B E T W E E N:

COLLEGE OF NURSES OF ONTARIO

- and -

TARA-LYNN BOSTON
REGISTRATION NO. AF166051

NOTICE OF HEARING

IT IS ALLEGED THAT:

1. You have committed acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that while working as a Registered Practical Nurse at St. Joseph's Healthcare Hamilton in Hamilton, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular:

    (a) from, in, or around December 24, 2019 to, in, or around January 21, 2020, your documentation with respect to various patients was inconsistent, misleading and/or inaccurate as set out in Appendix "A";

    (b) from, in, or around December 24, 2019 to, in, or around, January 21, 2020, you failed to adequately assess, document, and/or initiate appropriate interventions with respect to some or all of the incidents set out in Appendix "B";

    (c) from, in, or, around December 13, 2019, to, in, or, around January 25, 2020, you failed to correctly handle and/or administer medication, with respect to some or all of the incidents set out in Appendix "C";

    (d) from in or around August 12, 2020 to August 18, 2020, you failed to complete your competency assessment and made numerous errors during shifts supervised by nurse educators, including:

        i. failed to apply basic infection control practices;

        ii. demonstrated unsafe medication practices, including lack of knowledge of medications, inappropriate narcotic wastage, and/or failing to clean intravenous ports/IV lines;

iii. failed to prioritize patient care needs;

iv. frequently omitted and/or did not complete patient pain assessments;

v. failed to organize care appropriately or initiate care interventions;

vi. failed to transfer accountability appropriately;

vii. made multiple errors and omissions in clinical documentation; and/or

viii. failed to protect privacy and confidentiality; and/or

(e) on, around, or between August 17, 2020 to August 19, 2020:

a. you made inappropriate and/or unprofessional comments to your colleagues about your manager stating words to the effect of she "is a fucking bitch"; and/or

b. posted inappropriate and/or unprofessional comments about your manager on Facebook;

2. You committed acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(13) of *Ontario Regulation 799/93*, in that while working as a Registered Practical Nurse at St. Joseph's Healthcare Hamilton in Hamilton, Ontario, you failed to keep records as required, and in particular, from in or around December 24, 2019, to, in, or, around January 21, 2020, you created false, inaccurate, or incomplete medical records with respect to some or all of the incidents set out in Appendix "A";

3. You have committed acts of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that while working as a Registered Practical Nurse at St. Joseph's Healthcare Hamilton in Hamilton, Ontario, you engaged in conduct or performed acts, relevant to the practice of nursing, that, having regard to all the

circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and in particular:

(a) from, in, or around December 24, 2019 to, in, or around January 21, 2020, your documentation with respect to various patients was inconsistent, misleading and/or inaccurate as set out in Appendix "A";

(b) from, in, or around December 24, 2019 to, in, or around, January 21, 2020, you failed to adequately assess, document, and/or initiate appropriate interventions with respect to some or all of the incidents set out in Appendix "B";

(c) from, in, or, around December 13, 2019, to, in, or, around January 25, 2020, you failed to correctly handle and/or administer medication, with respect to some or all of the incidents set out in Appendix "C";

(d) from in or around August 12, 2020 to August 18, 2020, you failed to complete your competency assessment and made numerous errors during shifts supervised by nurse educators, including:

i. failed to apply basic infection control practices;

ii. demonstrated unsafe medication practices, including lack of knowledge of medications, inappropriate narcotic wastage, and/or failing to clean intravenous ports/IV lines;

iii. failed to prioritize patient care needs;

iv. frequently omitted and/or did not complete patient pain assessments;

v. failed to organize care appropriately or initiate care interventions;

vi. failed to transfer accountability appropriately;

vii. made multiple errors and omissions in clinical documentation; and/or

viii. failed to protect privacy and confidentiality; and/or

(e) on, around, or between August 17, 2020 to August 19, 2020:

a. you made inappropriate and/or unprofessional comments to your colleagues about your manager stating words to the effect of she "is a fucking bitch"; and/or

b. posted inappropriate and/or unprofessional comments about your manager on Facebook; and/or

4. You are incompetent, as that term is defined by subsection 52(1) of the *Health Professions Procedural Code* of the *Nursing Act,* 1991, S.O. 1991, c. 32, as amended, in that your professional care of several patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that you are unfit to continue to practice or that your practice should be restricted and, in particular on, between or around August 12, 2020 to 18, 2020, you:

a. failed to apply basic infection control practices;

b. demonstrated unsafe medication practices, including lack of knowledge of medications, inappropriate narcotic wastage, and/or failing to clean intravenous ports/IV lines;

c. failed to prioritize patient care needs;

d. frequently omitted and/or did not complete patient pain assessments;

e. failed to organize care appropriately or initiate care interventions;

f. failed to transfer accountability appropriately;

g. made multiple errors and omissions in clinical documentation; and/or

h. failed to protect privacy and confidentiality.

The allegations respecting professional misconduct on your part will be heard by a panel of the Discipline Committee of the College of Nurses of Ontario ("CNO"), pursuant to the *Nursing Act, 1991*, S.O. 1991, c.32, as amended, and subsection 38(1) of the *Health Professions Procedural Code,* on **May 1, 2, 3, 6 & 7, 2024 at 0930 hours or as soon after that time as the hearing can be commenced**, via electronic hearing by way of teleconference or videoconference.

The details for participating in the electronic hearing will be provided to you by a Hearings Administrator. If you have not heard from a Hearings Administrator at least 48 hours in advance of the hearing, you should contact the Hearings Administration Team at: Admin-Business.Support-Hearings@cnomail.org to obtain the details for participating in the electronic hearing.

If you believe that holding an electronic hearing rather than an oral hearing is likely to cause you significant prejudice, please communicate in writing the basis for asserting such prejudice to the Hearings Administration Team at the email address listed above. To ensure the claim of prejudice can be considered by the Discipline Committee, any such concerns should be communicated to the Hearings Administration Team as soon as possible, and no later than 21 days in advance of the hearing.

Take notice that at least 48 hours before the electronic hearing is scheduled to commence, you must provide notice to the Hearings Administration Team, at the email address listed above, of the telephone number and email address where you can be reached for the electronic hearing.

If you fail to participate in the electronic hearing in person or by representative, the panel of the Discipline Committee may proceed in your absence and you are thereafter not entitled to any further notice of the proceedings.

Where the panel of the Discipline Committee finds a member has committed an act of professional misconduct and/or incompetence, it may make an Order doing any one or more of the following:

1. directing the Registrar to revoke the member's certificate of registration;

2. directing the Registrar to suspend the member's certificate of registration for a specified period of time;

3. directing the Registrar to impose specified terms, conditions and limitations on the

member's certificate of registration for a specified or indefinite period of time;

4. requiring the member to appear before the panel to be reprimanded;

5. requiring the member to pay a fine of not more than $35,000.00 to the Minister of Finance;

6. requiring the member to reimburse CNO for funding provided for a program of therapy and counselling for a person if the act of professional misconduct was the sexual abuse of that person; and

7. requiring the member to post security acceptable to CNO to guarantee the payment of any amounts the member may be required to reimburse CNO for a program of therapy and counselling for a person who was sexually abused by the member.

Furthermore, the panel may suspend the effect of its Order for a specified period of time and on specified conditions and where it makes an Order under paragraph 2 or 3 above, it may specify criteria to be satisfied for the removal of a suspension or the removal of terms, conditions and limitations imposed by the Order on the member's certificate of registration.

Where a panel of the Discipline Committee finds a member has committed an act of professional misconduct and/or incompetence, it may make an Order requiring the member to pay all or part of the following costs and expenses:

1. CNO's legal costs and expenses;

2. CNO's costs and expenses incurred in investigating the matter; and

3. CNO's costs and expenses incurred in conducting the hearing.

CNO intends to introduce as business records, under section 35 of the *Evidence Act*, any writings or records that were made in the usual and ordinary course of business. Without limiting the generality of the foregoing, and where applicable, CNO intends to introduce as business records medical and hospital charts.

Appendix "A"

1.	In or around December 24, 2019, you failed to document the clinical basis for administering Nitroglycerin spray to [Patient A].
2.	In or around December 24, 2019, you documented that [Patient B] had a Stage 2 Pressure Ulcer; however, you also documented that you were unable to assess the wound site and reinforced the wound dressing.
3.	In or around December 25, 2019, you documented that [Patient C's] respiratory assessment was "within defined limits" while also documenting that [Patient C] was experiencing laboured respiratory efforts and producing diminished breath sounds.
4.	In or around December 24, 2019, with respect to [Patient D]: - you documented that the patient had a normal sinus rhythm, despite the patient not having completed the appropriate tests to identify the sinus rhythm; and/or - you documented that the patient's head, eyes, ears, nose and throat (HEENT) system was "within defined limits" while also documenting that the patient had mild impairments in both eyes.
5.	In or around January 21, 2020, with respect to [Patient E]: - you documented that the patient's respiratory and psycho-social domains were "within defined limits" while also documenting that the patient complained of shortness of breath and was experiencing agitation and abdominal distention; and/or - you documented that the patient had a normal sinus rhythm, despite the patient not having completed the appropriate tests to identify the sinus rhythm.
6.	In or around January 25, 2020, with respect to [Patient G], you failed to document and/or communicate to the medical team that the bolus intravenous infusion that you administered for the patient was not completed.

Appendix "B"

1.	In, around, or between December 23 and December 24, 2019, after observing a new presentation of a facial droop on [Patient A], you failed to appropriately escalate the situation to the medical team or provide further intervention.
2.	In or around January 21, 2020, you assessed [Patient F] to be in a non-responsive state with low blood pressure and failed to appropriately escalate this situation to the medical team or provide further intervention in a timely manner.

Appendix "C"

1.	On or around December 13, 2019, you left one or two Percocet tablet(s) unattended in a public area;
2.	In or around December 24, 2019, you administered Nitroglycerin to [Patient A] without any documented clinical reason.
3.	In or around the morning of January 21, 2020 at approximately 0800 hours you administered multiple medications to [Patient F] which were not appropriate given the patient's then current blood pressure and failed to communicate this to the medical team.
4.	In or around January 25, 2020, you failed to administer the complete intravenous bolus ordered for [Patient G].