

**IN THE MATTER OF A HEARING BY
THE DISCIPLINE COMMITTEE OF THE BRITISH COLUMBIA COLLEGE OF NURSING
PROFESSIONALS CONVENED PURSUANT TO THE PROVISIONS OF
THE *HEALTH PROFESSIONS ACT* RSBC 1996, c.183**

BETWEEN:

The British Columbia College of Nursing Professionals

(the “College” or “BCCNP”)

AND:

Amanda Parniak

(the “Respondent”)

DETERMINATION OF THE DISCIPLINE COMMITTEE

Hearing Dates: February 12 to 14, 2020

Discipline Committee Panel: Sheila Cessford, Chair
Dr. Thomas Ward
Dr. Catharine Schiller, RN

Counsel for the College: Michael Seaborn

No one appearing for the Respondent

Introduction

1. A panel of the Discipline Committee (the “Panel”) of the British Columbia College of Nursing Professionals (the “College” or “BCCNP”) conducted a hearing to determine, pursuant to section 39 of the *Health Professions Act* RSBC 1996 c.183 (the “Act” or the “HPA”), whether Amanda Parniak failed to comply with a standard imposed under the Act, breached the Act or bylaws, or committed unprofessional conduct.
2. For the reasons that are set out below, the Panel finds that allegations 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 29, and 30 of the citation dated October 1, 2019 (the “Citation”) are proven to the requisite standard. The Panel

finds that Ms. Parniak breached a standard imposed under the Act and committed professional misconduct in relation to the allegations which were proven. The Panel dismisses allegations 17, 18, 23, 24, 25, 27, 28, 31, 32, 33, 34, 35, and 36.

Background

3. The College alleges that Ms. Parniak diverted injectable hydromorphone and falsified medical records during nearly a six-month period at Campbell River Hospital (the "Hospital"). The Citation alleges three types of diversion: diversion from an individual patient; diversion while she was not on duty; and diversion involving multiple doses, using multiple transactions, not more than 5 minutes apart, for the same patient.
4. The particulars of the allegations against Ms. Parniak are set out in the Citation, as follows:

1. On or about November 21, 2017, you diverted a narcotic, hydromorphone, from patient JM, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

2. On or about November 21, 2017, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient JM, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

3. Between approximately March 4, 2018 and March 8, 2018, on multiple occasions, you diverted a narcotic, hydromorphone, from patient RN, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the

Medication Inventory Management Practice Standard, and the Privacy and Confidentiality Practice Standard.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

4. Between approximately March 4, 2018 and March 8, 2018, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient RN, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

5. Between approximately March 5, 2018 and March 8, 2018, on multiple occasions, you diverted a narcotic, hydromorphone, from patient AL, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

6. Between approximately March 5, 2018 and March 8, 2018, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient AL, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

7. On or about October 17, 2017, on multiple occasions, you diverted a narcotic, hydromorphone, from patient WP, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws,

under s.39 (1) of the Act.

8. On or about October 17, 2017, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient WP, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

9. On or about October 20, 2017, on multiple occasions, you diverted a narcotic, hydromorphone, from patient RH, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

10. On or about October 20, 2017, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient RH, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

11. Between approximately October 31, 2017, and November 1, 2017, on multiple occasions, you diverted a narcotic, hydromorphone, from patient WB, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

12. Between approximately October 31, 2017, and November 1, 2017, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in

relation to patient WB, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

13. On or about October 18, 2017, on multiple occasions, you diverted a narcotic, hydromorphone, from patient JA, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

14. On or about October 18, 2017, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient JA, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

15. On or about October 24, 2017, on multiple occasions, you diverted a narcotic, hydromorphone, from patient NL, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

16. On or about October 24, 2017, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient NL, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice*

Standard, the Medication Inventory Management Practice Standard, and the Privacy and Confidentiality Practice Standard.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

17. On or about October 31, 2017, you diverted a narcotic, hydromorphone, from patient JB, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

18. On or about October 31, 2017, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient JB, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

19. On or about October 25, 2017, you diverted a narcotic, hydromorphone, from patient WF, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

20. On or about October 25, 2017, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient WF, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

21. On or about November 5, 2017, on multiple occasions, you diverted a narcotic, hydromorphone, from patient JP, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

22. On or about November 5, 2017, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient JP, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

23. Between approximately October 31, 2017 and November 1, 2017, on multiple occasions, you diverted a narcotic, hydromorphone, from patient CM, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

24. Between approximately October 31, 2017 and November 1, 2017, on multiple occasions, you falsified medication documentation for a narcotic, hydromorphone, in relation to patient CM, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

25. On or about November 29, 2017, on multiple occasions, you withdrew a narcotic, hydromorphone, while not on duty, contrary to one or more of the following

Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

26. On or about January 17, 2018, on multiple occasions, you withdrew a narcotic, hydromorphone, while not on duty, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

27. On or about January 23, 2018, on multiple occasions, you withdrew a narcotic, hydromorphone, while not on duty, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

28. On or about January 24, 2018, on multiple occasions, you withdrew a narcotic, hydromorphone, while not on duty, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

29. On or about February 27, 2018, you withdrew a narcotic, hydromorphone, while not on duty, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

30. On or about March 23, 2018, on multiple occasions, you withdrew a narcotic, hydromorphone, while not on duty, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

31. On or about October 25 and October 26, 2017, you withdrew a narcotic, hydromorphone, in multiple doses, using multiple transactions, not more than 5 minutes apart, for the same patient, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

32. On or about November 6, November 7, November 13, November 16, November 24, November 26 and November 29, 2017, you withdrew a narcotic, hydromorphone, in multiple doses, using multiple transactions, not more than 5 minutes apart, for the same patient, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

33. On or about December 14, December 15, and December 31, 2017, you withdrew a narcotic, hydromorphone, in multiple doses, using multiple transactions, not more than 5 minutes apart, for the same patient, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws,

under s.39 (1) of the Act.

34. On or about January 4, January 8, January 12, January 15, January 17, January 23, January 24, January 27 and January 30, 2018, you withdrew a narcotic, hydromorphone, in multiple doses, using multiple transactions, not more than 5 minutes apart, for the same patient, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

35. On or about February 1, February 5, February 8, February 13, February 14, February 16 and February 20, 2018, you withdrew a narcotic, hydromorphone, in multiple doses, using multiple transactions, not more than 5 minutes apart, for the same patient, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

36. On or about March 3, March 6, March 9, March 12, March 13, March 17, March 21, and March 22, 2018, you withdrew a narcotic, hydromorphone, in multiple doses, using multiple transactions, not more than 5 minutes apart, for the same patient, contrary to one or more of the following Professional Standards and/or Practice Standards: the *Professional Responsibility and Accountability Professional Standard*, the *Client-Focused Provision of Service Professional Standard*, the *Ethical Practice Professional Standard*, the *Documentation Practice Standard*, the *Medication Administration Practice Standard*, the *Medication Inventory Management Practice Standard*, and the *Privacy and Confidentiality Practice Standard*.

This conduct also constitutes unprofessional conduct, or breach of the Act or bylaws, under s.39 (1) of the Act.

5. At the outset of the discipline hearing, the College advised that it would not be proceeding with the following allegations in the Citation:
 - a. Allegation 26;
 - b. Allegation 32 in relation to November 29, 2017;
 - c. Allegation 34 in relation to January 12, 2018;

- d. Allegation 35 in relation to February 14, 2018; and
 - e. Allegation 36 in relation to March 6, 2018.
6. The hearing took place at the College's offices at suite 900 – 200 Granville Street, Vancouver, British Columbia.
 7. The Respondent did not attend the hearing.
 8. The College led evidence at the hearing with respect to the allegations at issue. The Affidavit of Leila Hodges (sworn February 3, 2020) was marked as Exhibit 1. The College's Book of Documents was marked as Exhibit 2.
 9. The College called four witnesses:
 - a. Christina Rozema, Site Director for the Hospital;
 - b. Brittney Johnson, a colleague of Ms. Parniak at the Hospital;
 - c. Donna Buna, a Manager of Pharmacy Services at Island Health; and
 - d. Ticki MacKenzie, the BCCNP investigator assigned with investigating the original complaint.
 10. The College delivered oral and written submissions.
 11. The Panel's determination takes into account the evidence adduced at the hearing and the College's oral and written submissions.

Service of Citation and Proceeding in the Respondent's Absence

12. The Panel noted that the Respondent was absent for the discipline hearing which was scheduled to commence at 10:00 on February 12, 2020.
13. The College considered whether to proceed with the hearing in the absence of the Respondent pursuant to section 38 (5) of the Act:
 - 38 (5) If the respondent does not attend, the discipline committee may
 - (a) proceed with the hearing in the respondent's absence on proof of receipt of the citation by the respondent, and
 - (b) without further notice to the respondent, take any action that it is authorized to take under this Act.

14. Counsel for the College provided the Affidavit of Leila Hodges, setting out the College's service of the Citation. The Panel found that the College provided proof of service of the Citation. The Panel was satisfied that the Ms. Parniak was properly served with the Citation, which set out the charges against her and the date and place for the hearing. The Panel noted that it had not received any information from Ms. Parniak. For those reasons, the Panel decided pursuant to section 38(5) of the Act that it would proceed with this discipline committee hearing in the Respondent's absence.

Burden and Standard of Proof

15. The College bears the burden of proof and must prove its case on a "balance of probabilities". The leading authority of *F.H. v. McDougall*, 2008 SCC 53, states that the "evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test".

Relevant HPA Provisions, Bylaw Provisions and Professional and Practice Standards

HPA

16. Under section 39(1) of the HPA, the Discipline Committee may dismiss the matter, or determine that Ms. Parniak:

39(1)...

- (a) has not complied with this Act, a regulation or a bylaw,
- (b) has not complied with a standard, limit or condition imposed under this Act,
- (c) has committed professional misconduct or unprofessional conduct,
- (d) has incompetently practised the designated health profession, or
- (e) suffers from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs their ability to practise the designated health profession.

17. The College alleges breaches of section 39 (1) (a), (b), and (c).

College Bylaws

18. The relevant bylaw in force at the material times was bylaw 8.01 which stated “Registrants must conduct themselves in accordance with the standards of practice and the standards of professional ethics”.
19. That bylaw was enacted pursuant to section 19(1)(k) of the HPA.
20. The College has established both Professional and Practice Standards pursuant to this authority.

Professional and Practice Standards

21. The College alleges that the conduct at issue in the Citation engages a number of its standards. The specific standards are identified in paragraph 4.

Evidence

22. The College’s first witness was Christina Rozema. Ms. Rozema testified that:
 - a. She is the Site Director for the Hospital. She holds a Ph.D. and has been with Island Health for 10 years. Her responsibility is the overall functioning of the hospital.
 - b. In September 2017, the Hospital moved into a new building. This was a significant change which involved new equipment, new processes, and new ways of organizing work.
 - c. The medication dispensing system put in place at the new facility involved automated dispensing cabinets (“ADC”). The brand of ADC used at the facility is Omnicell. Logging in to the ADCs is done with fingerprints. The Hospital spent two months training staff on the new ADCs. Ms. Parniak received training on the new ADCs. Access to ADCs is not restricted to the unit on which a nurse is scheduled to work for a given shift. They can access all ADCs throughout the Hospital with the same login information.
 - d. Ms. Parniak began working at the Hospital in March 2017. She started as an agency nurse. By May 2017, she worked for the Hospital in the “relief pool” as a medical / surgery nurse.

- e. During the time that Ms. Parniak was working in the relief pool, she was identified as having very strong nursing skills and leadership qualities. Ms. Parniak was selected to train for a Clinical Coordinator position. The Clinical Coordinator position involves moving around the whole Hospital.
- f. Nursing shifts at the Hospital are from 7:30 to 19:30, and 19:30 to 7:30. Shifts can be extended for a couple of hours to stay late or come in early to provide additional support.
- g. Concerns first arose with Ms. Parniak on November 21, 2017. The issue came to Ms. Rozema's attention via the Coordinator of Site Operations who reported that nurse Brittany Johnson had attempted to withdraw pain medication for her patient. The ADC report for this patient indicated that 4 mg of hydromorphone had already been signed out but was not recorded in the medication administration record ("MAR"). Ms. Parniak had signed out this pain medication for this patient, however, she was not working on the unit that day. Ms. Parniak acknowledged to Ms. Johnson that she had taken out the medication on another unit and indicated that she must have drawn it out under the wrong patient name. Ms. Parniak said she would call the Hospital pharmacy about the discrepancy. When Ms. Johnson later contacted the pharmacy, the pharmacy said that Ms. Parniak had never called them to address the discrepancy. Inconsistencies were also noted with respect to chart entries.
- h. Ms. Rozema arranged a meeting with Ms. Parniak to review the incident from a learning perspective, recognizing that the move to the new building and the introduction of new processes may have played a role in the incident. Ms. Rozema wanted to make sure that the staff were supported through education. Ms. Rozema stated that Ms. Parniak had been considered an upstanding member of staff and was quite upset with herself about this incident. Following the meeting, Ms. Rozema attempted to organize another meeting with Ms. Parniak and her union steward to further discuss the inconsistencies.

- i. The next incident that came to Ms. Rozema's attention occurred on March 8, 2018. Ms. Parniak's withdrawals from the ADC were flagged as unusual because she had made three withdrawals of hydromorphone within a short period of time from a location where she was not scheduled to provide nursing care. Ms. Rozema spoke with Ms. Parniak who stated that she had wasted the medication in the presence of another nurse. When contacted by Ms. Rozema, the other nurse denied witnessing the wastage.
- j. Ms. Rozema attempted to have Ms. Parniak return for another meeting to discuss the March 8, 2018 incident. Ms. Parniak did not attend this scheduled meeting.
- k. Ms. Parniak was placed on paid leave and a Hospital investigation was initiated.
- l. As part of the investigation, the Hospital pharmacy prepared a report of all hydromorphone withdrawals by Ms. Parniak from October 2017 to March 2018 from all Hospital ADCs (the "Omniceil Report").
- m. Ms. Rozema asked one of the clinical coordinators from the ICU to perform a chart review (the "Chart Review"). The Chart Review examined the MAR, patients' charts and the Omnicell Report for a one-month period over October and November 2017. The Chart Review demonstrated many unusual instances and discrepancies. The results of the Chart Review were given to Ms. Rozema.
- n. After receiving the results of the Chart Review, Ms. Rozema stated she contacted Ms. Parniak by email, again advising of the need for a meeting with her and her union steward to discuss medications that had been signed out by Ms. Parniak but did not appear to have been delivered to patients and which were never disposed of according to protocols. Attempts to contact Ms. Parniak were unproductive. Ms. Parniak did not attend any such meeting or provide Island Health with her whereabouts or circumstances.

- o. By letter dated May 1, 2018 from Ms. Rozema, Ms. Parniak was terminated effective immediately from Island Health.
 - p. Ms. Rozema identified and testified to Employee Schedule Reports and Daily Flow Sheets for the period November 29, 2017 to March 26, 2018.
 - q. Ms. Rozema never observed Ms. Parniak exhibiting any signs of intoxication or impairment during the period Ms. Parniak worked at the new Hospital.
23. The College's next witness was Brittney Johnson, a colleague of Ms. Parniak at the Hospital. Ms. Johnson testified via video that:
- a. She is an RN at the Hospital.
 - b. On November 21, 2017, she worked on a temporary basis on unit CR3C, which is a surgical floor. She was on duty from 7:30 to 19:30 that day.
 - c. Patient JM was on unit CR3C and was assigned to Ms. Johnson. JM indicated that he was experiencing pain. Ms. Johnson went to the unit's ADC to try to sign out hydromorphone for JM, however, the ADC showed that Ms. Parniak had already signed out the hydromorphone for patient JM at 10:33 on November 21, 2017.
 - d. Ms. Johnson asked JM whether another nurse had given him the medication. JM told her that no other nurse had given him the medication.
 - e. Ms. Parniak was not assigned to work on unit CR3C that day.
 - f. Ms. Johnson asked Ms. Parniak about the hydromorphone. Ms. Parniak told Ms. Johnson that she had taken out the medication on another unit for a different patient. Ms Parniak indicated that she would call the pharmacy and inform them about the "mix up". Ms. Johnson later called the pharmacy to follow up and was advised that Ms. Parniak had not contacted them about this situation.
 - g. Ms. Johnson was eventually able to provide hydromorphone to JM but was delayed in managing his pain because of the situation. She

estimates that JM was delayed between 45 minutes to 1 hour in receiving his pain medication.

- h. The employment of Ms. Johnson and Ms. Parniak overlapped at the Hospital for approximately six months. During that time, Ms. Johnson worked with Ms. Parniak approximately a dozen times. Ms. Johnson never observed Ms. Parniak to appear intoxicated or impaired.

24. In response to Panel questions, Ms. Johnson testified that:

- a. There is an ADC on every patient unit. The ADC on unit CR3C is adjacent to the nursing station which is towards the south end of the surgical wing.
- b. Login for each ADC is via fingerprint and can be used to access any ADC in the Hospital.
- c. Ms. Johnson stated that the reference in the November 21, 2017 email to “Brittancy [sic] called Stacey to double check what she was seeing” referred to Ms. Johnson calling Stacey Stromme to confirm that she was correct in her understanding that the ADC showed that Ms. Parniak had taken out hydromorphone for JM. As the ADC was still quite new to staff at this time, Ms. Johnson wanted to confirm her understanding with Ms. Stromme, as Ms. Stromme was the charge nurse.
- d. Ms. Johnson confirmed that it is possible to access medications in the surgical day care unit (“SDC”) for a patient on unit CR3C. Medication can be signed out for any patient from any ADC anywhere in the Hospital.

25. The College’s third witness was Donna Buna. She testified that:

- a. She is the Pharmacy Manager at Island Health for Geographies 1 & 2 and long-term care. Each facility has a pharmacy within the hospital that provides medication distribution to patients in the hospital. Each of those sites has a supervisor reporting to Ms. Buna. Approximately 10 supervisors report to her.

- b. She has been a pharmacist for approximately 40 years. She has worked in hospital pharmacy and long-term care. Since 2013, she has been involved in the regional pain program.
- c. In September 2017, the Hospital moved to a brand new facility, and began using an entirely new system for medication dispensing – the ADCs. Omnicell is the brand of ADC used. The new system offered a number of safety factors that made it desirable. It is a physical cabinet stocked with medication which allows for inventory management and control. This ensures that a sufficient supply of each medication is maintained and within expiry dates. Each unit is checked regularly by pharmacy staff (three times a day, 365 days a year). Another advantage is documentation. The system electronically documents medication withdrawals and connects each withdrawal to a patient. An electronic cabinet system reduces the risk of selection error (such as wrong dose or wrong medication).
- d. The pharmacy staff stocks the ADCs and manages inventory control. The pharmacy staff work 7:30 to 17:00 on weekdays, and on weekends until 16:30.
- e. In the unlikely event that a particular cabinet runs out of a medication, a nurse can access medications from any Hospital ADC under their patient's name.
- f. Access to each Hospital ADC is done with a double entry system. At the start of each shift, a nurse has to identify themselves to their unit ADC with a username and a fingerprint or password. For 12 hours after this initial identification, a nurse can access that same ADC by biometrics only (i.e. fingerprint). If the nurse uses another ADC in the Hospital, they have to sign in using the double entry system again (username and fingerprint or password).
- g. All medication removed from the ADC must be linked to a specific patient.

- h. The drug hydromorphone is commonly prescribed and is carried in all of the ADCs in the Hospital. It is unlikely a nurse would need to access hydromorphone from another unit in the Hospital because of supply issues with the medication on their unit's ADC.
- i. The ADCs record the time the nurse accesses the cabinet and all aspects of the transaction: patient, drug, dose, time, the unit where the medication is withdrawn. It will also record if a nurse accesses the ADC but does not remove any medication.
- j. There was a lot of training and preparation for staff with the new ADC system. Staff were able to practice the processes and procedures and there was a peer mentorship system put in place, which provided additional support. The training started six months prior to the switch to the new system.
- k. The wastage procedure at the Hospital involves a "return bin" which is electronically connected to the ADC. The return bin is either bolted to the ADC or to the wall. It is a very secure process. The nurse opens the return bin, places the medication on a platform, and the medication is deposited to the lower part of the bin. Only pharmacy staff have access to the bin. Typically, wastage occurs when medication is removed from the ADC but only part of a dose is used. If a narcotic is wasted, there is a specific procedure which requires a witness (typically another RN) to the wastage. Evidence of narcotic wastage witnessing is done electronically in the ADC. Returned medications are done in a similar manner.
- l. Some of the red flags associated with medication diversion are: how often someone accesses a narcotic compared to their colleagues, accessing a cabinet without removing a medication, frequent discrepancies, accessing medications without orders, taking alternate forms of a medication (for example if a medication is ordered orally, but the medication removed is for subcutaneous or topical administration). Removing hydromorphone from a unit other than the one on which a nurse is working, making

withdrawals while not on duty, and making multiple withdrawals for the same patient within a short time frame are also considered red flags.

- m. Hydromorphone is known by the brand name Dilaudid. It is an opioid narcotic. It is five times more potent than morphine. Hydromorphone is commonly used in the acute care setting. It has perceived clinical advantages over morphine for pain management. It is a drug for which there is a concern about addiction. There is an illegal market for hydromorphone because of recent concerns with the quality of street supply being laced with Fentanyl.
 - n. Ms. Buna was involved in the investigation of Ms. Parniak. The investigation involved several individuals reviewing the Omnicell records and the corresponding patient charts. It was a very labour-intensive exercise.
 - o. Ms. Buna has been involved in other investigations. She described Ms. Parniak's conduct as having gone on for a longer period before the suspicious activity was identified.
 - p. Ms. Buna described the Health Canada reporting process that is required for narcotic losses. The original report pertaining to those dosages removed by Ms. Parniak was made on April 9, 2018. An updated report was made on June 5, 2018. The estimated quantity reported was 1650 mg of hydromorphone. A report was also made to the RCMP.
26. In response to Panel questions, Ms. Buna testified that:
- a. The investigation established that medications were not given to a patient because there is a requirement that a nurse sign in the MAR to indicate administration. By examining the records, it was possible to establish that the medication had been removed from the ADC but had not been administered to the patient.

- b. Where an order allows for multiple routes (ex. oral and injectable forms of hydromorphone), the nurse can choose the route. The ADC will record the form of the medication which is taken out.
- c. If there is an order for oral hydromorphone and no order for IV hydromorphone, a nurse could access the ADC after regular pharmacy hours and remove the injectable form of hydromorphone even though it is not on the order. The system will document that the injectable form of the medication was removed from the ADC.

27. The College's final witness was Ticki MacKenzie. She testified that:

- a. She has been an investigator with the College since 2015. She graduated in 1979, is an RN, and previously worked as a Coroner investigating over 11000 cases.
- b. She was the investigator of the College complaint against Ms. Parniak. Her investigation revealed three types of potential diversion:
 - i. Diversion from an individual patient
 - ii. Diversion while not on duty
 - iii. Diversion involving multiple doses, using multiple transactions, not more than five minutes apart for the same patient
- c. Ms. MacKenzie walked the Panel through the documentary evidence pertaining to each of the allegations in the Citation, specifically, the Omnicell Report, patient records, and staffing records.
- d. Ms. MacKenzie confirmed that each patient's personal identification number on the Omnicell Report matched the patient's personal identification number on their medical record.
- e. The College requested that Ms. Parniak convert her registration to non-practising status, which Ms. Parniak did on May 14, 2018.

- f. By March 2, 2019, Ms. Parniak failed to renew her registration and thereafter, became a former registrant. Ms. Parniak was a former registrant at the time of the hearing.
- g. All of the allegations of diversion in the Citation involved hydromorphone.
- h. Over 100 instances of potential diversion were identified.

Analysis and Findings of Fact

Allegations 1 to 24: Diversions from an individual patient

Allegation 1

- 28. Ms. Rozema and Ms. Johnson both testified about the incident of November 21, 2017. Their evidence is also summarized in an email report of November 21, 2017 which was admitted into evidence.
- 29. The Panel finds that Ms. Johnson worked on unit CR3C on November 21, 2017. Ms. Johnson was assigned to patient JM who was on unit CR3C on November 21, 2017. Ms. Parniak was not assigned to work on unit CR3C on November 21, 2017 and was not assigned to patient JM on November 21, 2017.
- 30. The Patient Care Orders for JM for Dilaudid for November 21, 2017 are 2-6 mg orally every 3 hours for pain and 1-4 mg subcutaneously every 3 hours for pain.
- 31. The Omnicell Report shows that on November 21, 2017 at 10:33 for patient #2424 (who is patient JM), Ms. Parniak took out 2 ampoules (4 mg) of hydromorphone in injectable form. The Omnicell Report shows that the medication was taken out of the CRSDC. CRSDC is the "Campbell River Surgical Day Care Unit" ("SDC") and is a different unit than CR3C. This withdrawal is also shown in a photograph of the SDC Omnicell's screen.
- 32. There is an entry in the Omnicell Report immediately above the one in question which shows another transaction by Ms. Parniak at the same date and time, relating to the same patient, and for the same medication. Specifically, on November 21, 2017 at 10:33 for patient JM, the Omnicell Report shows the "type" as "D-DI" and the quantity of injectable hydromorphone as "-1". "D-DI" is defined

as a discrepancy “issue”. Ms. MacKenzie was not able to explain what “-1” represented.

33. The Panel accepts Ms. Johnson’s evidence that JM was reporting pain to her. The patient record for November 21, 2017 records “reports moderate to severe pain” at 6:00 and at 14:40 “escalating pain”. At 19:17, the patient’s record shows “pain well controlled”.
34. The Panel finds Ms. Johnson attempted to withdraw hydromorphone for JM from the ADC on CR3C on November 21, 2017 but the ADC showed that 4 mg of injectable hydromorphone had already been taken out for her patient but was not recorded in JM’s MAR. The MAR shows that the hydromorphone that was administered to JM on November 21, 2017 was in oral and not injectable form.
35. The Panel finds that when confronted by Ms. Johnson, Ms. Parniak told Ms. Johnson that she removed the medication from the SDC for a patient in that unit and must have removed it in the wrong name. The Panel does not accept that explanation. Ms. Buna testified that if an individual accesses the ADC from the unit on which they are working, only the patients who are on that unit will appear in the list. If the individual accesses the ADC on a unit elsewhere in the hospital where they are not assigned to work that day, a global list of patient appears. Ms. Parniak would therefore have known when she selected JM’s name from the list of patients that she was accessing medications from a patient who was not on her assigned unit.
36. The Panel finds Ms. Parniak told Ms. Johnson that she was going to call the Hospital pharmacy to sort out the discrepancy. The Panel finds that Ms. Johnson called the Hospital pharmacy later that afternoon and was informed that Ms. Parniak had not contacted them to sort out the discrepancy.
37. Ms. Johnson’s evidence is consistent with Ms. Rozema’s evidence about receiving a report regarding this medication withdrawal and discrepancy. The Panel notes that the email report to Ms. Rozema was made on the same day as the occurrence itself.

38. The Omnicell Report tracks medication wastage and return. There is no evidence before the Panel that Ms. Parniak wasted or returned the 4 mg of hydromorphone which she withdrew in JM's name.
39. While there is no evidence confirming other patients did not receive their medication, the evidence before the Panel suggests that JM's medication remains missing and unaccounted for. Ms. Parniak did not address the discrepancy with the pharmacy and discontinued meetings with the Hospital to discuss this medication issue.
40. Based upon the information before the Panel, the Panel finds that 4 mg of hydromorphone was withdrawn by Ms. Parniak, is unaccounted for and, the Panel finds on a balance of probabilities, that at least 2 mg of that hydromorphone was diverted by Ms. Parniak. The Panel therefore finds that Ms. Parniak diverted hydromorphone from patient JM.
41. The Panel finds that because of Ms. Parniak's diversion of hydromorphone, JM was delayed by approximately 45 minutes to one hour in receiving pain management.

Allegation 2

42. The College submits that each time Ms. Parniak made a withdrawal of hydromorphone from an ADC for the purposes of diverting it from a patient, she was creating in the ADC record, as shown to the Panel in the Omnicell Report, false documentation relating to a particular patient.
43. The Panel accepts the College's submission in that regard. Ms. Parniak accessed the ADC on November 21, 2017 to withdraw the hydromorphone in allegation 1 by using at minimum her biometric data (fingerprint). The biometric entry is a positive identification of the individual who withdrew the medication. In doing so, she signed for the withdrawal of that medication. Ms. Parniak's withdrawal of the hydromorphone on November 21, 2017 under patient JM's name created the ADC record. The Panel finds Ms. Parniak falsified medication documentation of hydromorphone in relation to patient JM.

Allegation 3

44. The Omnicell Report shows that on March 4, Ms. Parniak made withdrawals from the ADC on the Post Anesthetic Care Unit (CRPACU) of injectable hydromorphone for patient RN:
 - a. 2 ampoules (4 mg) at 18:04.
 - b. 2 ampoules (4 mg) at 19:08.
45. There is no record of wastage or return of these medications.
46. The MAR shows that no hydromorphone was administered to patient RN on March 4, 2018. The hydromorphone order on the MAR for March 4, 2018 is indicated as “hydromorphone 2 mg oral”.
47. The medical records show that RN was not a patient on the CRPACU, which is the post anesthetic recovery unit. He was admitted to CR3C. The doctor’s notes show “repeated aspiration” on March 5, 2018 and “awaiting knee replacement of Rt knee” on March 12, 2018.
48. The flow sheet for March 4, 2018 shows that RN “denies pain” at 15:30 and at 22:40, an entry recording an assessment at 19:30 notes “no c/o pain”. The flow sheet shows that the nurse assigned to care for RN had the initials “N.M.”
49. The Omnicell Report shows that on March 5, 2018, Ms. Parniak withdrew 2 ampoules (4 mg) of injectable hydromorphone for patient RN at 01:03 from the CRPACU.
50. There is no record of wastage or return of this medication.
51. The MAR shows that no hydromorphone was administered to patient RN on March 5, 2018. The hydromorphone order on the MAR for March 5, 2018 is indicated as “hydromorphone 2 mg oral”.
52. The medical records show that RN was a patient of CR3C on March 5, 2018 and not CRPACU. The nurse assigned to RN on March 5, 2018 had the initials “N.A.” The flow sheet for March 5, 2018 records “denies pain” at 09:00 and 22:20.

53. The Omnicell Report shows that on March 8, 2018, Ms. Parniak made withdrawals of injectable hydromorphone for patient RN at from the CRPACU:
 - a. at 06:54 from CRPACU, 4 mg (2 ampoules).
 - b. at 07:09 from CRPACU, 4 mg (2 ampoules).
 - c. at 10:06 from CR3C 4 mg (2 ampoules).
54. There is no record of wastage or return of these medications in the Omnicell Report.
55. The MAR shows that no hydromorphone was administered to patient RN on March 8, 2018. The hydromorphone order on the MAR for March 8, 2018 is indicated as “hydromorphone 2 mg oral”.
56. The medical records show a nurse with initials other than Ms. Parniak’s was assigned to RN on March 8, 2018. The flow sheet for March 8, 2018 records 09:45 “denies pain” and “no concerns” at 06:45.
57. The Panel finds that between March 4 and March 8, 2019, on multiple occasions, Ms. Parniak diverted injectable hydromorphone from patient RN.

Allegation 4

58. The Panel finds that in withdrawing and diverting hydromorphone from an ADC between March 4 to 8, 2018 from patient RN, Ms. Parniak falsified medical documentation relating to patient RN.

Allegation 5

59. The Omnicell Report shows that on March 5, 2018, Ms. Parniak withdrew:
 - a. 2 ampoules (4 mg) of injectable hydromorphone for patient AL at 04:28 from the ADC on CR3C.
 - b. 3 ampoules (6 mg) of injectable hydromorphone for patient AL at 20:57 from the ADC on CR3C.
60. There is no record of wastage or return of this medication in the Omnicell Report.

61. The MAR shows no evidence that the hydromorphone which Ms. Parniak withdrew was administered to patient AL on March 5, 2018.
62. The hydromorphone order allowed for multiple routes of hydromorphone, however the records show that AL only received oral dosages of hydromorphone on March 5, 2018.
63. The Omnicell Report shows that on March 6, 2018, Ms. Parniak withdrew:
 - a. 1 ampoule (2 mg) of injectable hydromorphone for patient AL at 00:34 from the ADC on CR3C.
 - b. 2 ampoules (4 mg) of injectable hydromorphone for patient AL at 00:34 from the ADC on CR3C (i.e. this transaction took place immediately after the one above).
64. There is no record of wastage or return of this medication in the Omnicell Report.
65. The MAR shows no evidence that the hydromorphone which Ms. Parniak withdrew was administered to patient AL on March 6, 2018.
66. The medical records show that the nurse assigned to AL on the nightshift from March 5 to 6, 2018 had the initials "J.O".
67. The Omnicell Report shows that on March 7, 2018, Ms. Parniak withdrew:
 - a. 2 ampoules (4 mg) of injectable hydromorphone for patient AL at 12:39 from the ADC on CR3C.
 - b. 3 ampoules (6 mg) of injectable hydromorphone for patient AL at 14:07 from the ADC on CR3C.
68. There is no record of wastage or return of this medication in the Omnicell Report.
69. The MAR shows no evidence that the hydromorphone which Ms. Parniak withdrew was administered to patient AL on March 7, 2018.
70. The medical records show that the nurse assigned to AL on March 7, 2018 had the initials "J.S". The flow sheet for March 7, 2018 shows AL had no complaints of pain.

71. The Omnicell Report shows that on March 8, 2018, Ms. Parniak withdrew:
 - a. 3 ampoules (6 mg) of injectable hydromorphone for patient AL at 12:12 from the ADC on CR3D.
 - b. 3 ampoules (6 mg) of injectable hydromorphone for patient AL at 15:46 from the ADC on CR3C.
72. There is no record of wastage or return of this medication in the Omnicell Report.
73. The MAR shows no evidence that the hydromorphone which Ms. Parniak withdrew was administered to patient AL on March 8, 2018.
74. On March 8, 2018, a doctor's order was written to discontinue scheduled Dilaudid and a new order was written for oral Dilaudid. The orders were transcribed at 11:22 prior to the two withdrawals by Ms. Parniak. The progress notes for March 8, 2018 contain a note from the physician "no abdo pain". In the MAR for March 8, 2018, the order for hydromorphone 6 mg was cancelled.
75. The Panel finds that between March 5 and March 8, 2019, on multiple occasions, Ms. Parniak diverted injectable hydromorphone from patient AL.

Allegation 6

76. The Panel finds that in withdrawing and diverting hydromorphone from an ADC between March 5 to 8, 2018 from patient AL, Ms. Parniak falsified medical documentation relating to patient RN

Allegation 7

77. The Omnicell Report shows that on October 17, 2017, Ms. Parniak withdrew:
 - a. 2 ampoules (4 mg) of injectable hydromorphone for patient WP at 07:52 from the ADC on CRSDC.
 - b. 2 ampoules (4 mg) of injectable hydromorphone for patient WP at 11:01 from the ADC on CRSDC.
 - c. 2 ampoules (4 mg) of injectable hydromorphone for patient WP at 12:25 from the ADC on CRSDC.

- d. 2 ampoules (4 mg) of injectable hydromorphone for patient WP at 14:07 from the ADC on CRSDC.

- 78. There is no record of wastage or return of this medication in the Omnicell Report.
- 79. The MAR shows that while Ms. Parniak withdrew 4 mg of injectable hydromorphone at 07:52, she only administered 2 mg of injectable hydromorphone at 08:34. While Ms. Parniak withdrew 4 mg of injectable hydromorphone at 11:01, she only administered 2 mg of injectable hydromorphone at 11:05. While Ms. Parniak withdrew 4 mg injectable hydromorphone at 12:25, she only administered 2 mg injectable hydromorphone at 12:30. Ms. Parniak withdrew 4 mg injectable hydromorphone at 14:07 and at 14:15 she administered 4 mg injectable hydromorphone, suggesting she had not administered any of the excess hydromorphone to WP from the three previous withdrawals. There is no evidence that patient WP received the hydromorphone.
- 80. The Panel finds that on October 17, 2017, on multiple occasions, Ms. Parniak diverted injectable hydromorphone from patient WP.

Allegation 8

- 81. The Panel finds that in withdrawing and diverting hydromorphone from an ADC on October 17, 2017 from patient WP, Ms. Parniak falsified medical documentation relating to patient WP.

Allegation 9

- 82. The Omnicell Report shows that on October 20, 2017, Ms. Parniak withdrew:
 - a. 2 ampoules (4 mg) of injectable hydromorphone for patient RH at 00:15 from the ADC on CRPACU.
 - b. 2 ampoules (4 mg) of injectable hydromorphone for patient RH at 03:31 from the ADC on CRPACU.
 - c. 2 ampoules (4 mg) of injectable hydromorphone for patient RH at 06:25 from the ADC on CRPACU.

- d. 2 ampoules (4 mg) of injectable hydromorphone for patient RH at 09:37 from the ADC on CRPACU.
83. There is no record of wastage or return of this medication in the Omnicell Report.
84. The MAR shows that while Ms. Parniak withdrew 4 mg injectable of hydromorphone at 00:15, at 00:20 she only administered 2 mg hydromorphone. Ms. Parniak withdrew 4 mg of injectable hydromorphone at 03:31, she administered 4 mg hydromorphone and did not appear to use the excess hydromorphone from the 0020 dose. Ms. Parniak withdrew 4 mg injectable hydromorphone at 06:25, but the MAR shows no evidence that RH received any hydromorphone injectable at 06:25. The MAR shows that Ms. Parniak withdrew 4 mg injectable hydromorphone at 09:37 and administered 4 mg of hydromorphone at 09:50.
85. There is no evidence that the excess injectable hydromorphone from these withdrawals was administered to patient RH. The Panel finds that on October 20, 2017, on multiple occasions, Ms. Parniak diverted hydromorphone from patient RH.

Allegation 10

86. The Panel finds that in withdrawing and diverting hydromorphone from an ADC on October 20, 2017 from patient RH, Ms. Parniak falsified medical documentation relating to patient RH.

Allegation 11

87. The Omnicell Report shows that on October 31, 2017 Ms. Parniak withdrew:
 - a. 2 ampoules (4 mg) of injectable hydromorphone for patient WB at 07:35 from the ADC on CRED2.
 - b. 1 ampoule (2 mg) of injectable hydromorphone for patient WB at 12:39 from the ADC on CRED2.
88. There is no record of wastage or return of this medication in the Omnicell Report. There is no evidence on the MAR that the medication was administered to WB.

The MAR also shows that this patient was receiving morphine at the time that Ms. Parniak removed the hydromorphone for him.

89. The patient order was for 1-2 mg of hydromorphone and Ms. Parniak withdrew 4 mg at 07:35.
90. The Omnicell Report for October 31, 2017 shows Ms. Parniak withdrew 2 mg injectable hydromorphone under patient WB's name at 15:00, 17:22 and 19:14. The MAR for October 31, 2017 shows that all three of those doses were administered to WB.
91. The Omnicell Report shows that on November 1, 2017, Ms. Parniak withdrew:
 - a. 1 ampoule (2 mg) of injectable hydromorphone for patient WB at 07:24 from the ADC on CRED2.
 - b. 1 ampoule (2 mg) of injectable hydromorphone for patient WB at 07:33 from the ADC on CRED2.
 - c. 1 ampoule (2 mg) of injectable hydromorphone for patient WB at 13:31 from the ADC on CRED2.
 - d. 1 ampoule (2 mg) of injectable hydromorphone for patient WB at 13:54 from the ADC on CRED2.
 - e. 1 ampoule (2 mg) of injectable hydromorphone for patient WB at 16:59 from the ADC on CRED2.
 - f. 1 ampoule (2 mg) of injectable hydromorphone for patient WB at 18:20 from the ADC on CRED2.
92. There is no record of wastage or return of this medication in the Omnicell Report.
93. The MAR shows no evidence that 2 mg of injectable hydromorphone was administered to WB at 07:24 or 07:33.
94. The MAR shows that WB received 4 mg of hydromorphone at 08:34. The College submits that the 08:34 dose as documented in the MAR was changed from 2 mg to 4 mg and was initialed by Ms. Parniak. The Panel has not reviewed the original

document. The Panel is not able to ascertain whether Ms. Parniak altered this record and declines to make that finding.

95. The MAR shows no evidence the 2 mg of injectable hydromorphone withdrawn at 13:31 was administered to WB. The MAR shows the 2 mg injectable hydromorphone withdrawn at 13:54 was administered to WB at 14:00 hours. The MAR shows no evidence the 2 mg injectable hydromorphone withdrawn at 16:59 hours was administered to WB. The MAR shows the 2 mg injectable hydromorphone withdrawn at 18:20 was administered to WB at 19:00.
96. The Panel finds Ms. Parniak withdrew 6 doses on November 1, 2017 for WB, but only 4 of those were administered to WB.
97. The Panel finds that Ms. Parniak diverted hydromorphone from patient WB on October 31, 2017 and on November 1, 2017.

Allegation 12

98. The Panel finds that in withdrawing and diverting hydromorphone from an ADC on October 31, 2017 and November 1, 2017 from patient WB, Ms. Parniak falsified medical documentation relating to patient RH.

Allegation 13

99. The Omnicell Report shows that on October 18, 2017, Ms. Parniak withdrew:
 - a. 1 ampoule (2 mg) of injectable hydromorphone for patient JA at 19:46 from the ADC on CRSDC.
 - b. 1 ampoule (2 mg) of injectable hydromorphone for patient JA at 20:26 from the ADC on CRSDC.
 - c. 1 ampoule (2 mg) of injectable hydromorphone for patient JA at 23:30 from the ADC on CRSDC.
100. There is no record of wastage or return of this medication in the Omnicell Report.
101. The MAR shows no evidence that the injectable hydromorphone which was withdrawn at 19:46, 20:26 and 23:30 was administered to JA.

102. The patient order is for oral hydromorphone.

103. The Panel finds that Ms. Parniak diverted hydromorphone from patient JA on October 18, 2017.

Allegation 14

104. The Panel finds that in withdrawing and diverting hydromorphone from an ADC on October 18, 2017 from patient JA, Ms. Parniak falsified medical documentation relating to patient JA.

Allegation 15

105. The Omnicell Report shows that on October 24, 2017, Ms. Parniak withdrew:

- a. 1 ampoule (2 mg) of injectable hydromorphone for patient NL at 09:47 from the ADC on CRED2.
- b. 1 ampoule (2 mg) of injectable hydromorphone for patient NL at 12:27 from the ADC on CRED2.
- c. 1 ampoule (2 mg) of injectable hydromorphone for patient NL at 14:45 from the ADC on CRED2.
- d. 1 ampoule (2 mg) of injectable hydromorphone for patient NL at 17:32 from the ADC on CRED2.

106. There is no record of wastage or return of this medication in the Omnicell Report.

107. The MAR shows no evidence that the injectable hydromorphone which was withdrawn at 09:47, 12:27, 14:45, and 17:32 was administered to NL.

108. The patient order for NL was for 2 mg of oral hydromorphone. The MAR shows that 2 mg of oral hydromorphone was administered to NL at 09:00, 47 minutes before Ms. Parniak withdrew 2 mg of injectable hydromorphone at 09:47.

109. The Panel finds that Ms. Parniak diverted hydromorphone from patient NL on October 24, 2017.

Allegation 16

110. The Panel finds that in withdrawing and diverting hydromorphone from an ADC on October 24, 2017 from patient NL, Ms. Parniak falsified medical documentation relating to patient NL.

Allegation 17

111. The Omnicell Report shows that on October 31, 2017, Ms. Parniak withdrew 1 ampoule (2 mg) of injectable hydromorphone for patient JB at 09:39 from the ADC on CRED2.

112. There is no record of wastage or return of this medication in the Omnicell Report.

113. The MAR shows that JB was ordered hydromorphone 2 mg oral. The MAR shows that Ms. Parniak administered hydromorphone 2 mg at 09:40 but she did not identify the route used to administer the drug. The College submits that the MAR shows no evidence that JB was given 2 mg of injectable hydromorphone on October 31, 2017.

114. Ms. MacKenzie's evidence was that there was no need for this patient to receive injectable hydromorphone. The medical records show that JB was discharged home on October 31, 2017. The College submits the discharge likely occurred between 09:40 and 12:00 and he did not receive his 12:00 medication.

115. The Panel finds Ms. Parniak withdrew a medication route which was different than the order for patient JB, and that there is a lack of clarity about the route of hydromorphone which Ms. Parniak did administer to JB at 09:40 because her recording-keeping for that entry was inadequate. However, the Panel does not have records as to whether Ms. Parniak took out 2 mg of oral hydromorphone for patient JB, which might have been administered to him at 09:40. Ms. MacKenzie testified that the Omnicell Report was for all routes of hydromorphone Ms. Parniak withdrew from October 2017 to March 2018. In reviewing the documents, it is apparent that the Omnicell Report is only with respect to Ms. Parniak's withdrawals of injectable hydromorphone.

116. The Panel finds there is insufficient evidence to prove this allegation of diversion on a balance of probabilities.

Allegation 18

117. Because the diversion alleged in allegation 17 has not been proven, the corresponding allegation of falsification of records in allegation 18 is also not proven.

Allegation 19

118. The Omnicell Report shows that on October 25, 2017, Ms. Parniak withdrew 2 ampoules (4 mg) of injectable hydromorphone for patient WF at 15:36 from the ADC on CR3C.

119. There is no record of wastage or return of this medication in the Omnicell Report.

120. The MAR shows no evidence that the injectable hydromorphone which was withdrawn at 15:36 was administered to WF.

121. The medical records show there was no patient order for hydromorphone for WF. WF had an epidural catheter and was on patient controlled epidural analgesia (PCEA). Ms. MacKenzie testified that PCEA is an analgesic infusion administered by epidural catheter into a spinal site. When a patient feels the need for pain relief, they can self administer an analgesic dose by a button. The doses administered are recorded. The medical records for WF show that at 13:00 on October 25, 2017, WF was encouraged to use PCEA. This entry was signed by Ms. Parniak. At 23:00, the progress notes indicate that WF's PCEA was infusing well. At 13:00 on October 26, 2017, the doctor ordered the removal of the epidural. The MAR confirms that the analgesia provided was bupivacaine 0.1% - fentanyl 5 mcg/ml in normal saline 250 ml (not hydromorphone).

122. The Panel finds that Ms. Parniak diverted hydromorphone from patient WF on October 25, 2017.

Allegation 20

123. The Panel finds that in withdrawing and diverting hydromorphone from an ADC on October 25, 2017 from patient WF, Ms. Parniak falsified medical documentation relating to patient WF.

Allegation 21

124. The Omnicell Report shows that on November 5, 2017, Ms. Parniak withdrew:

- a. 2 ampoules (4 mg) of injectable hydromorphone for patient JP at 07:35 from the ADC on CR3C.
- b. 2 ampoules (4 mg) of injectable hydromorphone for patient JP at 08:36 from the ADC on CR3C.

125. There is no record of wastage or return of this medication in the Omnicell Report.

126. The MAR shows no evidence the medication that Ms. Parniak withdrew was administered to JP. The only hydromorphone administered to JP on November 5, 2017 was 4 mg of oral hydromorphone which was not administered by Ms. Parniak. The MAR indicates that JP received ketorolac (Toradol) 30 mg at 06:00 on November 5, 2017 as well as morphine ER 30 mg po at 06:00 on November 5, 2017. The progress notes for November 5, 2017 indicate that JP was lying comfortably in bed with ketorolac infusing.

127. The Panel finds that Ms. Parniak diverted hydromorphone from patient JP on November 5, 2017.

Allegation 22

128. The Panel finds that in withdrawing and diverting hydromorphone from an ADC on November 5, 2017 from patient JP, Ms. Parniak falsified medical documentation relating to patient JP.

Allegation 23

129. The Omnicell Report shows that on October 31, 2017, Ms. Parniak withdrew 2 ampoules (4 mg) of injectable hydromorphone for patient CM at 18:17 from the ADC on CRED2.

130. There is no record of wastage or return of this medication in the Omnicell Report.
131. The handwritten MAR for October 31, 2017 showed the order was transcribed as ordered, however “/SC” appears beside “PO” as a route. The College submits that “/SC” appears to be in different ink and different handwriting. Ms. Parniak charted on the MAR that she administered Dilaudid 4 mg subcutaneously to CM at 18:19. She was the only nurse to administer hydromorphone injectable to CM. A dose of 4 mg of oral hydromorphone was administered by nurse “D.S.” at 23:20.
132. The computer-generated MAR for November 1, 2017 shows the hydromorphone order “hydromorphone 4 mg oral Q4H PRN”. As noted, Ms. MacKenzie’s evidence was that Ms. Parniak likely altered the transcribed hydromorphone order to include the injectable form. The College also makes that submission for this allegation.
133. The Omnicell Report shows that on November 1, 2017, Ms. Parniak withdrew 2 ampoules (4 mg) of injectable hydromorphone for patient CM at 18:45 from the ADC on CRED2.
134. There is no record of wastage or return of this medication in the Omnicell Report.
135. The MAR shows that Ms. Parniak documented that she administered 2 mg of hydromorphone at 09:12 and again at 10:05 and 4 mg of hydromorphone at 13:44. She did not document the route used and the Omnicell Report shows no evidence of corresponding withdrawals. Ms. Parniak documented that she administered 4 mg of hydromorphone at 18:56 (which was consistent with the withdrawal) but she did not document the route used.
136. The Panel does not find that there is sufficient evidence before it to conclude on a balance of probabilities that Ms. Parniak altered the MAR to include an order for injectable hydromorphone. The Panel also cannot conclude that Ms. Parniak diverted injectable hydromorphone from patient CM on the basis that she withdrew injectable hydromorphone, the order was for oral hydromorphone, and no route is specified in the progress notes for the hydromorphone which was administered to the patient. The recorded dose administered to CM corresponds with the dose

withdrawn. The Panel agrees that the record-keeping is unsatisfactory but it is not prepared to infer diversion on the basis of the evidence presented.

137. The Panel concludes this allegation is not proven on balance of probabilities.

Allegation 24

138. Because the diversion alleged in allegation 23 has not been proven, the corresponding allegation of falsification of records in allegation 24 is also not proven.

Allegations 25 to 30: Diversions while not on duty

139. The College advises that while the words “diversion” or “diverted” do not appear in allegations 25 to 36 in the same manner as with allegations 1 to 24, these allegations also allege that Ms. Parniak diverted medication she withdrew while she was not on duty.

Allegation 25

140. The employee schedule records show that on November 29, 2017, Ms. Parniak worked on unit CRG 3D from 19:30 to November 30, 2017 at 7:30.

141. The manager’s staffing report shows that the manager confirmed Ms. Parniak worked the 19:30 to 7:30 shift for which she was scheduled.

142. The Omnicell Report shows that on November 29, 2017, Ms. Parniak withdrew:

- a. 2 ampoules (4 mg) of injectable hydromorphone for patient #9267 at 18:40 (i.e. 50 minutes before the start of her shift) from the ADC on CR3D.
- b. 2 ampoules (4 mg) of injectable hydromorphone for patient #9267 at 18:52 (i.e. 38 minutes before the start of her shift) from the ADC on CR3C.

143. There is no record of wastage or return of this medication on the Omnicell Report.

144. The Panel agrees that it is unusual that Ms. Parniak made 2 separate withdrawals for injectable hydromorphone, 12 minutes apart, on two different units, prior to the start of her scheduled (and worked) shift on November 29, 2017. The Panel considers that there are circumstances where nurses do arrive for their shifts early

(or leave late), for example if there are issues of short staffing. The Panel considers that arriving 50 minutes prior to the start of one's shift is possible. It is unusual to withdraw medication for a patient before or after a shift, particularly if a nurse had not yet been assigned to the patient for whom she was withdrawing medication. Nevertheless, the Panel does not have information regarding patient #9267, including whether Ms. Parniak was assigned to this patient on November 29, 2017, what medication was ordered for this patient, and whether this patient was administered injectable hydromorphone on November 29, 2017. While the Panel considers the evidence relating to allegation 25 to be very unusual, it does not find there is sufficient evidence to conclude on a balance of probabilities that Ms. Parniak diverted the medication which she withdrew on November 29, 2017.

Allegation 26

145. As noted above, the College indicated that it was not pursuing allegation 26.

Allegation 27

146. The staffing records show that on January 23, 2018, Ms. Parniak worked in the CR CDU (the emergency room / observation) from 07:30 to 19:30. She then worked another shift in the CR CDU from 19:30 to 23:30.

147. The Omnicell Report shows that on January 23, 2018, Ms. Parniak withdrew 2 ampoules (4 mg) of injectable hydromorphone for patient #2393 at 07:05 from the ADC on CRED2. This withdrawal was 25 minutes prior to Ms. Parniak commencing her shift.

148. There is no record of wastage or return of this medication in the Omnicell Report.

149. For the same reasons as were outlined with allegation 25, the Panel considers that it has insufficient evidence to conclude on a balance of probabilities that Ms. Parniak diverted the medication which she withdrew.

Allegation 28

150. Staffing records show that on January 24, 2018, Ms. Parniak worked in CR CDU from 07:30 to 19:30. She then worked another shift in the CR SDC from 19:30 to 23:30.

151. The Omnicell Report shows that on January 24, 2018, Ms. Parniak withdrew 1 ampoule (2 mg) of injectable hydromorphone for patient #1784 at 07:08 from the ADC on CRED2. This withdrawal was 22 minutes prior to Ms. Parniak commencing her shift. The Omnicell Report shows a second identical withdrawal immediately after.

152. There is no record of wastage or return of this medication in the Omnicell Report.

153. For the same reasons as were outlined with allegation 25, the Panel considers that it has insufficient evidence to conclude on a balance of probabilities that Ms. Parniak diverted the medication which she withdrew.

Allegation 29

154. The staffing records show that Ms. Parniak worked in CR3 from 19:30 on February 27, 2018 to 07:30 on February 28, 2018.

155. The Omnicell Report shows that on February 27, 2018, Ms. Parniak withdrew 2 ampoules (4 mg) of injectable hydromorphone from the ADC in the CRPACU (post anesthetic care unit) for patient #9236. This withdrawal took place 5 hours and 34 minutes prior to Ms. Parniak started her shift.

156. There is no record of wastage or return of this medication in the Omnicell Report.

157. The Panel considers that there is sufficient evidence to establish on a balance of probabilities that Ms. Parniak diverted the medication which she withdrew on February 27, 2018. Unlike with allegations 25, 27 and 28, Ms. Parniak's off duty withdrawal took place over 5 hours prior to the start of her shift on a different unit.

158. The Panel finds that Ms. Parniak diverted hydromorphone from patient #9236 on February 27, 2018.

Allegation 30

159. The staffing records show that on March 23, 2018, Ms. Parniak worked on CR3D from 07:30 to 15:30 and then in CR CDU from 15:30 to 19:30.

160. The Omnicell Report shows that on March 23, 2018, Ms. Parniak withdrew:

- a. 2 ampoules (4 mg) of injectable hydromorphone for patient #6952 at 05:25 from the ADC on the CRPACU. This withdrawal occurred 2 hours and 5 minutes prior to Ms. Parniak starting her shift.
- b. 2 ampoules (4 mg) of injectable hydromorphone for patient #0701 at 05:51 from the ADC on the CRPACU. This withdrawal occurred 1 hour and 39 minutes prior to Ms. Parniak starting her shift.

161. There is no record of wastage or return of this medication in the Omnicell Report.

162. The Panel considers that there is sufficient evidence to establish on a balance of probabilities that Ms. Parniak diverted the medication which she withdrew on March 23, 2018. As with allegation 29, and unlike allegations 25, 27, and 28, the withdrawals at issue were made long before the start of Ms. Parniak's shift. Ms. Parniak made the withdrawals from a different unit than where she was due to work. She made the withdrawals in two different patients' names.

Allegations 31 to 36: Diversions involving multiple doses, using multiple transactions, not more than five minutes apart for the same patient

Allegation 31

163. The Omnicell Report shows that on October 25, 2017, Ms. Parniak withdrew:

- a. 1 ampoule (2 mg) of injectable hydromorphone at 18:50 for patient #2441 from the ADC on CR3C.
- b. 1 ampoule (2 mg) of injectable hydromorphone at 18:50 for patient #2441 from the ADC on CR3C.

164. There is no record of wastage or return of this medication in the Omnicell Report.

165. The Omnicell Report shows that on October 26, 2017, Ms. Parniak withdrew:

- a. 1 ampoule (2 mg) of injectable hydromorphone at 14:27 from the ADC on CR3C for patient #2437.
- b. 1 ampoule (2 mg) of injectable hydromorphone at 14:27 from the ADC on CR3C for patient #2437.

- c. 1 ampoule (2 mg) of injectable hydromorphone at 15:08 from the ADC on CR3C for patient #2452.
 - d. 2 ampoule (4 mg) of injectable hydromorphone at 15:08 from the ADC on CR3C for patient #2452.
166. There is no record of wastage or return of this medication in the Omnicell Report.
167. While the Panel finds the transactions are unusual, the Panel does not find that the evidence of Ms. Parniak withdrawing multiple doses, using multiple transactions, not more than five minutes apart for the same patient is sufficient for it to conclude on a balance of probabilities that in those instances Ms. Parniak diverted the medication.
168. The Panel does not have any of the patient records relating to these patients which would allow the Panel to assess whether Ms. Parniak was assigned to these patients on the dates in question, what medication was ordered for these patients, and whether these patients were administered injectable hydromorphone on the dates in question.
169. It is apparent to the Panel that there are entries during the six-month period covered in the Omnicell Report, in which it is not disputed that Ms. Parniak did not divert injectable hydromorphone and rather, withdrew and administered that medication to her patients.
170. In addition, during Ms. MacKenzie's testimony, she advised the Panel to ignore the discrepancy in the Omnicell Report on November 16, 2017 at 22:44 where it appears Ms. Parniak withdrew 100 ampoules of injectable hydromorphone for patient #6569. Ms. MacKenzie noted that the amount withdrawn was too large and she attributed that discrepancy to a typographical error. The Panel notes that there is another entry for November 16, 2017 at 22:44 for patient #6569 where Ms. Parniak withdrew only 2 ampoules. It is not clear to the Panel the basis on which it should disregard the largest discrepancy for a withdrawal of multiple doses, using multiple transactions not more than five minutes apart for the same patient, but find diversion exists on the basis of the same pattern in this instance. It may be that

there is an explanation as to why the duplicate transactions on November 16, 2017 is a typographical error and the duplicate transactions in allegations 31 to 36 are not typographical errors, but the Panel has no such evidence before it.

171. The College submitted that the Panel was entitled to draw inferences of diversion where no patient medical records are present. The Panel accepts that it can draw inferences and that it can do so in the absence of patient records, however, with respect to this count, there was insufficient evidence on which to draw the inference. Absent other evidence, the Panel is not prepared to infer that multiple withdrawals for the same patient within a short period of time amounted to diversion in this allegation where Ms. MacKenzie's evidence was that a similar pattern did not constitute diversion in another instance because of the presence of a typographical error.

172. The Panel dismisses allegation 31.

Allegations 32 to 36

173. The Panel has reviewed all of the documents pertaining to allegations 32 to 36 and finds the transactions took place as alleged in the Citation. Nevertheless, the Panel dismisses allegations 32 to 36 for the same reasons as outlined in allegation 31.

Breach of Standards and Unprofessional Conduct

174. The magnitude of Ms. Parniak's drug diversion and falsification of medical documentation was significant. For approximately six months, Ms. Parniak engaged in a pattern of conduct where she falsified medical records and diverted injectable hydromorphone from specific patients at the Hospital. Hydromorphone is a pain medication. The patients from whom she diverted medication are vulnerable persons. The quantity of medication Ms. Parniak diverted was significant.

175. Ms. Parniak accessed private information of individuals who were not her patients. Ms. Parniak should not have accessed their patient orders or falsified their medical documentation.

176. Ms. Parniak's actions had serious consequences. In allegation 1, for example, the patient who complained of pain was delayed in receiving his pain medication and having his condition managed in a timely manner. Another nurse was caring for that patient and Ms. Parniak's actions caused concern and confusion among several members of the Hospital staff in relation to this incident. Ms. Parniak's falsification of patient medical records created serious risks to patient safety and continuity of care.
177. Ms. Parniak's actions departed from the professional and ethical responsibility to ensure the patient remains the focus and the primary concern. She failed to demonstrate honesty and integrity.
178. The Panel finds that the proven conduct in allegations 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 29, 30 is contrary to the following standards which were in force at the time of the relevant conduct:

Standard 1: Professional Responsibility and Accountability

Clinical Practice

- 1 Is accountable and takes responsibility for own nursing actions and professional conduct.
- 4 Takes action to promote the provision of safe, appropriate and ethical care to clients.

Standard 3: The Client-Focused Provision of Service

Clinical Practice

- 1 Communicates, collaborates and consults with clients and other members of the health care team about the client's care.
- 2 Coordinates client care in a way that facilitates continuity for the client.

Standard 4: Ethical Practice

Clinical Practice

- 1 Makes the client the primary concern in providing nursing care.

- 2 Provides care in a manner that preserves and protects client dignity.
- 3 Demonstrates honesty and integrity.
- 5 Protects client privacy and confidentiality.

Documentation Practice Standard

- 1 Nurses are responsible and accountable for documenting in the health record the care they personally provide to the client. Care provided by other staff members is best documented by those staff members, except in certain circumstances such as an emergency.
- 3 Nurses document all relevant information about clients in chronological order on the client's health record. Documentation is clear, concise, factual, objective, timely, and legible. Nurses clearly mark any "late entries," recording both the date and time of the late entry and of the actual event.
- 9 Nurses have a role in safeguarding the privacy, security and confidentiality of health records. Nurses access a health record only when they have a professional need. Nurses assist clients with the process of accessing information on their health record.

Medication Administration Practice Standard

- 3 Nurses adhere to "seven rights" of medication administration: right medication, right client, right dose, right time, right route, right reason and right documentation.
- 12 When a medication error or near miss occurs at any point in the process of prescribing, compounding, dispensing or administering a medication, nurses take appropriate steps to resolve and report it in a timely manner.

Privacy and Confidentiality Practice Standard

- 2 Nurses collect personal and health information on a need-to-know basis.
- 6 Nurses safeguard personal and health information learned in the context of the nurse-client relationship and disclose this information (outside of the health care team) only with client consent or when there is a specific ethical or legal obligation to do so.
- 10 Nurses access personal and health information only for purposes that are consistent with their professional responsibilities.

179. Section 39(1) of the HPA provides that on completion of a hearing, the Discipline Committee may determine that the Respondent has committed professional misconduct or unprofessional conduct.

180. Section 26 of the HPA defines professional misconduct and unprofessional conduct as follows:

"professional misconduct" includes sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession;

"unprofessional conduct" includes professional misconduct.

181. The College submits that "unprofessional conduct" can broadly be considered conduct "which violates the ethical code or rules of a profession or such conduct which is unbecoming a member of the profession in good standing" (*Re McLellan*, CRNBC 2018 para 54).

182. The College also relies upon *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2. S.C.R. 869. It submits that in *Pearlman*, the Supreme Court of Canada accepted that professional misconduct is "conduct which would be reasonably regarded as disgraceful, dishonorable, or unbecoming of a member of the profession by his well respected brethren in the group – persons of integrity and good reputation amongst the membership".

183. The College submits that the conduct alleged represents a pattern of professional misconduct that readily meets the description in *Pearlman*.

184. As noted above, the Panel finds the proven conduct in this case to be very serious and significant.

185. While it is not necessary for the Panel to find Ms. Parniak's conduct to be "disgraceful or dishonourable" in order to find that it amounts to professional misconduct, for the reasons described above, the Panel does find that Ms. Parniak's proven conduct, when taken together, represents a pattern of professional misconduct which is disgraceful, dishonourable and unbecoming of a member of the profession. It is also a marked departure from the conduct which the College expects of its registrants.

Order

186. The Panel determines pursuant to section 39(1)(b) and (c) of the Act that in relation to allegations 1, 2, 3, 4, 5, 6, 7, 8,9, 10, 11, 12, 13, 14,15, 16, 19, 20, 21, 22, 29, 30, Ms. Parniak has:

- a. Breached a standard imposed under the Act; and
- b. Committed professional misconduct.

187. The Panel dismisses allegations 17, 18, 23, 24, 25, 27, 28, 31, 32, 33, 34, 35, and 36.

Schedule for Submissions on Penalty and Costs

188. The Panel requests that the parties provide written submissions regarding the appropriate penalty and costs.

189. The Panel requests that the parties provide the written submissions in accordance with the following schedule:

- a. Submissions must be delivered by counsel for the College to Ms. Parniak and the Panel no later than October 1, 2020;
- b. Submissions must be delivered by Ms. Parniak to counsel for the College and the Panel no later than October 15, 2020; and
- c. Reply submissions may be delivered by counsel for the College to Ms. Parniak and the Panel no later than October 22, 2020.

190. Submissions for the Panel should be delivered to Susan Precious, counsel for the Panel and may be delivered electronically.

Notice of Right to Appeal

191. Ms. Parniak is advised that under section 40(1) of the Act, a respondent aggrieved or adversely affected by an order of the Discipline Committee under section 39 of the Act may appeal the decision to the Supreme Court. Under section 40(2), an appeal must be commenced within 30 days after the date on which this order is delivered.

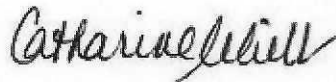
Date: September 3, 2020



Sheila Cessford, Chair



Dr. Thomas Ward



Dr. Catharine Schiller, RN