IN THE MATTER OF THE COLLEGE OF LICENSED PRACTICAL

NURSES OF BRITISH COLUMBIA (The "College")

AND

IN THE MATTER OF A HEARING PURSUANT TO SECTION 33 OF THE

***HEALTH PROFESSIONS ACT* INTO THE CONDUCT OF**

BRIGITTA PELCZ

REASONS FOR DECISION

1. This matter involves the hearing of an amended Citation dated 28 September 2016 in which the College makes certain allegations regarding the conduct of Ms. Brigitta Pelcz. By way of overview, Ms. Pelcz is a Licensed Practical Nurse who completed her training April 13, 2012 (Exhibit G) and became registered with the College on July 4, 2012 (#44857) per public registry.

2. Ms. Pelcz commenced employment at Sutherland Hills Rest Home (SHRH), initially as a health care aide (HCA) and then, after a period of orientation, as a Licensed Practical Nurse in or about February 2013. She continued her employment at SHRH until her indefinite suspension June 12, 2014.

3. The Citation raises a number of allegations and the College's Discipline Committee Panel (the Panel) had an opportunity to hear this matter over 9 days, including 13 witnesses called on behalf of CLPNBC and one (herself) on behalf of Ms. Pelcz.

4. Although these Reasons may not detail all of the evidence that has been provided in these hearings, in reaching its decision, the Panel has carefully considered the evidence of all witnesses and all documents introduced during the course of the hearing, along with the submissions from the parties with respect to this evidence.

5. The Panel further notes that, with the agreement of the parties, this decision deals only with the question of whether Ms. Pelcz has committed any of the breaches alleged in the Citation. The Panel will issue a final decision, setting out the appropriate remedies flowing from these reasons, after the parties have been able to make further submissions based on these reasons.

The "Staples" Incident

6. The first matter raised in the Citation 1(a) involves resident [redacted] In simple terms, the allegation is that the resident had staples removed from a wound on the back of her head as the result of a fall, on or about September 16, 2013 and that Ms. Pelcz incorrectly recorded in the progress notes of this resident that the staples were "dry and intact healing well" at 21:50 hours, when, in fact there were no staples as they had been removed earlier the same day. In particular, the progress notes for [redacted] indicated that [redacted], another LPN, had removed the staples at 13:45 hours September 16, 2013 and entered into the progress notes "Staples (4) back of head removed at this time. Left open to air". (Exhibit F)

7. [redacted] was called as a witness on behalf of the College and provided evidence that she removed the staples as indicated in the progress notes.

8. Ms Pelcz provided evidence that the staples were, in fact, not removed at the time she made her notes in the chart. However, the next day, namely September 17, 2013 at 18:00 hours, Ms. Pelcz recorded a correction to the previous day's progress notes that the staples had, in fact, been removed and charted, as follows: "Resident wound dry + intact, wound approximating well, no reddness (sic) or irritation noted". Ms. Pelcz did not provide any satisfactory explanation at the hearing as to the inconsistency between her position at the hearing, namely that her initial entry in the progress notes was correct, and her actions at the time in posting a correction to her initial entry.

9. The Panel is satisfied that the staples had been removed by [redacted] and that Ms. Pelcz failed to properly assess the resident, in that the staples had in fact been removed at the time Ms. Pelcz charted that the "staples were dry + intact, healing well…".

10. As a result, with respect to 1(a) the Panel finds that Ms. Pelcz has breached the following standards of practice:

CLPNBC Professional Standards of Practice 1.1.6
CLPNBC Professional Standards of Practice 1.1.9
CLPNBC Professional Standards of Practice 2.1.1
CLPNBC Professional Standards of Practice 2.2.1
CLPNBC Professional Standards of Practice3.2.1

CLPNBC 2010 Practice Guideline: Documentation
Foundations of practice;

An LPN draws upon knowledge of human biological sciences, pharmacology, and health-promotion and prevention strategies while formulating and implementing the nursing-care plan, as indicated by:

-Ensuring all relevant and preceding documentation has been reviewed, and that any unclear information has been clarified, prior to providing care to an assigned client
- Ensuring the document provides clear information about the nursing assessment, the plan of care for the client, identified nursing interventions based on assessment findings, and client outcomes based on the nursing interventions provided by the LPN. Documentation clearly demonstrates the use of critical thinking based on clinical decisions made by the LPN.

Professional Practice;

An LPN maintains standards of professional nursing practice, professional conduct, and safety in the practice setting, as indicated by:

-Providing evidence in documentation that nursing knowledge, skills, and clinical judgment are being utilized in accordance with expected professional standards.
-Documenting appropriately, as evidenced by documenting in a timely manner using agency – established and approve abbreviations, and completing the entire document to support the continuity of quality client care. The timeliness of documentation is

reflective of ongoing client assessments, completed nursing interventions, client outcomes, and revisions to care plans. The detail and frequency of documentation will be based on the acuity, complexity, and variability of the client.
-Understanding that the documentation in a healthcare record maybe used to evaluate services provided and outcomes achieved.

Legal practice

An LPN understands and adheres to the legal obligations and requirements of the profession when documenting, as indicated by:

-Entering information based on first-hand knowledge. The only exception is in an emergency in which the healthcare provider may be delegated the task of documenting care provided by other members of the healthcare team.

Intramuscular Injection Incident

11. Paragraph 1(b) of the Citation alleges that on or about September 21, 2013 Ms. Pelcz demonstrated a lack of knowledge or skill regarding the interpretation and implementation of doctor's orders regarding the administration of an intramuscular injection for resident [redacted]

12. The evidence is that the resident, [redacted], had a history of agitation and that there was a standing order for an intramuscular injection of a sedative, as needed, to address this agitation.

13. [redacted], another LPN employed by SHRH, was called by the College to provide evidence in respect of what occurred on this occasion. [redacted] testified that, during the evening of September 21, 2013, Ms. Pelcz approached her and stated that she had been approached by a HCA who stated that [redacted] was agitated and needed a sedative. Ms. Pelcz proceeded to ask [redacted] questions regarding the administration of an intramuscular (IM) injection.

14. [redacted] evidence was that Ms. Pelcz had in her hand a 1ml TB syringe used for subcutaneous (SC) injections, and that she stated to [redacted] that she was unclear as to how to calculate the required dose of medication and, further, that she was not sure what needle to use in administering the dose to the resident.

15. [redacted] evidence is that she asked Ms. Pelcz if she had assessed the resident herself and Ms. Pelcz said "No". [redacted] and Ms. Pelcz then attended the resident's room and saw that the resident had calmed down and was no longer in need of a sedative medication. [redacted] and Ms. Pelcz then had a discussion about the choice of needle gauge and calculation of the dosage ordered. [redacted] testified that Ms. Pelcz was unable to calculate either the dose or determine the correct needle gauge/size to use and [redacted] had to provide a detailed explanation on how to do so. [redacted] (Exhibit I) testified that she was afraid that Ms. Pelcz would not be willing to ask for help, in future, if an IM injection was needed for administration.

16. The allegation arising out of this matter is that:

a) Ms. Pelcz was unable to determine the appropriate dose of a PRN medication and the gauge/size of needle necessary; and,

b) Ms. Pelcz failed to assess (or to properly and accurately assess) the state of the resident [redacted]

17. Ms. Pelcz did not, during cross-examination, seriously challenge [redacted] on this evidence. Ms. Pelcz's response to this allegation in simple terms is that as a junior nurse it was not unreasonable for her to ask a colleague questions regarding needle choice and dose calculation.

18. On consideration of the entire evidence, it is the determination of the Panel that:

a) Ms. Pelcz should have been able to calculate the appropriate PRN medication dose, as that is a routine nursing skill and

b) Ms. Pelcz should have known the appropriate needle size/gauze used in administering injections, whether IM or SC.

19. As a result, with respect to 1(b) the Panel finds that Ms. Pelcz breached:

> **CLPNBC 2010 Practice Guideline: Medication Administration**
> **Professional practice**
>
> **An LPN maintains standards of professional nursing practice, professional conduct, and safety in the practice setting during medication administration, as indicated by:**
>
> -Administering medications according to health authority, facility, agency and or departmental policy. Baseline competencies permit an LPN to administer medications via routes including oral, rectal, vaginal, intra-muscular, subcutaneous aural (ear drop), ophthalmic (eye drops), intradermal, topical, nasal, sublingual, inhalation, nasogastric tube, jejunostomy tube, and gastrostomy tube.
> -Assessing one's own knowledge, skill and judgement to competently carry out medication administration; to use medication equipment; and to intervene during an adverse reaction.
>
> **Foundations of practice**
>
> **An LPN draws upon knowledge of human biological sciences, pharmacology, and health-promotion and prevention strategies, while formulating and implementing the nursing care plan, as indicated by:**
>
> -Assessing the appropriateness of the medication for a particular client. For example: reason for the medication; and the knowledge of the action, interactions, usual dose, route, client's allergies, sensitivities, and previous adverse reactions.
> -Performing the appropriate assessment prior to, and after, the administration of medications.
> -Determining the appropriate dose from an available range dose to achieve a therapeutic effect for the client. An order change is required if a range dose is unavailable. Record the dose, route, and a time on the medication administration record

20. With respect to the assessment of the resident, the Panel is not of the view that Ms. Pelcz's conduct constituted a breach of the standard of care. In particular, it is the determination of the Panel that, given the history of agitation on the part of this resident and the information provided to Ms. Pelcz by the HCA, it was reasonable for her to draw up the medication prior to attending the resident's room. There is no basis to conclude that Ms. Pelcz would have administered the medication upon observing the resident was no longer in a state of agitation.

The Catheter Incidents

21. It is also alleged in the Citation 1(d) and 1(e) that on three (3) occasions Ms. Pelcz failed to insert a urinary catheter in accordance with the appropriate procedure.

22. [redacted], an LPN at SHRH, was called to provide evidence that she was working as a [redacted] nurse on December 4, 2013 and accompanied Ms. Pelcz to observe the insertion of an "in and out" urinary catheter in an elderly, female resident. [redacted] provided evidence that Ms. Pelcz did not follow the appropriate procedure in maintaining a sterile field and, in particular, she opened and put on the sterile gloves too early in the procedure, thus contaminating the field. [redacted] also stated that Ms. Pelcz dropped the catheter onto the bed linen, out of the sterile field, and then proceeded to utilize the same catheter during the procedure instead of discarding it and obtaining a new one.

23. Ms. Pelcz's response was a general denial of these allegations.

24. [redacted], [redacted], also provided evidence that she observed Ms. Pelcz attempt urinary catheterizations on both a male resident and a female resident in March 2014 and April 2014, respectively. [redacted] testified that Ms. Pelcz "broke" the sterile field on both occasions by touching the resident's legs with the sterile gloves, did not change the contaminated gloves, and then continued to attempt the catheterization procedures until stopped by [redacted].

25. Ms. Pelcz cross-examined both of these witnesses and provided evidence in which she denied the allegations.

26. The Panel found the evidence of [redacted] to be compelling and we accept her evidence. We also accept the evidence of [redacted], that Ms. Pelcz failed to maintain a sterile field during the performance of the catheterization attempts in her evidence.

27. As such, the Panel finds in respect of paragraph 1(d) and 1(e) of the Citation that Ms. Pelcz failed to follow the correct procedure in respect of these three (3) catheterization procedures.

28. With respect to 1(d) and 1(e) the Panel concludes that Ms. Pelcz breached**:**

CLPNBC 2010 Professional Standards of Practice 1.1.2
CLPNBC 2010 Professional Standards of Practice 1.1.6
CLPNBC 2010 Professional Standards of Practice 1.1.9
CLPNBC 2010 Professional Standards of Practice 2.3.1
CLPNBC 2010 Professional Standards of Practice 2.3.2
CLPNBC 2010 Professional Standards of Practice 3.2.2
CLPNBC 2010 Professional Standards of Practice 3.3.1

Charting Issues

29. Paragraph 1(f) of the Citation alleges that Ms. Pelcz demonstrated poor understanding of previous charting and/or poor judgement by charting in the progress notes of the resident [redacted] in respect of collection of a urine specimen. In general terms, it is alleged that Ms. Pelcz attempted to collect a urine sample from a resident for delivery to the lab when, in fact, a sample had already been obtained and sent for culture and sensitivities.

30. The progress notes of [redacted] (Exhibit K) indicate that on December 9, 2013, [redacted] LPN on duty, obtained and sent a urine specimen to the Kelowna General Hospital (KGH) lab at 13:30 hours. The progress notes entry by Ms. Pelcz on December 10, 2013 at 21:45 hours state as follows: "Was unable to collect urine culture this evening."

31. The further evidence of [redacted] LPN was that in respect of certain matters, an erasable whiteboard is maintained in the nursing station to be used as a "reminder" or a "prompt" of tasks to be completed during the shift. However, the evidence provided was that, while the whiteboard is to be used as a reminder/prompt, the actual chart and or progress notes are to be reviewed prior to any procedures being initiated for a resident. Ms. Pelcz confirmed this practice on her evidence.

32. The evidence of Ms. Pelcz was that, based on the whiteboard notation, she did attempt to obtain a urine sample from [redacted] However, she does not provide any explanation as to why she attempted to collect a urine sample when, if she had reviewed the progress notes, the progress notes would have shown that the urine specimen had already been collected and sent to the KGH lab the previous day.

33. In the result, the Panel finds that Ms. Pelcz demonstrated poor understanding of charting and poor judgement by not reviewing the progress notes of [redacted] prior to attempting collection of a urine specimen and relied on the whiteboard prompt that she admits she knew not to be appropriate in the circumstances.

34. As a result, with respect to 1(f) the Panel finds that Ms. Pelcz breached:

> **CLPNBC 2010 Practice Guideline: Documentation**
>
> **Foundations of Practice**
>
> **An LPN draws upon knowledge of human biological sciences, pharmacology, and health-promotion and prevention strategies while formulating and implementing the nursing-care plan, as indicated by:**
>
> -Ensuring that all relevant and preceding documentation has been reviewed, and that any unclear information has been clarified, prior to providing care to an assigned client.
>
> **Professional Practice**
>
> **An LPN maintains standards of professional nursing practice, professional conduct, and safety in the practice setting, as indicated by:**
>
> -Understanding that documentation in a health-care record may be used to evaluate

services provided and outcomes achieved.

The "Fall" Incident

35. In paragraph 1(g) of the Citation, it is alleged that Ms. Pelcz failed to sufficiently assess the state of resident [redacted] per SHRH Falls Protocol and Post Fall Assessment Checklist after the resident had a fall February 1, 2014 at 21:40 hours. In particular, it is alleged that Ms. Pelcz:

    a) failed to undertake a weight bearing assessment immediately upon assessing the resident post fall to determine whether the resident had suffered any broken bones or other serious injury;

    b) failed to ensure that a one hour post fall assessment, required under SHRH Falls Protocol, was undertaken. Specifically, given that Ms. Pelcz's shift ended within the one hour post fall assessment period, she failed to insert a flag in the resident's chart in accordance with the SHRH flag protocol in order to alert a subsequent nurse to undertake the one hour post fall assessment; and,

    c) failed to notify a family member of the fall but rather called a "family friend".

36. As indicated above, the evidence provided was that a SHRH Falls Protocol was in place that described in general terms the actions a nurse on duty was required to follow subsequent to a resident fall. That document sets out the need to perform a one hour post fall assessment.

37. In addition, there was also a SHRH Post Fall Checklist which was to be completed that set out the process in further detail. That document sets out the need to perform the weight bearing assessment. However, the evidence was that at the time of this fall, the post fall assessment checklist, although in existence, was not routinely used.

38. Despite this, Ms. Pelcz's evidence is that she performed a weight bearing assessment after the fall, and verbally advised [redacted] LPN, the nurse who would be on duty one hour post fall, to perform the one hour post fall assessment as her shift would be over.

39. A SHRH Incident Report was initiated by Ms. Pelcz recording the actions she took in respect to the fall of [redacted] That report indicates that Ms. Pelcz was informed by the HCA that the resident had fallen. Ms. Pelcz attended the resident's room where [redacted] was found sitting on the floor outside the bathroom door, awake and breathing. The report states "x3 assist using medi-man to bed".

40. In respect of the section of the incident report for the post fall assessment it states "not completed". Noted as well, there is no reference to a weight bearing assessment being done by Ms. Pelcz.

41. The resident's progress notes (Exhibit P) completed by Ms. Pelcz record that she did a head to toe assessment, performed a full range of motion, recorded resident's vital signs, reflexes, noted strong hand grips, no complaints of pain, no noticeable bruising, and with the two (2) assistant HCAs, lifted the resident into bed using the Medi-man lift, and that the resident was talkative. The entry then says "one hour post fall assessment to be completed by partner nurse". The fall is noted to have occurred at 21:40 hours and that the "family friend" was called at 22:00 to explain the incident, that the family friend was very thankful for call, and that the resident was lying on the bed at this time.

42. Although not recorded in either the progress notes or the incident report, the evidence of Ms. Pelcz was that she did perform a weight bearing assessment by standing the resident beside the bed after using the lift to get the resident onto the bed. Of note, there is a progress note reference to the fall incident being charted on the "resident monthly flow sheet" although this was not entered as an exhibit. In respect of the one hour post fall assessment Ms. Pelcz states she verbally told [redacted] LPN, [redacted], to complete the assessment.

43. That nurse, [redacted], provided evidence at the hearing and did not dispute that Ms. Pelcz verbally told [redacted] to complete the one hour assessment. In fact, the evidence given by [redacted] was that [redacted] had been separately disciplined, as [redacted] admitted that [redacted] was not listening to Ms. Pelcz at the end of her shift and, as such, did not hear or make note of Ms. Pelcz informing [redacted] of the fall and the need to conduct a one hour post fall assessment. As well, [redacted] evidence was that [redacted] would not check the residents progress notes on any of Ms. Pelcz's residents during the one hour [redacted] was in charge of all 60+ residents. As well, Ms. Pelcz stated she left the incident report of [redacted] fall on the nursing desk for [redacted] to review.

44. The Panel notes that such an incident report was in fact initiated by Ms. Pelcz, as it was introduced into evidence. (Exhibit O"). We also note that [redacted] recollection of the events of that incident was very limited. For example, [redacted] testified that a resident had broken her hip, which was not true regarding this resident, (Exhibit P/page 3/reference to a fax from KGH) and [redacted] had limited recall of other matters that evening.

45. In the circumstances, the Panel is satisfied that Ms. Pelcz advised [redacted] of the need to perform the one hour post fall assessment. Further, we note that given that [redacted] admits [redacted] did not check these resident's charts, that is the only way a need for a one hour post assessment would have been noted by the only nurse present on [redacted] at SHRH, in the one hour post fall time frame. We also are unable to find that Ms. Pelcz did not place the completed incident report on the nursing station desk for [redacted] to review.

46. Of significance is that [redacted], a Registered Nurse employed at SHRH [redacted], was called to provide evidence. When asked in respect of procedure to be followed in the event a resident has a fall, she testified that if there is no evidence that a resident has suffered a serious injury it may well be appropriate to simply lift the resident back into bed following an assessment while the resident was still on the floor.

47. As well, and of some additional concern to the Panel, it was determined during the hearing that the resident had, in fact, fallen two other times in the previous few days. There was no evidence provided in respect of the details of those falls and in particular whether:

    a) post fall assessments had been completed;

    b) whether the chart had been flagged as a result of those prior matters or any results in that respect; or,

    c) whether the resident's family had been notified in respect of the previous falls.

48. Ms. Pelcz provided evidence, as indicated, that she conducted the post fall assessment. She also provided evidence that, as a result of the previous falls, [redacted] chart would already have been flagged by the previous nurses, the identities of which were not disclosed at the hearing. Ms. Pelcz was not challenged on cross-examination in respect of her assertion that the chart was

already flagged.

49. Also of concern is an entry that was recorded in the progress notes of February 2,2014 at 23:15 hours which states “Late entry for 0600. Resident slept all night. No c/o pain when up to toilet”. That note was entered by [redacted], an LPN employed at SHRH. The evidence in that respect was that [redacted] was not, in fact, on duty at the time of this supposed observation but rather, that she recorded this late entry for the nurse that was on duty at that time. That nurse was not called to provide evidence.

50. That late entry was entered into the resident’s progress notes approximately 24 hours after the fall incident and no satisfactory explanation was provided by [redacted] as to why she would make an entry for a shift she did not work, other than to say she was asked to chart it by [redacted] for the HCAs that were on duty.

51. In the result, the Panel does not find the College has established that Ms. Pelcz failed to perform the one hour assessment. Moreover, the Panel does not find Ms. Pelcz failed to flag the chart as the chart must have been already flagged due to the previous falls.

52. As indicated above, it is also alleged in the Citation that Ms. Pelcz failed to properly record the call to a family member immediately post fall. In particular, the progress notes (Exhibit P) indicate “family friend called at 22:00”. Ms. Pelcz recorded a correction/error to her progress note entry of February 1, 2014 on February 2, 2014 which indicated that “writer contacted [redacted] at 22:00 not family friend”. [redacted] is the daughter of [redacted] and it would have been appropriate to notify her of the resident’s fall.

53. There is no direct evidence that Ms. Pelcz was incorrect with respect to her assertion that she contacted the daughter, [redacted], immediately post fall. In particular, [redacted] was not called to provide evidence and Ms. Pelcz was not challenged on cross-examination on this issue. In the result, we do not find that the College has established that Ms. Pelcz failed to follow the post fall protocol in failing to contact [redacted], not a family friend. That being said, even if Ms. Pelcz did contact [redacted], she incorrectly charted in the progress notes that she contacted a family friend.

54. In the result, our findings with respect to this matter are as follows:

    a) We do not find that the College established that Ms. Pelcz failed to undertake the weight bearing assessment;

    b) We do not find that the College has established that Ms. Pelcz failed to flag the chart for a one hour post fall assessment as the chart should have been flagged from the previous falls;

    c) We do not find that Ms. Pelcz acted improperly by telling [redacted] verbally to do the one hour post fall assessment;

    d) We do not find that Ms. Pelcz failed to give the incident report to [redacted]; and

    e) We do find that Ms. Pelcz called the daughter, [redacted], charted it incorrectly but, the next day, February 2, 2014, did another entry into the progress notes correcting the previous notation regarding calling a "family friend" in an acceptable manner.

Administration of Sleeping Medication Incident

55. In paragraph 1(h) of the Citation it is alleged that on February 6, 2014, Ms. Pelcz exhibited lack of care, knowledge and judgement in interpreting doctor's orders and administering excessive sleeping medication, namely 15mg Oxazepam (also referred to as Serax) and 7.5mg Zopiclone to resident [redacted]

56. Extensive evidence was provided with respect to this matter, and the doctor's orders were also admitted into evidence. In general terms, this matter arises initially out of an error committed by the resident's physician [redacted], in providing what is, at best, confusing and, at worst, incorrect medication orders. In particular:

a) On February 4, 2014, a Request for an Assessment was faxed to [redacted] asking for an increase to a sleeping medication for [redacted] (Exhibit U). At that time the resident was receiving 3.75mg Zopiclone at bedtime;

b) In response, the physician hand wrote on the return fax of the Request for Assessment form to "Trial Oxazepam 15mg po nocte. Review efficacy in 10 days." In addition, the physician posed certain other questions on the return fax, including "1. When does she fall asleep?" and "2. For how long?";

c) The nurse who received the information requested by the physician appropriately answered the questions and faxed the form back to the physician; and,

d) The physician then faxed back the Request for Assessment which had the additional order for "RX Zopiclone 7 ½ po nocte, review efficacy in 10 days".

57. In the result, after the exchange of these faxes between SHRH and [redacted], the physician orders for [redacted] now included two (2) sleeping medications, namely Zopiclone 7.5mg po nocte and Oxazepam 15mg po nocte, for an efficacy assessment period of 10 days for both. This apparent medication error or, at a minimum, confusion, in the orders was not detected by the pharmacist who filled the order and as a result both medications were sent to SHRH for this resident.

58. The cause of the difficulties which gave rise to this Citation allegation were an error by the physician in providing medication orders that were, at best, confusing and, at worst, a prescribing error with a further error by the pharmacist in not detecting the fact that it was inappropriate for such a large increase in sleeping medication for [redacted] and then sending the doubled medication to SHRH in the resident's medication roll.

59. The relevant entry in the progress notes (Exhibit S) in respect to this matter first appear on February 5, 2014, when Ms. Pelcz recorded the following "Writer held 20:00 Zopiclone as charted in calendar due to trial oxazepam, med given".

60. The evidence was that there was a document referred to as "the calendar" in which key matters were recorded. Regrettably, the calendar was not introduced into evidence.

61. It appears however, from the progress notes that a nurse, whose identity was not revealed during the hearing, wrote in the calendar that an error had been made in respect to the medication for this resident. As a result, Ms. Pelcz having reviewed the calendar that the Zopiclone 7.5mg should be held pending clarification of the physician's orders.

62. As a result, it appears from the progress notes that, the physician's error and the pharmacist's error were, in fact, detected by someone at SHRH and that the error was duly recorded in the calendar, which was available for the nursing staff to review. The evidence also appears that Ms.

Pelcz noted the error in the calendar and withheld the Zopiclone 7.5mg on February 5, 2014. This was duly recorded by Ms. Pelcz in the electronic medication record (eMAR) which records the medication and administration time when scanned. The eMAR entered into evidence shows that Ms. Pelcz withheld the Zopiclone and administered the Oxazepam 15mg on that shift. In other words, the eMAR indicates that Ms. Pelcz followed the direction in the calendar and withheld one medication, presumably, pending clarification of the order.

63. The evidence in respect of the manner of recording medications is that the medications are received from pharmacy in a package referred to as a "roll". The roll has a bar code on it which is scanned by a hand-held device attached to the medication cart thus "entering" the medication into the program. The medication is then "verified" by the nurse at which point, the computer indicates the drug is to be administered to the resident. Each resident has their own drawer of medications and the medications are scanned as they are removed for administration by the nurse. There can be up to four (4) medications in each pouch scanned.

64. The allegation in the Citation arises out of the fact that although the eMAR records disclose that on February 5, 2014 Ms. Pelcz withheld one of the medications, the eMAR record for February 6, 2014 shows that she scanned both sleeping medications for administration.

65. However, Ms. Pelcz provided evidence that the apparent error arose due to the manner in which these medications are scanned. In particular, she provided evidence that, when a nurse scans the medication pouch, all medications in the pouch are entered into the eMAR as administered by the nurse. She further gave evidence that it is necessary to manually remove the entry out of the eMAR for medications not administered. Ms. Pelcz stated that she asked [redacted] to assist her to remove or "zero" the Zopiclone entry as she was unsure as to how to do it properly. And further, that [redacted] did not assist Ms. Pelcz, per her request, to do so.

66. Although Ms. Pelcz did not cross-examine [redacted] on this matter, [redacted] gave no direct evidence on this point, we note that this evidence was elicited through cross-examination by College counsel. Ms. Pelcz was not seriously challenged on this evidence, nor was there any application made to recall [redacted] to provide clarification in this respect.

67. In addition to the EMAR records, the progress notes for the evening of February 6, 2014 were introduced into evidence. In those notes at 21:30 hours Ms. Pelcz writes: "writer gave 20:00 medications from new roll received this evening. Partner nurse spoke to pharmacy to clarify if the roll is correct. Two sleeping aids are in 20:00 packages received in new roll. Roll pulled from med cart placed to side. Pharmacy will call tomorrow morning, also clarify doctor's orders…"

68. Ms. Pelcz then continues the charting entry to include the vital signs of the patient at that time.

69. Ms. Pelcz was challenged on cross-examination with respect to this entry and, in particular, it was suggested that given the use of the word ***"medications",*** Ms. Pelcz must have given both Zopiclone 7.5mg and Oxazepam 15mg. However, Ms. Pelcz noted, correctly, that the resident [redacted] had more medications scheduled than just the sleeping medications (Exhibit T) for administration at 20:00 hours, and that this was why she used the plural ***"medications".***

70. [redacted] provided evidence that she checked the return medication disposal system used for excess medications and did not find the Zopiclone medication in the container. However, the evidence in this respect was entirely unsatisfactory. In particular, the evidence was that, although there is a container which is utilized for holding medications not administered, there

are no records of when or what is placed in that container. There was also no evidence that the container or medication was labelled, nor when the container was emptied. According to [redacted], she inspected this container after receiving a letter from Ms. Pelcz dated February 20, 2014 (Exhibit Y) where Ms. Pelcz further denied that she administered two sleeping medications to the resident. As such, we place no weight on the evidence of [redacted] inspection of the excess medication return container 14 days after the alleged incident.

71. It was also noted that Ms. Pelcz was taking [redacted] vital signs after administering the excess medication. This was alleged to support a conclusion that she understood both sleeping medications had been administered. However, a review of the progress notes (Exhibit S) indicates that the resident had been complaining of shortness of breath at 19:00 hours the evening of February 6, 2014 and that Ms. Pelcz had appropriately assessed the resident and recorded her vital signs at that time. As such, the recording of the vital signs at 21:30 hours, as set out in the progress notes, is entirely consistent with the complaint of [redacted] that she was suffering from shortness of breath and does not necessarily support the conclusion that Ms. Pelcz was monitoring the resident for over medication issues.

72. As well, there is a record in the progress notes on February 7, 2014 at 01:30 hours, approximately 4 hours after the alleged over medication, which states as follows: "due to concerns of over medication, writer woke res-0 (zero) concerns, resident awoke easily, will monitor". As such, it would appear that the resident was easily awoken 4 hours after the time the two (2) sleeping medication were alleged to have been administered to the resident. This is inconsistent with an elderly, health compromised, resident being given two sleeping medications in error.

73. [redacted] was questioned with respect to this matter and we found, once again, [redacted] evidence to be unclear. [redacted] provided evidence that Ms. Pelcz had incorrectly given both medications as the doctor had discontinued the Zopiclone 7.5mg. However, as indicated, that evidence is clearly incorrect. The physician had not discontinued the Zopiclone and Exhibit X, a note authored by [redacted] and introduced into evidence, confirms that the physician had not discontinued the Zopiclone 7.5mg at that time, on February 6, 2014. It was not, in fact, discontinued until February 7, 2014, after a query by the pharmacist (Exhibit W).

74. Of significance, as indicated above, is that Ms. Pelcz's progress notes record that [redacted] called the pharmacist the evening of February 6, 2014. We note that [redacted] was unable to recall that telephone call and, further, the pharmacist was not called to provide evidence on this matter.

75. As a result, we do not find the College has established that Ms. Pelcz did, in fact, administer both sleeping medications to [redacted] We also find the fact that the eMAR discloses that both medications were administered simply arises out of the manner of scanning and verifying the pouches into the program and not zeroing out the entry for the "returned" medication. The Panel finds the College has not proven the over medication allegation occurred but the Panel finds Ms. Pelcz to have breached the following, due to failing to ensure the incorrect medication entry into the eMAR was not zeroed out;

76. As a result, with respect to 1(h) the Panel finds Ms. Pelcz breached:

CLPNBC 2010 Practice Guideline: Documentation

Foundations of Practice:

An LPN draws upon knowledge of human biological sciences, pharmacology, and health-promotion and prevention strategies while formulating and implementing the nursing-care plan, as indicated by:

-Ensuring that documentation (written or electronically generated) provides clear information about the nursing assessment, the plan of care for the client, identified nursing interventions based on assessment findings, and client outcomes based on the nursing interventions provided by the LPN. Documentation clearly demonstrated the use of critical thinking based on clinical decisions made by the LPN.

The Failure to Properly Process a Verbal Physician's Order

77. In paragraph 1(j) of the Citation it is alleged that on February 23, 2014, Ms. Pelcz exhibited a lack of knowledge, care and/or skill in processing a verbal telephone order from a physician regarding a resident, [redacted] It is alleged that Ms. Pelcz failed to include the first initial of the physician's name, creating confusion given that there were two (2) physicians in Kelowna with the same surname. As well, it is alleged that Ms. Pelcz failed to correctly record the proper manner of administering the medication by using a q'd notation, rather than the approved abbreviation q.i.d.

78. After reviewing the evidence, we are not satisfied that the College has established this allegation.

79. In particular, Ms. Pelcz correctly recorded the surname of the physician. There was evidence that it is only necessary to record the first initial of the physician's name it if is known that there are two (2) physicians with the same surname. There was no evidence that Ms. Pelcz ought to have known that there were two [redacted].

80. In respect of the allegation that Ms. Pelcz incorrectly recorded the abbreviation, again we do not find that the College has established that Ms. Pelcz committed an error in that respect. In coming to that conclusion, we find that:

    a) [redacted] initially gave incorrect evidence as to what the abbreviation meant and what the abbreviation should have been;

    b) Ms. Pelcz meant to write "qid";

    c) The pharmacist never questioned the abbreviation and expressed no confusion over the handwritten notation; and,

    d) [redacted] wrote in a note (Exhibit AA) that the correct abbreviation was "Qid" when, in fact, the list of approved abbreviations introduced into evidence (Exhibit BB) reveal that [redacted] abbreviation is incorrect in that the correct abbreviation is all lower-case letters.

81. Although it is alleged that Ms. Pelcz did not sign the order correctly, her signature does appear in the box marked "Nurse 1" with the time of 18:10 and the date of February 23, 2014 is noted also.

82. In this result, we do not find this element of the Citation has been proven.

The Emesis Incident

83. The next element in the Citation is set out in paragraph 1(k). In particular, it is alleged that on March 2, 2014, Ms. Pelcz exhibited a lack of judgement and critical thinking and failed to appropriately communicate with other members of the health care team when told by resident, [redacted], that he had vomited, possibly due to the consumption of rice. The progress notes of Ms. Pelcz recorded that the resident reported having vomited to Ms. Pelcz after eating dinner March 2, 2014. Ms. Pelcz noted in the progress notes (Exhibit DD) as follows: "Resident stated to writer 'I threw up again' Writer could not observe resident has flushed toilet. Resident states 'I may be throwing up from rice'. Writer encouraged resident to monitor with possible trying not to consume rice a week and see if this makes a difference. Resident happy with the thought, will monitor meals to comfort resident and assess."

84. It is alleged that Ms. Pelcz ought to have known that this resident was an alcoholic, suffered mild dementia and also had a history of GI (gastro-intestinal) problems. Unfortunately, no records of that nature were introduced into the hearing and, in fact, Ms. Pelcz was not challenged on cross-examination in respect of her knowledge of these matters. However, there is a note previously in the progress notes of [redacted] dated February 16/14, that states "Resident informed writer pc (after) supper that he vomited all his supper. C/o (complained of) having symptoms of 'choking'. Phlegm in throat which causes res to vomit. Will monitor". That entry into the progress notes was made by [redacted] LPN.

85. It is of note that there is no indication that [redacted] LPN took any further steps to communicate this resident's concerns to any other member of the health care team in the progress notes of [redacted] (Exhibit DD).

86. Evidence was provided by [redacted] and [redacted] LPN that Ms. Pelcz ought to have not simply advised the resident to stop eating rice, but should have taken steps to advise the physician and the kitchen to withhold rice and request a dietary assessment as the previous nurse had done. Although, in fact, there was no evidence presented to verify this claim, by [redacted], that previous action had been taken.

87. However, as indicated above, there is no evidence that Ms. Pelcz was aware that this resident had GI problems and Ms. Pelcz was not cross-examined in that respect.

88. As well, it would appear that the previous nurse, when advised by the resident of the same symptoms, took none of the actions it is alleged Ms. Pelcz ought to have undertaken. That being said, the Panel does accept that Ms. Pelcz should have done some type of follow up other than to simply advise the resident not to consume rice, given that there were now two entries into the progress notes for this resident regarding vomiting following a meal. At minimum, a dietary assessment should have been initiated by Ms. Pelcz.

89. As a result, with respect to 1(k) the Panel finds Ms. Pelcz in breach of:

CLPNBC 2010 Professional Standards of Practice 2.1.1
CLPNBC 2010 Professional Standards of Practice 2.1.2
CLPNBC 2010 Professional Standards of Practice 2.2.1
CLPNBC 2010 Professional Standards of Practice 2.2.2
CLPNBC 2010 Professional Standards of Practice 2.3.1
CLPNBC 2010 Professional Standards of Practice 2.3.3

Telephone Call Regarding Resident

90. Paragraph 1(l) of the Citation alleges that on March 26, 2014, Ms. Pelcz exhibited a lack of responsibility, judgement and care in respect of resident [redacted], when she answered a telephone call regarding this resident from an individual who indicated that the resident had "stopped bleeding at the hospital and would be staying overnight". It is alleged that Ms. Pelcz could not have determined the identity off the person calling, nor did she record the information in the resident's progress notes at that time. Instead, it is alleged that, she wrote a note about the telephone call and asked another LPN to chart the information.

91. The progress notes of [redacted] (Exhibit LL) indicate that Ms. Pelcz recorded a late entry on March 26, 2014 at 15:00 hours, for March 25, 2014 about the telephone call received from a male she noted as being "the husband". A nursing colleague pointed out that [redacted] was a widow and, as such, did not have a husband. Following that, another late entry was recorded by Ms. Pelcz, into the resident's progress notes, which corrected the previous entry and described that the "Son" called from the hospital.

92. In the result, we find that Ms. Pelcz failed to exercise the requisite judgement and committed an error by not identifying the male caller who was providing this information and, further, not recording the information correctly into the resident's chart at that time.

93. With respect to 1(l) the Panel finds that Ms. Pelcz is in breach of:

> **CLPNBC 2010 Practice Guideline: Documentation**
>
> **Professional Practice**
>
> **An LPN maintains standards of professional nursing practice, professional conduct, and safety in the practice setting, as indicated by:**
>
> -Understanding relevant legislation and health authority, facility, agency and/or departmental policies regarding client confidentiality, sharing, retention, and disposal of information collected in the client's health-care record. Recognizing that documentation should be objective, using factual statements.

The Administration of Cipro Incident

94. Paragraph 1(m) of the Citation alleges that Ms. Pelcz, on May 27, 2014, exhibited a lack of knowledge, judgement and care when she failed to follow a doctor's medication order and incorrectly administered Cipro 250mg x 2 from the contingency medication supply to resident [redacted] The physician had, in fact, ordered Cipro XL 500mg to treat symptoms of a urinary tract infection.

95. The evidence was that Cipro XL is an extended release medication while Cipro, although the same medication, is not an extended release form of the drug. It is alleged that Ms. Pelcz did not know what the letters "XL" meant on the physician's order and ought not to have administered the Cipro 250mg x 2 until she had obtained authorization to do so.

96. The progress notes, entered by Ms. Pelcz, for [redacted] are as follows: "as per doctor orders, Cipro 500mg od 2/52 given 21:00, used from contingency 2x250mg Cipro. Writer phoned pharmacy that XL was not given out of contingency this evening, pharmacy said 'no problem for this first dose, XL Cipro will be delivered tomorrow' infection monitoring sheet started, white board, res temp 36.8 C at 21:15".

97. Ms. Pelcz provided evidence that she placed the call to pharmacy before providing the medication to the resident. However, the Panel does not accept that evidence. In particular, the notation in the records clearly indicates that she called the pharmacy at 21:50 hours, subsequent to administering the medication which is recorded on the eMAR as being administered at 21:15 hours (Exhibit RR). In particular, Ms. Pelcz charted that "writer telephoned pharmacy that XL was <u>not given</u> out of contingency this evening".

98. Apart from Ms. Pelcz' evidence, there is no indication that the call was placed prior to administering the medication. Further, [redacted] evidence in this respect was very clear that Ms. Pelcz asked what the difference was between Cipro and Cipro XL subsequent to administration of Cipro 250mg x 2 to the resident.

99. In the result, we find that Ms. Pelcz did administer the Cipro prior to obtaining a clarification from the pharmacist. We find that she ought not to have administered the medication until she was able to determine what XL meant and, further, that she had obtained the authorization to do so.

100. With respect to 1(m) Ms. Pelcz breached:

> **<u>CLPNBC 2014 Professional Standards for LPNs:</u>**
>
> **Standard 1**: Responsibility and Accountability
>
> **The LPN maintains standards of nursing practice and professional conduct established by CLPNBC.**
>
> **Indicators: 4,5,6,7**
>
> **<u>CLPNBC 2014 Professional Standards for LPNs:</u>**
>
> **The LPN provides nursing services and works with others in the best interest of clients.**
>
> **Standard 3**: Client-Focused Provision of Service
>
> **Indicator 5**
>
> **<u>CLPNBC 2014 Professional Standards for LPNs:</u>**
>
> **The LPN understands, upholds and promotes the ethical standards of the nursing profession.**
>
> **Standard 4**: Ethical Practice

Indicator 1

CLPNBC 2014 Practice Standard: Documentation

Principles

2. When caring for clients, LPNs document the nursing process (assessment, planning, intervention and evaluation), including information or concerns reported to another healthcare provider and when appropriate, the healthcare provider's response.

3. LPNs document all relevant information about clients in chronological order on the client's health record. Documentation is clear, concise, factual, objective, timely, and legible and includes agency approved abbreviations.

CLPNBC 2014 Practice Standard: Medication Administration

Principles

2. LPNs are knowledgeable about the effects, side effects and interactions of medications and take action as necessary.

3. LPNs adhere to the 'rights' of medication administration. These include: right medication, right client, right dose, right time, right route, right reason and right documentation.

8. LPNs verify that medication orders, pharmacy labels and/or medication administration records are complete and include the name of the client; the name of the medication; the medication strength; and the dosage, route and frequency with which the medication is to be administered.

Further Allegations

101. The foregoing deals with the specific allegations that are cited in support of the Citation. The Citation then goes on to make a number of general allegations that Ms. Pelcz, in simple terms, asked repetitive and unnecessary questions during the course of her duties and, further, that this placed an inappropriate burden on her colleagues.

102. It is also alleged, generally, that she made other medication and charting errors by failing to follow the flag protocol at SHRH on a repetitive basis. The Panel has concluded that absent of any specific evidence of incidents, it is unable to conclude, as a general matter, that Ms. Pelcz failed to flag charts routinely. Evidence was entered by [redacted] LPN that she told Ms. Pelcz to stop flagging so much.

103. The issue in respect of the repeated questions is again a matter very difficult to determine. As well, it is not unreasonable for a nurse in the first few years of her nursing career to ask questions from time to time to clarify things, and, in fact, should be recognized as good practice.

104. It is, of course, very difficult to determine whether the questions were excessive and whether the questions constitute a failure to meet the requisite standard of care. In the result, the Panel is unable to conclude that the College has established that the general allegations regarding charting, excessive questions and matters of a like nature have been made in this case.

Conclusion

105. As the parties agreed during the course of the hearing of this matter, the Panel will not, at this time, be making any orders flowing from the above breaches. Rather, now that the Panel has determined that some of the breaches alleged in the Citation have been proven, the parties may make submissions to the Panel with respect to what, if any, remedies under the *Health Professions Act*, should be ordered by the Panel.

106. College counsel indicated at the close of the last hearing date that, depending on the Panel's determination at this stage of the proceedings, the College may wish to lead further evidence in support of its submissions as to the appropriate remedy for the above breaches.

107. Accordingly, we direct both the College and Ms. Pelcz to advise the Panel (through Panel counsel) and the other party by December 22, 2016, if there is a desire on their part to provide further evidence with respect to the appropriate remedy, along with a summary of this evidence and estimate as to the time necessary to hear this evidence along with closing submissions. The Panel will then consider whether there are any admissibility or relevancy issues, before establishing hearing dates for the purpose of hearing this evidence and submission with respect to penalty.

108. If, however, neither party wishes to lead further evidence, and are prepared to make their submissions with respect to remedy on the basis of the evidence that is already before the Panel, then the Panel will establish hearing dates on that basis and ask the parties to provide an estimate as to the necessary hearing time.

December 12, 2016

Madelon Stevens, Chair (for the Panel) — Date