COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF

A HEARING UNDER THE HEALTH PROFESSIONS ACT,

AND IN THE MATTER OF A HEARING REGARDING

THE CONDUCT OF BROOKLYN BRAXTON

DECISION OF THE HEARING TRIBUNAL

OF THE

COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF A HEARING UNDER THE HEALTH PROFESSIONS ACT

IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF BROOKLYN BRAXTON, LPN# 47180, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Videoconference using Zoom on December 17, 2020 with the following individuals present:

Hearing Tribunal:
Michelle Stolz, Licensed Practical Nurse ("LPN") Chairperson
Koreen Balaban, LPN
James Lees, Public Member

Staff:
Evie Thorne, Legal Counsel for the Complaints Consultant, CLPNA
Kevin Oudith, Complaints Consultant, CLPNA

Investigated Member:
Brooklyn Braxton, LPN ("Ms. Braxton or "Investigated Member")
Carol Drennan, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

There were no objections to the members of the Hearing Tribunal hearing the matter, and no Hearing Tribunal member identified a conflict. There were no objections to the jurisdiction of the Hearing Tribunal.

The Hearing was conducted by way of an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Joint Submission on Penalty.

(3) Background

Brooklyn Braxton was an LPN within the meaning of the *Health Professions Act* ("Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Brooklyn Braxton was initially licensed as an LPN in Alberta on January 9, 2019.

The College of Licensed Practical Nurses ("CLPNA") received a complaint dated August 21, 2020 (the "Complaint") from Tanis Gillingham, Interim Program Manager – Provincial Staffing Services, at the Peter Lougheed Centre (the "Facility") in Calgary, Alberta, pursuant to s. 57 of the Act. The Complaint stated Ms. Brooklyn Braxton, LPN, had received a one-day suspension of her employment at the Facility for making a significant error administering methadone and failing to follow directions for a co-signature.

In accordance with s. 55(2)(d) of the Act, Ms. Sandy Davis, the Complaints Director of the CLPNA (the "Complaints Director") appointed Kathryn Emter, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint. At this time, the Complaints Director delegated her authority and powers under Part 4 of the Act to Kevin Oudith, Complaints Consultant for the CLPNA (the "Complaints Consultant") pursuant to s. 20 of the Act.

By way of letter dated August 25, 2020, the Complaints Director provided Ms. Braxton with notice of the Complaint and of the appointment of the Investigator. Through this letter, Ms. Braxton received notice of the Complaints Consultant's intent to request a condition of supervised practice on her practice permit and provided Ms. Braxton the opportunity to provide submissions on the matter.

By letter dated August 25, 2020, the Complaints Consultant requested that Jeanne Weis, Executive Director for the CLPNA, impose a condition of supervised practice on Ms. Braxton's practice permit pursuant to s. 65(1)(a) of the Act due to the serious nature of the medication error which resulted in harm to a patient and as it was in the best interests of public safety.

On August 30, 2020, Ms. Braxton provided submissions to Ms. Weis.

By letter dated September 1, 2020, Ms. Weis granted the request for a condition of supervision on Ms. Braxton's practice permit and notified Ms. Braxton accordingly.

On September 17, 2020, the Investigator concluded the investigation into the Complaint and submitted an Investigation Report to the Complaints Consultant.

Following receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence that the issued raised in the Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Braxton received notice the matter was referred to a hearing, as well as a copy of the Statement of Allegations and the Investigation Report, on October 26, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Braxton under cover of letter dated November 23, 2020.

(4) Allegations

The Allegations in the Statement of Allegations (the "Allegations") are:

"It is alleged that BROOKLYN BRAXTON, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about August 3, 2020, failed to follow proper medication administration process with regards to Client DI, particulars of which include one or more of the following:

    a) Failed to obtain a co-signature for the administration of Methadone 30 mg, as required;

    b) Administered Methadone 390 mg instead of the ordered dose of Methadone 30 mg, resulting in client DI's admittance to the Intensive Care Unit (ICU);

    c) Incorrectly documented on the Record of Narcotic and Controlled Drugs sheet the remaining balance of Methadone 130mg/13ml as 3 vials instead of the actual remaining amount of 0 vials.

2. On or about August 3, 2020, falsely documented colleague UJ's initials as a co-signature in the Sunrise Clinical Manager (SCM) electronic record for the administration of Methadone 30 mg to Client DI, without authorization."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits an investigated member to make an admission of unprofessional conduct. An admission under s. 70 of the Act must be acceptable in whole or in part to the Hearing Tribunal.

Ms. Braxton acknowledged unprofessional conduct to all the allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and verbally admitted unprofessional conduct to all the allegations set out in the Statement of Allegations during the hearing.

Legal Counsel for the Complaints Consultant submitted, where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Statement of Allegations
Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3: Joint Submission on Penalty

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give viva voce testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #2.

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two-part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #2 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. Braxton's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Ms. Braxton.

Allegation 1:

Ms. Braxton admitted on or about August 3, 2020, she failed to follow proper medication administration process with regards to Client DI, particulars of which include one or more of the following:

a) Failed to obtain a co-signature for the administration of Methadone 30 mg, as required;

b) Administered Methadone 390 mg instead of the ordered dose of Methadone 30 mg, resulting in client DI's admittance to the Intensive Care Unit (ICU);

c) Incorrectly documented on the Record of Narcotic and Controlled Drugs sheet the remaining balance of Methadone 130mg/13ml as 3 vials instead of the actual remaining amount of 0 vials.

On August 3, 2020, Ms. Braxton worked from 0700 hours to 1515 hours at the Peter Lougheed Centre and provided care for client DI. Client DI was ordered Methadone 30mg PO q24h. Client DI's August 2-3, 2020 electronic medication administration record indicated that the Methadone 30mg was to be mixed with orange juice and ingestion supervised. At 1235 hours, Ms. Braxton went to the medication room and removed 3 vials of Methadone 130 mg/13 ml instead of the ordered Methadone 30mg. Ms. Braxton failed to obtain the required co-signature on the Record of Narcotic and Controlled Drugs sheet for the administration of Methadone 30mg.

Ms. Braxton incorrectly documented on the Record of Narcotic and Controlled Drugs sheet the remaining balance of Methadone 130mg/13ml as "3" vials instead of the actual remaining amount of "0". At approximately 1242 hours, Ms. Braxton administered Methadone 390 mg instead of the ordered dose of Methadone 30 mg.

At approximately 1430 hours, Dominic Salcedo, LPN, noticed the error when he attended the medication room to get Methadone for his own patient. At this time, Mr. Salcedo noticed that there were no 130mg/13ml vials left in the medication cupboard. After reviewing the Record of Narcotic and Controlled Drugs sheet, Mr. Salcedo identified that Ms. Braxton had last administered Methadone 3x 130mg. Mr. Salcedo spoke to Ms. Braxton and alerted her to the error.

Ms. Braxton alerted the charge nurse, Janet Murray, RN to the error. As a result of the 390mg of Methadone administered to client DI, client DI was transferred to the Intensive Care Unit ("ICU") on August 3, 2020 and remained in ICU for five days for treatment and monitoring.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice; and
iii. Conduct that harms the integrity of the regulated profession.

Ms. Braxton's conduct displayed a significant lack of knowledge and judgment by failing to adhere to the principles of medication administration. She failed to obtain a co-signature as required for the administration of Methadone. Further, she administered a dose many times greater than what had been ordered for the client under her care. She also failed to keep an accurate record

by failing to properly fill out the Narcotic and Controlled Drug Sheet. The result of Ms. Braxton's behaviour was significant harm to the client who, as a result of the administration of an excess of Methadone, spent five days in the ICU recovering from the effects of the excessive dose administered.

Ms. Braxton harmed the integrity of the profession by failing to perform her duties in the same manner as other LPNs in the same or similar circumstances. She should have performed the basic principles of medication administration (including but not limited to ensuring right dose). This would have ensured proper dosing of the medication, which would have avoided the significant harm to the client. Finally, if Ms. Braxton had doubts as to the dosing or was not familiar with the medication she was administering, she should have ensured she had an independent double-check by a co-worker which could have brought the error to light before the medication was administered and thereby saved the client from significant harm.

Ms. Braxton's conduct breached the following principles and standards set out in CLPNA's Code of Ethics ("Code") and the CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("Standards"):

<u>CLPNA Code of Ethics:</u>

a. Principle 1: Responsibility to the Public – LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically provides that LPNs

    - 1.1 Maintain the standards of practice, professional competence and conduct.

    - 1.2 Provide only those functions for which they are qualified by education or experience.

    - 1.5 Provide care directed to the health and well-being of the person, family, and community.

    - 1.6 Collaborate with clients, their families (to the extent appropriate to the client's right to confidentiality), and health care colleagues to promote the health and well-being of individuals, families and the public.

b. Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

    - 2.8 Use evidence and judgment to guide nursing decisions; and

    - 2.9 Identify and minimize risks to clients.

c. Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:

    - 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.

    - 3.3. Practice in a manner that is consistent with the privilege and responsibility of self-regulation.

    - 3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable.

d. Principle 4: Responsibility to the Profession – LPNs develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals. Principle 4 specifically provides that LPNs:

    - 4.2 Collaborate with colleagues in a cooperative, constructive and respectful manner with the primary goal of providing safe, competent, ethical, and appropriate care to individuals, families and communities.

e. Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 specifically provides that LPNs:

    - 5.1 Demonstrate honesty, integrity and trustworthiness in all interactions.

    - 5.2 Recognize their capabilities and limitations and perform only the nursing functions that fall within their scope of practice and for which they possess the required knowledge, skills and judgment.

    - 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.

<u>CLPNA Standards of Practice:</u>

a. Standard 1: Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

- 1.1 Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.
- 1.4 Recognize their own practice limitations and consult, as necessary.
- 1.6 Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.
- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.
- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

b. Standard 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice. Standard 2 specifically provides that LPNs:

   - 2.7 Demonstrate understanding of their role and interrelation with clients and other health care colleagues.

c. Standard 3: Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

   - 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice

   - 3.6 Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

d. Standard 4: Ethical Practice – LPNs uphold, promote and adhere to the values and beliefs as described in the Canadian Council for Practice Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

   - 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.

   - 4.8 Collaborate with colleagues to promote safe, competent and ethical practice.

   - 4.9 Support and contribute to healthy and positive practice environments.

- 4.10 Practice with honesty and integrity to maintain the values and reputation of the profession.

Ms. Braxton breached the aforementioned provisions of the Code and Standards. Ms. Braxton's conduct, in failing to follow appropriate procedures and in ensuring she administered the ordered dose of Methadone, breached her responsibility to the public in that she did not provide care that maintained the standards of practice and professional competence. Administering a dosage of medication multiple times more than ordered is deeply problematic for an LPN. Further, in failing to obtain a co-signature she did not collaborate with her health colleagues in promoting the well-being of the client and thereby also failed to provide appropriate care.

It is clear that in failing to ensure she administered the correct dosage she failed the client, who subsequently spent five days in the ICU, a significant negative outcome for the client due to Ms. Braxton's error. Further, she did not follow workplace policies and procedures, as well as, professional standards which would have operated to intervene and prevent this significant medication error.

Ms. Braxton failed to practice in accordance with requirements which bind her. Her error only came to light upon the discovery of a colleague. Her error in documentation was also brought to light by a colleague rather than by Ms. Braxton's own observation.

Allegation 2:

On or about August 3, 2020, Ms. Braxton falsely documented colleague UJ's initials as a co-signature in the Sunrise Clinical Manager (SCM) electronic record for the administration of Methadone 30mg to Client DI, without authorization.

On August 3, 2020, Ms. Braxton worked from 0700 hours to 1515 hours at the Facility and provided care for client DI. At approximately 1242 hours, Ms. Braxton electronically signed colleague UJ's initials on the Sunrise Clinical Manager (SCM) electronic record for the administration of Methadone 30mg to client DI. Ms. Braxton was not partnered with colleague UJ during her shift and they were working on different hubs in the Facility.

Ms. Braxton did not have authorization to sign UJ's initials on the medication administration record.

The Hearing Tribunal finds that the conduct admitted to in both allegations amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;

xii. Conduct that harms the integrity of the regulated profession.

The CLPNA expects LPNs to conduct themselves in their practice honestly and with integrity. Ms. Braxton did not meet this expectation when she signed the SCM record on behalf of her colleague without authorization. It was bad enough Ms. Braxton did not seek the assistance of a colleague but, by signing on behalf of her colleague without authorization, she was attempting to cover up the practice which she should not have engaged in. There is no doubt this conduct harms the integrity of the profession by undermining the trust members of the public necessarily repose in LPNs to provide competent care in accordance with established practices. Ms. Braxton's deceit showed a grave lack of judgment in carrying out her professional services.

This conduct additionally ran afoul of the Standards and the Code for many of the reasons discussed in Allegation #1. Additionally, however, she did not act in a manner that upholds the integrity of the profession or which is consistent with the responsibility of self-regulation. Self-regulation depends on every member of a profession to consistently engage in their practice honourably and in accordance with the parameters established for safe practice. Applying a colleague's signature without authorization flouts the responsibility of a member of a self-regulated professional. A regulated professional must demonstrate the trust placed in them is not misplaced and thereby honour the privilege afforded to them to practice. Ms. Braxton failed to do so and accordingly engaged in unprofessional conduct.

(9) <u>Joint Submission on Penalty</u>

The Complaints Consultant and Ms. Braxton jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #3. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Ms. Braxton shall pay 25% of the costs of the investigation and hearing to be paid over a period of 24 months from service of the Decision.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Braxton shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Braxton shall provide to the Complaints Consultant, a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA

documents will impact their professional practice within thirty (30) days of service of the Decision:

a) Code of Ethics for Licensed Practical Nurses in Canada;

b) Standards of Practice for Licensed Practical Nurses in Canada;

c) CLPNA Practice Policy: Professional Responsibility & Accountability;

d) CLPNA Practice Policy: Documentation;

e) CLPNA Competency Profile A1: Critical Thinking;

f) CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

g) CLPNA Competency Profile U2: Medication Preparation and Administration; and

h) CLPNA Practice Guideline: Medication Management.

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.

4. In the event the reflective paper is not satisfactory to the Complaints Consultant, Ms. Braxton shall within two (2) weeks of being notified by the Complaints Consultant the reflective paper is not satisfactory, or such longer period as determined by the Complaints Consultant at his sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

5. Ms. Braxton shall complete the LPN Ethics Course available online at http://www.learninglpn.ca/index.php/courses. Brooklyn Braxton shall provide the Complaints Consultant with a certificate confirming successful completion of the course within ninety (90) days of service of the Decision.

6. Ms. Braxton shall complete the Medication Drug Calculation Self-Study Course available online at https://studywithclpna.com/drugcalculations/. Ms. Braxton shall provide the Complaints Consultant with a certificate confirming successful completion of the course within ninety (90) days of service of the Decision.

7. Ms. Braxton shall complete, at her own cost, the following courses offered on-line by NCSBN Learning Extension at https://www.ncsbn.org/index.htm. Ms. Braxton shall provide the Complaints Consultant, with a certificate(s) confirming successful completion of the course(s) within ninety (90) days of service of the Decision.

a) Righting A Wrong: Ethics and Professionalism in Nursing; and

b) Medication Errors: Causes and Prevention.

8. Should any of the above course(s) becomes unavailable, then Ms. Braxton shall request in writing to be assigned an alternative course prior to the deadline. The Complaints Consultant shall, in his sole discretion, reassign a course. Ms. Braxton will be notified by the Complaints Consultant, in writing, advising of the new course required.

9. Ms. Braxton must within thirty (30) days of service of the Decision:

    a) Provide her supervisor(s) with a copy of the Decision in this matter;
    b) Provide her supervisor(s) with a copy of CLPNA's Medication Administration Skills Evaluation Tool; and
    c) Provide the Complaints Consultant with a written acknowledgement signed by her supervisor(s) confirming the receipt of a copy of the Decision.

10. Upon completion of three (3) months, the supervisor(s) must provide an evaluation of Ms. Braxton's medication administration to the Complaints Consultant.

11. In the even the supervisor(s)'s evaluation referred to in paragraph 9 identify concerns with Ms. Braxton's practice, the Complaints Consultant may treat the information as a complaint in accordance with s. 56 of the Act.

12. The sanctions set out above at paragraphs 3-10 will appear as conditions on Ms. Braxton's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial education, readings/reflection paper, and evaluation outlined at paragraphs 3-10 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Braxton 's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings/Reflection Paper;
        ii. Ethics course;
        iii. Medication Drug Calculation Self-Study course;
        iv. Righting A Wrong: Ethics and Professionalism in Nursing course; and
        v. Medication Errors: Causes and Prevention.

    b) The requirement to practice under supervision will continue to appear on Ms. Braxton's practice permit and the Public Registry until she provides proof to the Complaints Consultant that she has successfully completed the requirements set out above at paragraph 10; and

c) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Ms. Braxton's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

13. The conditions on Ms. Braxton 's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 12.

14. Ms. Braxton shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Ms. Braxton will keep her contact information current with the CLPNA on an ongoing basis.

15. Should Ms. Braxton be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

16. Should Ms. Braxton fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Consultant may do any or all of the following:

    (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

    (b) Treat Ms. Braxton non-compliance as information for a complaint under s.56 of the Act; or

    (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Braxton practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

Legal Counsel for the Complaints Consultant submitted the primary purpose of orders from the Hearing Tribunal is to protect the public. The Hearing Tribunal is aware that s. 82 of the Act sets out the available orders the Hearing Tribunal is able to make if unprofessional conduct is found.

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should defer to a joint submission unless the proposed sanction is unfit, unreasonable or contrary to public interest. Joint submissions make for a better process and

engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions and may significantly impair the ability of the Complaints Director to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Braxton and the Complaints Consultant.

(10) Decision on Penalty and Conclusions of the Hearing Tribunal

The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable and proportionate, taking into account the facts of this case.

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Braxton has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

1. The nature and gravity of the proven Allegations
2. The age and experience of the investigated member
3. The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
4. The age and mental condition of the victim, if any
5. The number of times the offending conduct was proven to have occurred
6. The role of the investigated member in acknowledging what occurred
7. Whether the investigated member has already suffered other serious financial or other penalties as a result of the Allegations having been made
8. The impact of the incident(s) on the victim
9. The presence or absence of any mitigating circumstances
10. The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
11. The need to maintain the public's confidence in the integrity of the profession
12. The range of sentence in other similar cases

The Hearing Tribunal considered each of the *Jaswal* factors, as set out below:

1) The nature and gravity of the proven allegations: The client in this case ended up in ICU for five days. The Hearing Tribunal finds the proven conduct is very serious and required significant

medical intervention. The Hearing Tribunal placed significant weight on the seriousness of the actions Ms. Braxton admitted to.

2) The age and experience of the investigated member: Ms. Braxton has been registered with the CLPNA and has been working as an LPN since December 2018. While Ms. Braxton did not have many years of experience, the Hearing Tribunal felt that the time she had been practising was ample time to know the significance of following proper policies and procedures.

3) The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: To the knowledge of the Hearing Tribunal, there were no other complaints or convictions against Ms. Braxton.

4) The age and mental condition of the victim, if any: The Hearing Tribunal was not provided with information regarding the age of the victim.

5) The number of times the offending conduct was proven to have occurred: The conduct only occurred once.

6) The role of the investigated member in acknowledging what occurred: Ms. Braxton did acknowledge the allegations and was cooperative in bringing forth the Agreed Statement of Facts as well as the Joint Submission on Penalty.

7) Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Braxton did have a one-day suspension and has had a condition on her licence for supervised practice since August 25, 2020 regarding the administration of narcotics, high alert and controlled substances.

8) The impact of the incident(s) on the victim: Patient DI was sent to ICU for five days for monitoring and treatment. The Hearing Tribunal was not made aware of any long-term impact on the victim.

9) The presence or absence of any mitigating circumstances: Ms. Braxton did write a letter to Ms. Weis on August 30, 2020 and stated she lacked education on Methadone. However, she also stated the error occurred when she failed to check the order on SCM against the eMAR.

10) The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: It is imperative that the penalty demonstrates how serious the College is regarding errors such as this. The orders on penalty must deter Ms. Braxton from performing such significant errors, as well as, letting the other members know that such actions will not be tolerated. The Hearing Tribunal believes the penalties assessed in the Joint Submission on Penalty do provide both specific and general deterrence. The importance of protecting the public is demonstrated through the Hearing Tribunal's order.

11) The need to maintain the public's confidence in the integrity of the profession: The public needs to trust the regulated members of the CLPNA. The penalties in this case are intended, in part, to demonstrate to the public that the College takes such matters seriously and to ensure the public is protected.

The range of sentence in other similar cases: The Hearing Tribunal is of the belief that the range of sentence being sought is similar to the penalties ordered in similar cases. It is important to the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) <u>Orders of the Hearing Tribunal</u>

The Hearing Tribunal is authorized under s. 82(1) of the Act to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Ms. Braxton shall pay 25% of the costs of the investigation and hearing to be paid over a period of 24 months from service of the Decision.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Braxton shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Braxton shall provide to the Complaints Consultant, a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact their professional practice within thirty (30) days of service of the Decision:

a) Code of Ethics for Licensed Practical Nurses in Canada;

b) Standards of Practice for Licensed Practical Nurses in Canada;

c) CLPNA Practice Policy: Professional Responsibility & Accountability;

d) CLPNA Practice Policy: Documentation;

e) CLPNA Competency Profile A1: Critical Thinking;

f) CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

g) CLPNA Competency Profile U2: Medication Preparation and Administration; and

h) CLPNA Practice Guideline: Medication Management.

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.

4. In the event the reflective paper is not satisfactory to the Complaints Consultant, Ms. Braxton shall within two (2) weeks of being notified by the Complaints Consultant the reflective paper is not satisfactory, or such longer period as determined by the Complaints Consultant at his sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

5. Ms. Braxton shall complete the LPN Ethics Course available online at http://www.learninglpn.ca/index.php/courses. Brooklyn Braxton shall provide the Complaints Consultant with a certificate confirming successful completion of the course within ninety (90) days of service of the Decision.

6. Ms. Braxton shall complete the Medication Drug Calculation Self-Study Course available online at https://studywithclpna.com/drugcalculations/. Ms. Braxton shall provide the Complaints Consultant with a certificate confirming successful completion of the course within ninety (90) days of service of the Decision.

7. Ms. Braxton shall complete, at her own cost, the following courses offered on-line by NCSBN Learning Extension at https://www.ncsbn.org/index.htm. Ms. Braxton shall provide the Complaints Consultant, with a certificate(s) confirming successful completion of the course(s) within ninety (90) days of service of the Decision.

    a) Righting A Wrong: Ethics and Professionalism in Nursing; and

    b) Medication Errors: Causes and Prevention.

8. Should any of the above course(s) becomes unavailable, then Ms. Braxton shall request in writing to be assigned an alternative course prior to the deadline. The Complaints

Consultant shall, in his sole discretion, reassign a course. Ms. Braxton will be notified by the Complaints Consultant, in writing, advising of the new course required.

9. Ms. Braxton must within thirty (30) days of service of the Decision:

    d) Provide her supervisor(s) with a copy of the Decision in this matter;
    e) Provide her supervisor(s) with a copy of CLPNA's Medication Administration Skills Evaluation Tool; and
    f) Provide the Complaints Consultant with a written acknowledgement signed by her supervisor(s) confirming the receipt of a copy of the Decision.

10. Upon completion of three (3) months, the supervisor(s) must provide an evaluation of Ms. Braxton's medication administration to the Complaints Consultant.

11. In the even the supervisor(s)'s evaluation referred to in paragraph 9 identify concerns with Ms. Braxton's practice, the Complaints Consultant may treat the information as a complaint in accordance with s. 56 of the Act.

12. The sanctions set out above at paragraphs 3-10 will appear as conditions on Ms. Braxton's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial education, readings/reflection paper, and evaluation outlined at paragraphs 3-10 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Braxton 's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings/Reflection Paper;
        ii. Ethics course;
        iii. Medication Drug Calculation Self-Study course;
        iv. Righting A Wrong: Ethics and Professionalism in Nursing course; and
        v. Medication Errors: Causes and Prevention.

    b) The requirement to practice under supervision will continue to appear on Ms. Braxton's practice permit and the Public Registry until she provides proof to the Complaints Consultant that she has successfully completed the requirements set out above at paragraph 10; and

c) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Ms. Braxton's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

13. The conditions on Ms. Braxton 's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 12.

14. Ms. Braxton shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Ms. Braxton will keep her contact information current with the CLPNA on an ongoing basis.

15. Should Ms. Braxton be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

16. Should Ms. Braxton fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Consultant may do any or all of the following:

    (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

    (b) Treat Ms. Braxton non-compliance as information for a complaint under s.56 of the Act; or

    (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Braxton practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, s. 87(1)(a), (b) and 87(2) of the Act, the Investigated Member has the right to appeal:

> "87(1) An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that

(a) identifies the appealed decision, and
(b) states the reasons for the appeal.

(2) A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 25th DAY OF JANUARY 2021 IN THE CITY OF CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

M. Stolz
Michelle Stolz, LPN
Chair, Hearing Tribunal