assigned tasks.

There is an abundance of evidence from various witnesses about the fallout of Ms. Boychuk's conduct on her clients and colleagues. There can be no doubt that these parties were impacted by her actions to various degrees. The Hearing Tribunal considers that this is therefore an aggravating factor.

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 protect the public and ensure the safe and proper practice:

There is a need to impose a sanction that deters Ms. Boychuk from repeating this conduct as well as a sanction that would deter other LPNs from engaging in similar conduct. The sanctions that are ordered should send a message to both Ms. Boychuk as well as other LPNs to state that this type of conduct will not be tolerated. There are two aspects to deterrence.

The first is specific deterrence, meaning that the orders imposed ought to deter the member from repeating the conduct in the future. The second aspect of deterrence is general deterrence, meaning that the orders ought to deter other members of the profession from engaging in similar conduct. A professional discipline hearing involves not just the individual, but also the effect of the individual's conduct on their patients and on the profession. This public dimension is of critical significance. Ms. Boychuk's conduct indicates that concern for patient wellbeing and care was not a priority.

Ms. Boychuk had the opportunity to reflect and correct her conduct but chose to remain willfully blind to the impact her conduct had on everyone around her. The orders sought by the Complaints Officer are suited to deter Ms. Boychuk from conducting herself in such a manner again by imposing a combination of remedial and punitive sanctions. The orders also reflect an appropriate response to the unprofessional conduct at issue and would serve as general deterrence for other members of the profession. It will send a message to other members of the profession that this conduct is unacceptable and that such conduct will be addressed with appropriate sanctions.

The need to maintain the public's confidence in the integrity of the profession:

Of importance in this case is the necessity of holding members of the CLPNA to the standards and obligations expected of them. Particularly regarding fundamental aspects of an LPN's practice such as medication administration and documentation. The Hearing Tribunal must consider what message it will send to the public to maintain confidence in the profession. The public would therefore expect a Hearing Tribunal to sanction Ms. Boychuk in a manner that would deter such conduct from occurring again and which demonstrates the regulator has taken the conduct seriously. The orders sought by the Complaints Officer will maintain the public's confidence in the integrity of the profession.

The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct:

It is clear to the Hearing Tribunal that Ms. Boychuk's conduct is a departure from the conduct expected of an LPN.

The range of sentences in other similar cases:

The Hearing Tribunal has considered the sentencing in similar cases. The Hearing Tribunal's decisions indicate that a sanction focusing on remedial education and an order for costs are appropriate in a situation involving numerous medication administration and documentation errors.

It is important for 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 Ms. Boychuk's actions, in light of the *Jinnah* decision and the direction of the ABCA found therein as well as the submissions of the Complaints Officer. 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 submission on penalty is appropriate, reasonable and serves the public interest and therefore accepts the proposed penalties.

(7) 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.

- a) The Hearing Tribunal's written reasons for the Decision shall serve as a reprimand.
- b) Ms. Boychuk shall pay 50% of the costs of the investigation and hearing to be paid over a period of 24 months from service of the Hearing Tribunal's written decision addressing sanction (the "Sanction Decision").
- c) Ms. Boychuk will not be eligible to apply for registration or reinstatement until she has complied with the following:
 - i. Ms. Boychuk 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. Boychuk shall provide a signed written declaration to the Complaints Officer attesting she has reviewed the documents:

- i. Code of Ethics for Licensed Practical Nurses in Canada;
- ii. Standards of Practice for Licensed Practical Nurses in Canada;
- iii. CLPNA Practice Policy: Professional Responsibility & Accountability;
- iv. CLPNA Practice Guideline: Medication Management;
- v. CLPNA Practice Guideline: Infection Prevention and Control;

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

- ii. Ms. Boychuk shall complete the following remedial education, at her own cost. Ms. Boychuk shall provide the Complaints Officer with a certificate confirming successful completion of the remedial education.

- i. LPN Code of Ethics Learning Module available online at <https://www.clpna.com/members/continuing-education/study-with-clpna/>
- ii. Medication Administration Course available online at <https://studywithclpna.com/medicationadministration/>
- iii. Reducing Medication Errors: A Focus on the Med Pass Course available online at [https://pedagogyeducation.com/Courses/Reducing-Medication-Errors-A-Focus-on-the-Med-\(1\)](https://pedagogyeducation.com/Courses/Reducing-Medication-Errors-A-Focus-on-the-Med-(1))

Should any of the above courses become unavailable, then Ms. Boychuk shall request in writing to be assigned an alternative course prior to the deadline. The Complaints Officer shall, in her sole discretion, reassign a course. Ms. Boychuk will be notified by the Complaints Officer, in writing, advising of the new course required.

d) Once Ms. Boychuk has completed the requirements set out in paragraph (c) and provided that she is not in default of the requirement for payment of costs as set out in paragraph (b), she will be eligible to apply for reinstatement.

e) If, upon receiving her application for registration, the Registrar determines that Ms. Boychuk meets the CLPNA's requirements for reinstatement, Ms. Boychuk's practice permit shall be reinstated.

f) Ms. Boychuk 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. Boychuk will keep her contact information current with the CLPNA on an ongoing basis.

g) Should Ms. Boychuk 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:

- i. Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

- ii. Treat Ms. Boychuk non-compliance as information for a complaint under s. 56 of the Act;
or

- iii. In the case of non-payment of the costs described in paragraph (b) above, suspend Ms. Boychuk'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.

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 19th DAY OF JUNE 2024 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

A handwritten signature in black ink, appearing to read 'Kunal Sharma'.

Kunal Sharma, LPN,
Chair, Hearing Tribunal