STATEMENT OF ALLEGATIONS

KAYLA MICHELLE BOYD
Registration number #035026

IT IS ALLEGED THAT:

1. At all material times, Kayla Michelle Boyd ("**Ms. Boyd**") was duly registered as a Registered Nurse with the College of Nursing of New Brunswick (the "**College**"), which was then called the Nurses Association of New Brunswick.

2. At all material times, Ms. Boyd was working at the Emergency Department of the […] (the "**Hospital**").

3. On or between January 3, 2025 and January 4, 2025, Ms. Boyd committed acts of professional misconduct as defined in subsection 2(1) of the ***Nurses Act*** in that, while working as a Registered Nurse at the Hospital, she digressed from established or recognized professional standards or rules of practice of the profession, including but not limited to the ***Standards of Practice for Registered Nurses***, as they were then called, the ***Standards for Medication Management***, the ***Standards for Documentation***, and the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***, and she engaged in conduct unbecoming a nurse as provided by subparagraph 28(1)(a)(ii) of the ***Nurses Act***, in one or more of the following ways:

    a. Ms. Boyd was working at the Hospital's Emergency Department on the night shift from January 3, 2025, to January 4, 2025, and was providing orientation to a Registered Nurse who was nearing the end of his orientation period (the "**RN**"). On this shift, Ms. Boyd decided to assign primary responsibility for the nursing care of a thirty-nine (39) year old patient (the "**Patient**") to the RN;

    b. While the Patient was waiting to be assessed by a physician, the RN made a serious medication error by administering one (1) mg of Epinephrine to the Patient intravenously (the "**Medication Error**");

    c. Ms. Boyd was present at the time of the Medication Error;

    d. Before the Medication Error, Ms. Boyd prepared the one (1) mg of Epinephrine in a syringe before the Patient was assessed in anticipation that the Patient might need it;

    e. The dosage prepared by Ms. Boyd exceeded the dosage set out in the Hospital's *Clinical Order Set Directive for Anaphylaxis Treatment*;

    f. Ms. Boyd labelled the syringe with a "high alert" sticker and marked its contents and dosage;

g. Ms. Boyd assessed the Patient and concluded that it was not necessary to administer the Epinephrine. Ms. Boyd did not communicate, or did not clearly communicate, her assessment and conclusion to the RN;

h. Ms. Boyd placed the Epinephrine-filled syringe on the bedside table while she collected equipment. The RN then picked up the syringe and administered the full one (1) mg of Epinephrine to the Patient via the Patient's IV, contrary to the Hospital's *Clinical Order Set Directive for Anaphylaxis Treatment*, which contemplates 0.5 mg of Epinephrine to be administered intramuscularly, and only when clinically necessary;

i. Ms. Boyd failed to report and/or effectively communicate the Medication Error to a physician in a timely manner;

j. Ms. Boyd failed to document, record and/or account for the Medication Error;

k. Ms. Boyd failed to document the nursing care she provided to the Patient before, during, or after the Medication Error;

l. Ms. Boyd failed to communicate the Medication Error to the Patient and/or the Patient's partner.

4. As a result of the Medication Error, the Patient suffered severe adverse drug reactions and symptoms and had to be admitted to the Hospital for treatment and monitoring.

5. Ms. Boyd failed to utilize clinical judgment, critical thinking, and evidence-informed decision-making, in contravention of the ***Standards for Medication Management***.

6. Ms. Boyd failed to ensure that her medication management was evidence-informed, in contravention of section 2.1 of the ***Standards for Medication Management***.

7. Ms. Boyd failed to practice medication management according to the Hospital policy, in contravention of section 2.4 of the ***Standards for Medication Management***.

8. Ms. Boyd failed to promote and implement safety precautions as she handled, prepared, and stored medication, including but not limited to leaving pre-poured high-alert medication unattended, in contravention of section 3.5 of the ***Standards for Medication Management***.

9. Ms. Boyd failed to take appropriate action to minimize the risk of harm to the Patient from the Medication Error and/or adverse drug reaction, in contravention of section 3.7 of the ***Standards for Medication Management***.

10. Ms. Boyd failed to report the Medication Error and/or the Patient's adverse reaction, in contravention of section 3.8 of the ***Standards for Medication Management***.

11. Ms. Boyd failed to collaborate and/or communicate with other members of the health-care team in her medication management, in contravention of standard 4 of the ***Standards for Medication Management***.

12. Ms. Boyd failed to document her involvement in the Medication Error in accordance with standards and the Hospital's policy, in contravention of section 4.2 of the ***Standards for Medication Management***.

13. Ms. Boyd failed to practice safely, competently and ethically, in contravention of standard 1 of the ***Standards of Practice for Registered Nurses***.

14. Ms. Boyd failed to practice in accordance with relevant with standards and relevant employer policy, in contravention of standard 1.2 of the ***Standards of Practice for Registered Nurses***, including the Hospital's *Disclosure of Harm Procedure*.

15. Ms. Boyd failed to practice in accordance with the ***Canadian Nurses Association's Code of Ethics for Registered Nurses***, in contravention of standard 1.3 of the ***Standards of Practice for Registered Nurses***.

16. Ms. Boyd failed to recognize and take action in a situation where client safety was potentially or actually at risk, in contravention of standard 1.6 of the ***Standards of Practice for Registered Nurses***.

17. Ms. Boyd failed to practice using evidence-informed knowledge, skill, and judgment, in contravention of standard 2 of the ***Standards of Practice for Registered Nurses***.

18. Ms. Boyd failed to exercise reasonable judgment, in contravention of standard 2.5 of the ***Standards of Practice for Registered Nurses***.

19. Ms. Boyd failed to apply evidence-informed practices, in contravention of standard 2.6 of the ***Standards of Practice for Registered Nurses***.

20. Ms. Boyd inappropriately assigned and delegated nursing activities to the RN in light of the RN's role and competence and the requirements of the practice setting, in contravention of standard 2.7 of the ***Standards of Practice for Registered Nurses***.

21. Ms. Boyd failed to maintain accurate and timely documentation and failed to document all aspects of the nursing process and nursing care she provided to the Patient, in contravention of standard 2.9 of the ***Standards of Practice for Registered Nurses*** and in contravention of standard 1.1 of the ***Standards for Documentation***.

22. Ms. Boyd failed to communicate effectively with the Patient and other team members to promote continuity and the delivery of safe, competent and ethical care, in contravention of standard 3.2 and standard 4.3 of the ***Standards of Practice for Registered Nurses***.

23. Ms. Boyd failed to practice in collaboration with members of the health care team while understanding and respecting other team members' scope of practice and contributions in the delivery of safe, competent, compassionate, and ethical care, in contravention of standard 4.7 of the ***Standards of Practice for Registered Nurses***.

24. Ms. Boyd failed to document the nursing care she provided to the Patient, including all aspects of the nursing process, in contravention of standard 1.1 of the ***Standards for Documentation***.

25. Ms. Boyd failed to document communication with the Patient, the Patient's significant other, and other care providers that may impact the Patient's health outcome or the plan of care, noting the date, time, and content of the communication, in contravention of standard 1.4 of the ***Standards for Documentation***.

26. Ms. Boyd failed to complete documentation during or as soon as possible after the Medication Error or after her care of the Patient, in contravention of standard 2.1 of the ***Standards for Documentation***.

27. Ms. Boyd failed to document more frequently and/or at all, when the Patient was at an increased risk of harm, was unstable, or there was a higher degree of complexity involved in the nursing care, in contravention of standard 2.2 of the ***Standards for Documentation***.

28. Ms. Boyd failed to document the date and time(s) she provided care to the Patient, in contravention of standard 2.3 of the ***Standards for Documentation***.

29. Ms. Boyd failed to document unanticipated, unexpected and/or abnormal client incidents according to the Hospital's policies, namely, she failed to document the facts of the Medication Error and the subsequent care she provided, in contravention of standard 2.8 of the ***Standards for Documentation***.

30. Ms. Boyd failed to conduct herself according to ethical responsibilities and practice standards in contravention of Part 1, section A, item 1 of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

31. Ms. Boyd failed to take all necessary actions to prevent and/or minimize a patient safety incident, in contravention of Part 1, section A, item 5 and Appendix B of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses.***

32. Ms. Boyd failed to collaborate with other health-care providers and others to maximize health benefits to persons receiving care and with health-care needs and concerns, recognizing and respecting the knowledge, skills and perspectives of all, in contravention of Part 1, section B, item 4 and Appendix B of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

33. Ms. Boyd failed to utilize practice standards, best practice guidelines, and policies to minimize risk and maximize safety for persons receiving care, in contravention of Part 1, section D, item 6 of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurse***.

34. Ms. Boyd failed to practise according to the values and responsibilities in the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses*** and in keeping with the professional standards supporting ethical practice, in contravention of Part 1, section G, item 1 of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

35. Ms. Boyd failed to be accountable for her practice and work with the RN and the physician on duty as part of a team, in contravention of Part 1, section G, item 4 of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.