STATEMENT OF ALLEGATIONS

TYLER SCOVILLE
Registration number #035684

IT IS ALLEGED THAT:

1. At all material times, Tyler Scoville ("**Mr. Scoville**") 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, Mr. Scoville was working at the Emergency Department of the […] (the "**Hospital**") and was nearing the end of his orientation.

3. On or between January 3, 2025 and January 4, 2025, Mr. Scoville 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, he 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 called then, the ***Standards for Medication Management***, the ***Standards for Documentation***, and the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***, and 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. Mr. Scoville administered medication, namely one (1) mg of Epinephrine, by intravenous injection to a thirty-nine (39) year old patient (the "**Patient**") in the Hospital's Emergency Department, contrary to the Hospital's *Clinical Order Set Directive for Anaphylaxis Treatment* and in circumstances where it was not clinically appropriate (the "**Medication Error**");

    b. The Patient presented at the Emergency Department on the night of January 3, 2025, and was waiting to be assessed by a physician. Before administering the one (1) mg of Epinephrine, Mr. Scoville:

        i. failed to review the Hospital's *Clinical Order Set Directive for Anaphylaxis Treatment*;
        ii. failed to assess and/or failed to adequately assess the Patient to determine if medication administration was warranted;
        iii. failed to review the label on the syringe to determine the contents and the dosage.

    c. In administering the one (1) mg of Epinephrine, Mr. Scoville:

        i. administered medication which he had not drawn or prepared himself;

ii. administered medication via the wrong route;
iii. administered the incorrect dose of medication;
iv. administered medication when it was not clinically warranted; and
v. administered medication without obtaining the Patient's informed consent.

d. After realizing the Medication Error, Mr. Scoville failed to report and effectively communicate the Medication Error to the physician to ensure proper response and treatment of the Patient;

e. Mr. Scoville failed to comprehensively document, record and/or account for the Medication Error in the Patient's chart;

f. Mr. Scoville failed to document his subsequent nursing care and observations in a timely manner; and

g. Mr. Scoville failed to disclose the Medication Error to the Patient and/or to the Patient's partner, contrary to the Hospital's *Disclosure of Harm Procedure*.

4. As a result of Mr. Scoville's Medication Error, the Patient suffered severe adverse drug reactions and symptoms and had to be admitted to the Hospital to be treated and monitored.

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

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

7. Mr. Scoville failed to assess the appropriateness of medication administration to the Patient, in contravention of section 2.2 and Appendix D of the ***Standards for Medication Management***.

8. Mr. Scoville failed to know the limits of his own knowledge, skill and judgement, and failed to get help as needed, in contravention of section 2.3 of the ***Standards for Medication Management***.

9. Mr. Scoville failed to practice medication management according to Hospital policies, in contravention of section 2.4 of the ***Standards for Medication Management***.

10. Mr. Scoville failed to collaborate with the Patient in making decisions about the care plan in relation to medication management, in contravention of section 3.4 of the ***Standards for Medication Management***.

11. Mr. Scoville failed to promote and implement safety precautions as he handled and administered medication to the Patient, in contravention of section 3.5 of the ***Standards for Medication Management***.

12. Mr. Scoville failed to take appropriate action to resolve or minimize the risk of harm to the Patient as a result of the Medication Error and/or the Patient's adverse drug reaction, in contravention of section 3.7 of the ***Standards for Medication Management.***

13. Mr. Scoville failed to report the Medication Error and/or adverse drug reaction of the Patient in a timely manner, in contravention of section 3.8 of the ***Standards for Medication Management***.

14. Mr. Scoville failed to document the Medication Error in accordance with standards and the Hospital's policy, in contravention of section 4.2 of the ***Standards for Medication Management***.

15. Mr. Scoville failed to practice safely, competently and ethically, and/or failed to be accountable to the Patient, in contravention of standard 1 of the ***Standards of Practice for Registered Nurses***.

16. Mr. Scoville failed to practice in accordance with relevant standards and employer policies, in contravention of standard 1.2 of the ***Standards of Practice for Registered Nurses***, including the Hospital's *Disclosure of Harm Procedure*.

17. Mr. Scoville failed to practice in accordance with standards and 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***.

18. Mr. Scoville 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***.

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

20. Mr. Scoville failed to use critical inquiry to assess, intervene and evaluate the Patient's care, in contravention of standard 2.1 of the ***Standards of Practice for Registered Nurses***.

21. Mr. Scoville failed to recognize and practice within his own level of competence and to seek additional knowledge and assistance when needed, in contravention of standard 2.4 of the ***Standards of Practice for Registered Nurses***.

22. Mr. Scoville failed to exercise reasonable judgment, in contravention of standard 2.5 of the ***Standards of Practice for Registered Nurses***.

23. Mr. Scoville failed to apply evidence-informed practices, in contravention of standard 2.6 of the ***Standards of Practice for Registered Nurses***.

24. Mr. Scoville failed to maintain accurate and timely documentation in accordance with standards and the Hospital's policies, in contravention of standard 2.9 of the ***Standards of Practice for Registered Nurses*** and section 4.2 of the ***Standards for Medication Management***.

25. Mr. Scoville 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***.

26. Mr. Scoville failed to respect the Patient's dignity, rights to informed decision-making, and informed consent, in contravention of standard 3.8 of the ***Standards of Practice for Registered Nurses***.

27. Mr. Scoville failed to document pertinent and comprehensive information concerning his nursing interventions, in contravention of standard 1 of the ***Standards for Documentation***.

28. Mr. Scoville failed to document all aspects of the nursing process and the nursing care he provided to the Patient, in contravention of standard 1.1 of the ***Standards for Documentation***.

29. Mr. Scoville failed to document and/or to obtain informed consent for the treatment or intervention performed, in contravention of standard 1.3 of the ***Standards for Documentation***.

30. Mr. Scoville 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***.

31. Mr. Scoville failed to complete documentation during or as soon as possible after the Medication Error, and during or as soon as possible after his subsequent observations and nursing care, in contravention of standard 2.1 of the ***Standards for Documentation***.

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

33. Mr. Scoville failed to document unanticipated, unexpected and/or abnormal client incidents according to the Hospital's policies, namely, he failed to properly document the facts of the Medication Error, the Patient's reaction, and the subsequent related care provided, in contravention of standard 2.8 of the ***Standards for Documentation***.

34. Mr. Scoville failed to conduct himself 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***.

35. Mr. Scoville failed to take all necessary actions to prevent and/or minimize patient safety incidents, 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.***

36. Mr. Scoville failed to practice within his own level of competence and seek direction and/or guidance, seek additional information or knowledge, and/or to report to his supervisor or a competent practitioner, in contravention of Part 1, section A, item 6 and Part 1, section G, item 3 of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

37. Mr. Scoville failed to recognize, respect, and promote the Patient's right to be informed and make decisions, in contravention of Part 1, section C of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

38. Mr. Scoville failed to provide the Patient with the information he needed to make an informed and autonomous decision related to his health and well-being. Mr. Scoville failed to give health information to the Patient in an open, accurate, understandable and transparent manner, in contravention of Part 1, section C, item 1 of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

39. Mr. Scoville failed to provide nursing care with the Patient's informed consent and failed to recognize and support a capable person's right to refuse or withdraw consent for care or treatment, in contravention of Part 1, section C, item 3 of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

40. Mr. Scoville failed to utilize practice standards, best practice guidelines, policies and research 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***.

41. Mr. Scoville 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***.

42. Mr. Scoville failed to practice with integrity in all his professional interactions with the Patient, in contravention of Part 1, section G, item 2 of the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

43. Mr. Scoville failed to be accountable for his practice and work with physician and/or other Registered Nurse(s) 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***.