

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 LACEY MACMILLAN**

**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 LACEY MACMILLAN, LPN #48608, WHILE A MEMBER OF THE COLLEGE OF
LICENSED PRACTICAL NURSES OF ALBERTA (“CLPNA”)**

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via videoconference on June 21, 2024, with the following individuals present:

Hearing Tribunal:

Kelly Annesty, Licensed Practical Nurse (“LPN”) Chairperson
Sarah Kawaleski, LPN
Vince Paniak, Public Member
Patricia Hull, Public Member

Staff:

Vita Wensel, Legal Counsel for the Complaints Director, CLPNA
Susan Blatz, Complaints Director, CLPNA

Investigated Member:

Lacey MacMillan, LPN (“Ms. MacMillan” or “Investigated Member”)
Lee Watson, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. MacMillan was an LPN within the meaning of the *Health Professions Act* (“the Act”) at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. MacMillan was initially licensed as an LPN in Alberta in 2019.

On March 20, 2023, the CLPNA received a complaint (the “Complaint”) about Ms. MacMillan, LPN. The Complaint alleged concerns regarding Ms. MacMillan’s practice as an LPN while working at George Spady Society in Edmonton (the “GSS”). The Complaint raised concerns regarding inappropriate boundaries with MG, a patient who was receiving assistance and nursing services from the GSS (“Patient MG”).

The Complaint was made by _____, a member of the public and the sister of Patient MG (the “Complainant”). The Complaint was submitted pursuant to s. 55 of the *Health Professions Act* (the “Act”).

By letter dated March 20, 2023, the CLPNA’s Complaints Director, Ms. Sanah Sidhu (the “Complaints Director”) provided Ms. MacMillan with Notice of the Complaint. Within the letter, Ms. Sidhu appointed Ms. Susan Blatz, Complaints Officer for the CLPNA (the “Complaints Officer”), to handle the Complaint pursuant to s. 20(1) of the Act.

In accordance with s. 55(2)(d) of the Act, the Complaints Director also appointed Mr. Kerry Palyga, Investigator for the CLPNA (the “Investigator”), to investigate the Complaint. The Investigator concluded his investigation on September 10, 2023, and submitted his investigation report to the Complaints Officer.

The Complaints Officer 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. By way of letter dated April 10, 2024, Ms. MacMillan received notice that the matter was referred to a hearing and was provided with a copy of the Statement of Allegations.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. MacMillan by way of letter dated May 6, 2024.

(4) Allegations

The Allegations in the Statement of Allegations (the “Allegations”) are:

“It is alleged that Lacey MacMillan, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. Between June 3, 2022, and July 21, 2022, failed to maintain appropriate professional boundaries with Patient MG including one or more of the following:
 - a. Took a personal photo with Patient MG;
 - b. Posted one or more photos of Patient MG on your Facebook profile;
 - c. While on and/or off shift as an LPN, allowed Patient MG to use your cellphone on more than one occasion, including to use your Facebook messenger account.
2. Between June 3, 2022, and July 21, 2022, failed to maintain Patient MG’s confidentiality when you posted one or more photos of Patient MG on your Facebook profile and identified her by name.

3. Between March 15, 2023, and March 16, 2023, failed to communicate in a respectful and professional manner with MW and JW, including via phone, Facebook messenger and/or email, including one or more of the following:
 - a. Stating:
 - i. "I know you were mean to her" to MW;
 - ii. "Probably to take her away from your put downs, you were so jealous of her, she said, that's sad" to MW;
 - iii. "your sister's death is your guilt", or words to that effect to MW;
 - iv. "you're not a good person and karma is gonna get you", or words to that effect to MW;
 - v. "you're a drug addict like your sister", or words to that effect to MW;
 - vi. That MW looks like "one of those Guatemalan villagers" or words to that effect to JW; and
 - vii. "you're a drunk and a pervert" to JW.
 - b. Being dishonest about police involvement.
4. On March 16, 2023, failed to maintain Patient MG's confidentiality in an email to MW's employer and/or colleagues.

It is further alleged that this conduct constitutes "unprofessional conduct" as defined in s. 1(1)(pp)(i), (ii) and (xi) of the *Health Professions Act*, RSA 2000 c H-7 (the "HPA") and in particular this conduct breaches one or more of the following:

1. *Standards of Practice for Licensed Practical Nurses in Canada (2020)*: Standards 1.1, 1.8, 3.1, 4.3, 4.4, 4.4, 4.6;
2. *Code of Ethics for Licensed Practical Nurses in Canada (2013)*: Responsibilities 2.3, 2.3.1, 2.3.3, 2.3.4, 2.7, 3.1, 3.4, 5.1."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits an investigated member to make an admission of unprofessional conduct. An admission under s. 70 of the Act must be acceptable in whole or in part to the Hearing Tribunal.

Ms. MacMillan acknowledged unprofessional conduct to all the allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and verbally admitted unprofessional conduct to all the allegations set out in the Statement of Allegations during the hearing.

Legal Counsel for the Complaints Director submitted that where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

- Exhibit #1: Statement of Allegations
- Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
- Exhibit #3: Joint Submission on Penalty

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #2.

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two-part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #2 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. MacMillan's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Ms. MacMillan.

Allegation 1

Ms. MacMillan admitted between June 3, 2022, and July 21, 2022, she failed to maintain appropriate professional boundaries with Patient MG including one or more of the following:

- a. Took a personal photo with Patient MG;
- b. Posted one or more photos of Patient MG on your Facebook profile;
- c. While on and/or off shift as an LPN, allowed Patient MG to use your cellphone on more than one occasion, including to use your Facebook messenger account.

While Ms. MacMillan was employed as an LPN at GSS and was providing support to patient MG, she took a photo with patient MG. This photo was not necessary nor appropriate within Ms. MacMillan's nursing or employment duties.

Ms. MacMillan was required to maintain appropriate professional boundaries with patient MG, including not conducting personal conversations during, or after, work hours.

Ms. MacMillan, at the time of these allegations, had a personal Facebook profile under her name “Lacey MacMillan”. Around the beginning of July 2023, Ms. MacMillan posted the personal photo to her Facebook profile page, tagging patient MG’s Facebook profile, which was also under her full name. The photo had a caption “my Grrrrr!” with a heart.

Ms. MacMillan also posted a photo of patient MG with patient MG’s child in the same post to her Facebook profile. This photo was not necessary nor appropriate within Ms. MacMillan’s role at GSS.

When Ms. MacMillan posted the two photos that depicted Patient MG to her Facebook profile, and included her name, she breached patient MG’s confidentiality as a patient of GSS.

Ms. MacMillan also allowed patient MG to use her cellphone while on and off shift as an LPN. Specifically, she permitted patient MG to use her Facebook Messenger application and profile to contact Ms. MacMillan’s sister MW, who is the Complainant. The messages that were sent from Ms. MacMillan’s Facebook account to the complainant MW are about paying for a storage unit on Sunday, July 9, 2022 around 10:30 PM, and were sent by patient MG.

Ms. MacMillan also allowed patient MG to use her cellphone while on and off shift to call and Facetime the complainant MW. Specifically, a call on Friday, July 7, 2022 at 10:46 AM, a Facetime call on Saturday, July 8, 2022 at 5:44 PM, and Monday, July 10, 2022 at 1:34 PM. The phone number used was Ms. MacMillan’s phone number while employed at GSS.

Patient MG described Ms. MacMillan as her “best friend” in a message to the Complainant MW from her own Facebook account.

After receiving messages from patient MG from Ms. MacMillan’s Facebook profile, and from patient MG directly, the complainant MW reported her concerns to the GSS.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. MacMillan’s Acknowledgement of Unprofessional Conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 1 did in fact occur.

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

- i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

- ii. Contravention of the Act, a code of ethics or standards of practice; and
- xii. Conduct that harms the integrity of the regulated profession.

Ms. MacMillan displayed a lack of knowledge by taking a personal photo with Patient MG who was receiving care from Ms. MacMillan at the time. Ms. MacMillan then proceeded to post that photo, along with another photo of Patient MG and her child, on her personal Facebook page. The photos that were uploaded to Ms. MacMillan's personal Facebook page were not necessary or appropriate with respect to Ms. MacMillan's role at GSS.

This type of behavior harms the integrity of the LPN profession as LPNs should not be taking photos with patients who are in their care and posting them to their personal Facebook page is not a behavior that is expected.

The conduct breached the following principles and standards set out in the Code of Ethics for Licensed Practical Nurses in Canada, adopted by the CLPNA on June 3, 2013 ("CLPNA Code of Ethics") and the 2020 Standards of Practice for Licensed Practical Nurses in Canada, adopted by the CLPNA ("CLPNA Standards of Practice"), as acknowledged by Ms. MacMillan in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct.

The Hearing Tribunal finds that the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out below, and that such breaches are sufficiently serious to constitute unprofessional conduct. The specific provisions are set out below.

CLPNA Code of Ethics:

Ms. MacMillan acknowledges that her conduct breached one or more of the following requirements in the CLPNA Code of Ethics, which includes the following requirements:

Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

- 2.3 Respect and protect client privacy and hold in confidence information disclosed except in certain narrowly defined circumstances.
 - 2.3.1 Safeguard health and personal information by collecting, storing, using and disclosing it in compliance with relevant legislation and employer policies.
 - 2.3.3 Ensure that any discussion/communication (verbal, written or electronic) is respectful and does not identify the client unless appropriate.
 - 2.3.4 Maintain professional boundaries in the use of electronic media.
- 2.7 Develop trusting, therapeutic relationships, while maintaining professional boundaries.

Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:

- 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
- 3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principals, standards, laws and regulations under which they are accountable.

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

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

CLPNA Standards of Practice:

Ms. MacMillan acknowledges that her conduct in the Complaint breached one or more of the following CLPNA Standards of Practice:

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

- 1.1 Practice within applicable legislation, regulations, by-laws, and employer policies.
- 1.8 Are accountable and responsible for their own practice, conduct, and ethical decision-making.

Standard 3: Protection of the public through self-regulation – LPNs collaborate with clients and other members of the healthcare team to provide safe care and improve health outcomes. Standard 3 specifically provides that LPNs:

- 3.1 Establish, maintain, and appropriately end the professional therapeutic relationship with the client and their families.

Standard 4: Professional and Ethical Practice – LPNs adhere to the ethical values and responsibilities described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

- 4.3 Advocate for the protection and promotion of clients’ right to autonomy, confidentiality, dignity, privacy, respect, and access to care and personal health information.

- 4.4 Maintain professional boundaries in the nurse/client therapeutic relationship.
- 4.5 Demonstrate effective, respectful, and collaborative interpersonal communication to promote and continue to a positive practice culture.
- 4.6 Demonstrate practice that upholds the integrity of the profession.

Allegation 2

Ms. MacMillan admitted between June 3, 2022, and July 21, 2022, she failed to maintain Patient MG's confidentiality when she posted one or more photos of Patient MG on her Facebook profile and identified her by name.

While Ms. MacMillan was employed as an LPN at GSS and was providing support to patient MG, she took a photo with patient MG. This photo was not necessary or appropriate within Ms. MacMillan's nursing or employment duties.

Ms. MacMillan, at the time of these allegations, had a personal Facebook profile under her name "Lacey MacMillan". Around the beginning of July 2023, Ms. MacMillan posted the personal photo to her Facebook profile page, tagging Patient MG's Facebook profile, which was also under her full name. The photo had a caption "my Grrrrr!" with a heart.

Ms. MacMillan also posted a photo of Patient MG with Patient MG's child in the same post to her Facebook profile.

When Ms. MacMillan posted the two photos that depicted Patient MG to her Facebook profile, and included her name, she breached Patient MG's confidentiality as a patient of GSS.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. MacMillan's Acknowledgement of Unprofessional Conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 2 did in fact occur.

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

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

Ms. MacMillan displayed a lack of knowledge by taking a personal photo with Patient MG as well as a photo with Patient MG's child in the picture. When it was posted, Ms. MacMillan tagged

Patient MG's Facebook profile, meaning that Patient MG's full name was displayed with the photo. This photo was not necessary nor appropriate for Ms. MacMillan's role while working at GSS. This was a breach of MG's confidentiality as a patient at GSS. It demonstrates a severe lack of judgment on the part of Ms. MacMillan to have posted such a photo, using Patient MG's name.

This type of behavior harms the integrity of the LPN profession as LPNs should not be taking photos with patients or their families who are in their care and posting them to their personal Facebook page. The public would expect that patient confidentiality would be kept in mind at all times, and that an LPN would not post anything to a Facebook profile which reveals the name of a patient, or a photo of the patient's child.

The Hearing Tribunal finds the conduct breached in the CLPNA Code of Ethics, CLPNA Standards of Practice as acknowledged by Ms. MacMillan in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 3

Ms. MacMillan admitted between March 15, 2023, and March 16, 2023, she failed to communicate in a respectful and professional manner with MW and JW, including via phone, Facebook messenger and/or email, including one or more of the following:

- a. Stating:
 - i. "I know you were mean to her" to MW;
 - ii. "Probably to take her away from your put downs, you were so jealous of her, she said, that's sad" to MW;
 - iii. "your sister's death is your guilt", or words to that effect to MW;
 - iv. "you're not a good person and karma is gonna get you", or words to that effect to MW;
 - v. "you're a drug addict like your sister", or words to that effect to MW;
 - vi. That MW looks like "one of those Guatemalan villagers" or words to that effect to JW; and
 - vii. "you're a drunk and a pervert" to JW.
- b. Being dishonest about police involvement.

On March 15, 2023, after Patient MG passed away, the Complainant messaged Ms. MacMillan, through her Facebook profile, regarding Patient MG's death and her concerns with Ms. MacMillan's actions as an LPN. In response to the Complainant's message, Ms. MacMillan made numerous inappropriate and disrespectful comments to the Complainant about Patient MG and the Complainant's relationship with Patient MG.

On March 16, 2023, Ms. MacMillan also messaged the Complainant, indicating that she was going to be "charged", that she knew the Complainant contacted her employer and cited an Edmonton Police Service (EPS) file number, "37894-F". Ms. MacMillan also advised the Complainant that she would be "charged", that she was "warned" and to leave her alone. Ms. MacMillan also

stated she would block the Complainant but did not do so. The Complainant responded and advised that she would be sharing the messages with the CLPNA and Ms. MacMillan continued to respond to the Complainant with negative and unprofessional comments. Eventually, the Complainant blocked Ms. MacMillan.

Additionally, on March 16, 2023, using her Alberta Health Services email address, Ms. MacMillan then contacted the Complainant via email, copying numerous other email addresses including the Complainant's spouse Mr. JW ("JW"), the Complainant's employer, and the Complainant's colleagues, LM and KG. Ms. MacMillan also included an email address "constablerolek@gmail.com".

In her email, Ms. MacMillan included Patient MG's name, referenced Patient MG's struggle with addiction, confirmed that Patient MG was a client and that she resided where Ms. MacMillan used to work. By doing so, Ms. MacMillan provided personal and confidential information about Patient MG to LM and KG, unrelated and unknown third-party individuals.

In her email, Ms. MacMillan also claimed that the Complainant was warned by the EPS to not contact her and re-referenced the file number "37894-F". In later emails, Ms. MacMillan referenced that she was obtaining a restraining order and indicated that any contact from the Complainant would breach the restraining order and result in the Complainant or JW being charged.

On the same day, the Complainant, JW, and Ms. MacMillan had a series of phone calls. During the calls, Ms. MacMillan did not act professionally towards the Complainant and JW.

JW also called the phone number provided by Ms. MacMillan via email while discussing the EPS's involvement. During the phone call, JW learned that it was the phone number for the partner of Ms. MacMillan.

Based on Ms. MacMillan providing a police file number, the Complainant and JW contacted the EPS and confirmed that the file number and officer name were not valid. JW also forwarded Ms. MacMillan's email to an EPS email address and contacted the Royal Canadian Mounted Police and the CLPNA to report Ms. MacMillan's conduct.

Ms. MacMillan was dishonest to the Complainant and JW about EPS's involvement, including providing a fake file number, a fake phone number for a police officer, and a fake email address for a police officer. Ms. MacMillan was also dishonest about the existence of a restraining order and that the EPS warned the Complainant not to contact her.

Ms. MacMillan agrees that her messages and emails included all statements listed within Allegation 3 and further agrees that the statements were inflammatory, inappropriate and disrespectful.

Ms. MacMillan and the complainant MW have not had any contact since March 16, 2023.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. MacMillan's Acknowledgement of Unprofessional Conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 3 did in fact occur.

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

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

Ms. MacMillan displayed a lack of judgment in that she was communicating with MG's sister, the Complainant, and the Complainant's spouse JW, in a disrespectful and unprofessional manner after MG passed away on March 3, 2023. Ms. MacMillan reached out to MW and JW via phone, Facebook messenger and email, which was not appropriate as Patient MG was no longer receiving care from Ms. MacMillan, and the content of these communications was inflammatory, inappropriate, and disrespectful, as acknowledged by Ms. MacMillan. When this communication was taking place, there was no reason why Ms. MacMillan should have been in contact with the Complainant or JW.

The Hearing Tribunal finds the conduct breached in the CLPNA Code of Ethics, CLPNA Standards of Practice as acknowledged by Ms. MacMillan in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 4

Ms. MacMillan admitted on March 16, 2023, she failed to maintain Patient MG's confidentiality in an email to MW's employer and/or colleagues.

As expressed in the facts found for Allegation 3, there was an email sent by Ms. MacMillan on March 16, 2023 which was sent to the Complainant's employer, and two of her colleagues, LM and KG.

In her email, Ms. MacMillan included Patient MG's name, referenced Patient MG's struggle with addiction, confirmed that Patient MG was a client and that she resided where Ms. MacMillan used to work. By doing this, Ms. MacMillan provided personal and confidential information about Patient MG to LM and KG, who were unrelated and unknown third-party individuals.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. MacMillan's Acknowledgement of Unprofessional Conduct. The Hearing Tribunal found that the

facts and documents included in Exhibit #2 prove that the conduct for Allegation 4 did in fact occur.

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

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

Ms. MacMillan displayed a lack of knowledge of or lack of skill in that Ms. MacMillan made the decision to share private and confidential information which included Patient MG's struggle with addiction and where she was receiving care at to members of the public who did not require this knowledge. Medical information should only be communicated to individuals who are legally authorized to obtain that information, or with the consent of the patient. At the time of the email, Patient MG had passed away. Within the email, Ms. MacMillan was dishonest with the involvement of the EPS and made up a file number as well as an officer's name and email address.

Ms. MacMillan's conduct harms the integrity of the regulation profession as the public has trust that any care that they receive is kept confidential and will not be made public knowledge nor that it would be shared in emails without proper authorization or the patient's consent. The public expects an LPN to take the covenants related to patient confidentiality seriously, and to uphold them at all times. By engaging in this conduct, Ms. MacMillan compromised that trust.

The Hearing Tribunal finds the conduct breached in the CLPNA Code of Ethics, CLPNA Standards of Practice as acknowledged by Ms. MacMillan in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

In addition, Ms. MacMillan failed to adhere to the GSS employee manual which required Ms. MacMillan to maintain appropriate boundaries with patients and keep personal information confidential. Ms. MacMillan sent an email to Patient MG's family as well as Patient MG's sister, the Complainant, the Complainant's husband JW, the Complainant's employer and her colleagues, who were unrelated and unknown third-party individuals. This is not acceptable behavior of an LPN, as patients trust that their care and information is kept confidential and is not going to be shared except in accordance with the GSS employee manual, and the law. This communication was not appropriate nor necessary to Patient MG's care, as she was deceased at the time of this email.

(9) Joint Submission on Penalty

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

1. The Hearing Tribunal's written reasons for decision (the “**Decision**”) shall serve as a reprimand.
2. Ms. MacMillan shall pay a fine of \$500.00 within **ninety (90) days** of service of the Decision.
3. Ms MacMillan shall pay 25% costs of the investigations and the hearing to a maximum of \$2000.00 (the “**Costs**”), to be paid over a period of 24 months from service of the Decision.
 - a. A letter advising of the final costs will be forwarded to Ms. MacMillan when final costs have been confirmed by CLPNA;
 - b. the Costs must be paid to the CLPNA, whether or not Ms. MacMillan holds an active practice permit with the CLPNA; and
 - c. the Costs is a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered by the CLPNA as an action of debt.
4. Ms. MacMillan shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA’s website <http://www.clpna.com/> in the “Knowledge Hub”. Ms. MacMillan shall provide a signed written declaration to the Complaints Officer, within **thirty (30) days** of service of the Decision, attesting she has reviewed the CLPNA’s documents:
 - a) Code of Ethics for Licensed Practical Nurses in Canada;
 - b) Standards of Practice for Licensed Practical Nurses in Canada;
 - c) Standards of Practice for Licensed Practical Nurses on Boundary Violations;
 - d) The CLPNA Policy: Professional Responsibility and Accountability;
 - e) The CLPNA Practice Guideline: Confidentiality;
 - f) The CLPNA Practice Guideline: Professional Boundaries;
 - g) The CLPNA Practice Guideline: Social Media and e-Professionalism Guideline for Nurses.

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

5. Ms. MacMillan shall complete the following remedial education, at her own cost. Ms. MacMillan shall provide the Complaints Officer with certificates confirming successful completion within **sixty (60) days** from service of the Decision.

a) **Professional Boundaries & Ethical Practice** available online at <https://concordiacollege.configio.com>.

b) **Conflict Resolution Online Training** available online at <https://esafetyfirst.com>.

If any of the required education becomes unavailable, Ms. MacMillan shall make a written request to the Complaints Officer to be assigned alternative education. Upon receiving Ms. MacMillan's written request, the Complaints Officer, in her sole discretion, may assign alternative education in which case, Ms. MacMillan will be notified in writing of the new education requirements.

6. The orders set out above at paragraphs 2-5 will appear conditions on Ms. MacMillan's practice permit and the Public Registry subject to the following:

a) The requirement to complete the remedial education and readings outlined at paragraphs 4-5 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. MacMillan's practice permit and the Public Registry until all requirements outlined in paragraph 4-5 have been satisfactorily completed by Ms. MacMillan.

b) The requirement to pay costs/fines, will appear as "Conduct Cost/Fines" on Lacey MacMillan's practice permit and the Public Registry until all fines and costs have been paid as set out above at paragraph 2-3.

7. The conditions on Ms. MacMillan's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 6.

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

9. Should Ms. MacMillan be unable to comply with any of the sanctions' deadlines identified above, Ms. MacMillan may request an extension. The request for an extension must be submitted in writing to the Complaints Officer, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Officer shall, in their sole discretion, determine whether a time extension is accepted. Ms. MacMillan will be notified by the Complaints Officer, in writing, if the extension has been granted.

10. Should Ms. MacMillan fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:
- a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;
 - b) Treat Ms. MacMillan's non-compliance as information for a complaint under s. 56 of the Act; or
 - c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. MacMillan's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

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

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

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. MacMillan has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the investigated member
- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

The nature and gravity of the proven allegations: Ms. MacMillan allowed Patient MG to use her personal cell phone for communication with her family as well as between Ms. MacMillan and Patient MG. Ms. MacMillan also took pictures with MG, and her child, and posted these pictures to Facebook, tagging Patient MG's profile which included her name, which is not acceptable behavior. It is clear that Ms. MacMillan did not understand the proper boundaries between herself and her patient for this to have occurred. In addition, she did not respect the confidentiality of a patient's personal information and health information. Anyone receiving care should be able to trust that their personal information is not going to be shared with anyone unless necessary. Finally, Ms. MacMillan sent inflammatory, inappropriate and disrespectful email correspondence to family members of Patient MG, and unrelated individuals who work with the Complainant. Again, this suggests that Ms. MacMillan did not understand the importance of maintaining client confidentiality, or the high standards required of LPNs interacting with family members of patients, and the public. Although these allegations are not the most grave allegations that could face an LPN, the Hearing Tribunal did find that they are serious, as they indicate some fundamental errors in judgment on the part of Ms. MacMillan.

The age and experience of the investigated member: Ms. MacMillan has been an LPN since she was initially registered with CLPNA in 2019. Prior to this, Ms. MacMillan worked as a Health Care Aide for approximately two years. Ms. MacMillan began working at the GSS as an LPN in 2019 and then joined the mobile support team in 2021. Accordingly, although she is not a senior member of the profession, an LPN of any vintage should understand the fundamentals that went awry in this case – patient boundaries, breaches of confidential information, and inappropriate communications.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The Hearing Tribunal was not made aware of any prior complaints or convictions.

The age and mental condition of the victim: Patient MG was in a vulnerable condition. Ms. MacMillan was Patient MG's nurse and befriended Patient MG. Ms. MacMillan led Patient MG to believe that they were friends and had referred to this relationship on Facebook. The boundary violations found in this case are more egregious given Patient MG's personal vulnerabilities, and Ms. MacMillan's role in her recovery, due to Ms. MacMillan providing support at GSS.

The number of times the offending conduct was proven to have occurred: The Hearing Tribunal was not made aware of any other instances where Ms. MacMillan had similar boundary violations, confidentiality breaches, or inappropriate communications beyond what occurred here with Patient MG.

The role of the investigated member in acknowledging what occurred: Ms. MacMillan acknowledged that her conduct harmed the integrity of the LPN profession. Ms. MacMillan acknowledged the unprofessional conduct and has taken responsibility for her actions.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. MacMillan was terminated from her position with GSS on July 21, 2022.

The impact of the incident(s) on the victim: The Hearing Tribunal did not hear of the impact of the result of the behavior with respect to Patient MG, as Patient MG had passed away on March 3, 2023. The Hearing Tribunal did hear how Patient MG's sister MW was impacted as she was receiving messages from Ms. MacMillan and this caused a lot of stress and distress for MW, as Ms. MacMillan was (incorrectly) suggesting that there was police involvement and a restraining order involved.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was not made aware of any mitigating circumstances.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: There is a need to impose a sanction that deters Ms. MacMillan from repeating this conduct as well as a sanction that would deter other LPNs from engaging in similar conduct. The sanctions that are ordered state that this type of conduct will not be tolerated by the CLPNA. The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches in the CLPNA Code of Ethics and CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

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

The range of sentence in other similar cases: The Hearing Tribunal was referred to two decisions (Baxter and Howell) that were both decisions of a Hearing Tribunal of the CLPNA, in which similar costs and courses were included in the Joint Submission on Sanctions, which was in turn adopted by the Hearing Tribunal as sanctions in those cases.

It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and the CLPNA Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

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

1. The Hearing Tribunal's written reasons for decision (the "**Decision**") shall serve as a reprimand.
2. Ms. MacMillan shall pay a fine of \$500.00 within **ninety (90) days** of service of the Decision.
3. Ms MacMillan shall pay 25% costs of the investigations and the hearing to a maximum of \$2000.00 (the "**Costs**"), to be paid over a period of 24 months from service of the Decision.
 - a. A letter advising of the final costs will be forwarded to Ms. MacMillan when final costs have been confirmed by CLPNA;
 - b. the Costs must be paid to the CLPNA, whether or not Ms. MacMillan holds an active practice permit with the CLPNA; and
 - c. the Costs is a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered by the CLPNA as an action of debt.
4. Ms. MacMillan shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website <http://www.clpna.com/> in the "Knowledge Hub". Ms. MacMillan shall provide a signed written declaration to the Complaints Officer, within **thirty (30) days** of service of the Decision, attesting she has reviewed the CLPNA's documents:
 - a) Code of Ethics for Licensed Practical Nurses in Canada;

- b) Standards of Practice for Licensed Practical Nurses in Canada;
- c) Standards of Practice for Licensed Practical Nurses on Boundary Violations;
- d) The CLPNA Policy: Professional Responsibility and Accountability;
- e) The CLPNA Practice Guideline: Confidentiality;
- f) The CLPNA Practice Guideline: Professional Boundaries;
- g) The CLPNA Practice Guideline: Social Media and e-Professionalism Guideline for Nurses.

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

5. Ms. MacMillan shall complete the following remedial education, at her own cost. Ms. MacMillan shall provide the Complaints Officer with certificates confirming successful completion within **sixty (60) days** from service of the Decision.

- a) **Professional Boundaries & Ethical Practice** available online at <https://concordiacollege.configio.com>.

- b) **Conflict Resolution Online Training** available online at <https://esafetyfirst.com>.

If any of the required education becomes unavailable, Ms. MacMillan shall make a written request to the Complaints Officer to be assigned alternative education. Upon receiving Ms. MacMillan's written request, the Complaints Officer, in her sole discretion, may assign alternative education in which case, Ms. MacMillan will be notified in writing of the new education requirements.

6. The orders set out above at paragraphs 2-5 will appear conditions on Ms. MacMillan's practice permit and the Public Registry subject to the following:

- a) The requirement to complete the remedial education and readings outlined at paragraphs 4-5 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. MacMillan's practice permit and the Public Registry until all requirements outlined in paragraph 4-5 have been satisfactorily completed by Ms. MacMillan.

- b) The requirement to pay costs/fines, will appear as "Conduct Cost/Fines" on Lacey MacMillan's practice permit and the Public Registry until all fines and costs have been paid as set out above at paragraph 2-3.

7. The conditions on Ms. MacMillan's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 6.

8. Ms. MacMillan 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. MacMillan will keep her contact information current with the CLPNA on an ongoing basis.
9. Should Ms. MacMillan be unable to comply with any of the sanctions' deadlines identified above, Ms. MacMillan may request an extension. The request for an extension must be submitted in writing to the Complaints Officer, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Officer shall, in their sole discretion, determine whether a time extension is accepted. Ms. MacMillan will be notified by the Complaints Officer, in writing, if the extension has been granted.
10. Should Ms. MacMillan fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:
 - a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;
 - b) Treat Ms. MacMillan's non-compliance as information for a complaint under s. 56 of the Act; or
 - c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. MacMillan's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

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

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

- (a) identifies the appealed decision, and
- (b) states the reasons for the appeal.

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

DATED THE 10th DAY OF JULY 2024 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

A handwritten signature in cursive script that reads "Kelly Anesty".

Kelly Anesty, LPN
Chair, Hearing Tribunal