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 CARLA CORPIN

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* REGARDING THE CONDUCT OF CARLA CORPIN, LPN #42848, 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 September 4, 2020 with the following individuals present:

Hearing Tribunal:
Michelle Stolz, Licensed Practical Nurse ("LPN") Chairperson
Verna Ruskowsky, LPN
Nancy Brook, Public Member

Staff:
Katrina Haymond, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Carla Corpin, LPN ("Ms. Corpin or "Investigated Member")
Kathie Milne, 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

Ms. Corpin was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Corpin was initially licensed as an LPN in Alberta on August 31, 2016.

On May 1, 2019, the CLPNA received a complaint from Robin Brooks ("Ms. Brooks"), Community Manager at Extendicare Eau Claire ("Extendicare") in Edmonton, Alberta (the "Complaint"). The Complaint was sent pursuant to s. 54 of the Act, stating that Ms. Carla Corpin, LPN failed to follow medication administration procedures resulting in greater than 70 medication errors.

Ms. Sandy Davis, Complaints Director for the CLPNA, delegated her authority and powers under Part 4 of the Act to Susan Blatz, Complaints Consultant for the CLPNA, (the "Complaints Consultant") pursuant to s. 20 of the Act.

The Complaints Consultant conducted an investigation into the Complaint.

Ms. Corpin received notice of the Complaint and the Investigation by letter dated May 9, 2019.

On May 16, 2019, the Complaints Consultant made a written request to Teresa Bateman, Senior Director of the CLPNA, requesting that a condition of supervised medication administration be placed on Ms. Corpin's practice permit.

On May 24, 2019, Ms. Bateman placed an interim condition on Ms. Corpin's practice permit restricting her from medication preparation and administration unless she had direct supervision.

On January 31, 2020, the Complaints Consultant concluded the investigation and submitted the Investigation Report to the CLPNA.

Following the Investigation Report, the Complaints Consultant determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Corpin received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated March 30, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Corpin under cover of letter dated July 17, 2020.

(4) Allegations

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

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

1. On or about December 31, 2018 administered Hydromorphone 3 mg to client LR without a physician's order.

2. On or about January 1, 2019 did one or more of the following:
    1. Failed to sign the narcotic shift count at 1500 hours on the Daily Narcotic & Controlled Drug Administration record;
    2. Failed to sign for the removal of Tylenol #3 at 1700 hours on the Daily Narcotic & Controlled Drug Administration record for client BI.
3. On or about March 21, 2019 made one or more of the following errors relating to medication administration and/or documentation:
    a. Administered insulin at 0800 hours to client GG when there was a Physician's Order to hold the insulin;
    b. Incorrectly documented on the Medication Administration Record for the administration of Telmisartan 40 mg at 0800 hours for client PT when the medication had been discontinued on February 24, 2019 and was not provided by pharmacy;
    c. Failed to document on the Medication Administration Record for the administration of Acetaminophen 650 mg at 1700 hours for client DM.
4. On or about March 22, 2019 failed to appropriately document medication administration to one or more clients as set out below:
    a. Failed to document on the Medication Administration Record for the administration of Saccharomyces and PEG 17 g at 0800 hours and Biotene mouth spray at 1200 hours for client AB (RM 3304);
    b. Failed to document the reason for the removal of Hydromorphone 1 mg from the Daily Narcotic & Controlled Drug record at 1300 hours for client AB (RM 3304);
    c. Failed to document on the Medication Administration Record for the administration of Hydromorphone 1 mg at 1400 hours for client AB (RM3304);
    d. Failed to document on the Medication Administration Record the administration of Almagel, Resource and Beneprotein at 1700 hours for client AB (RM 2320);
    e. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for 1700 hours medications for client JZ;
    f. Failed to document on the Medication Administration Record for the administration of Acidophilus at 2100 hours for client GC;
    g. Failed to properly correct an error on the Medication Administration Record by crossing out her initials for Estrogens at 2000 hours for client SKL.
5. On or about March 23, 2019 failed to appropriately document medication administration to one or more clients as set out below:

a. Failed to document on the Medication Administration Record for the administration of Acidophilus at 2100 hours for client GC;
b. Failed to document on the Medication Administration Record for the administration of Lantus 20 units at 2100 hours to client AG;
c. Failed to document on the Medication Administration Record for the administration of Baby Shampoo and Tear Gel Eye Lubricant at 1700 hours for client FG;
d. Failed to document on the Medication Administration Record for the administration of Metoprolol 62.5 mg at 2100 hours for client KH;
e. Failed to document on the Medication Administration Record for the administration of Trazadone 50 mg at 2100 hours for client WL;
f. Failed to document on the Medication Administration Record for the administration of Sennosides, Tobrex Eye Drops, Tums, Diclofenac to back and Diclofenac to joints at 2100 hours for client LR;
g. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Folic Acid at 1700 hours for client EC;
h. Failed to document on the Medication Administration Record for the administration of Ferrous Fumarate 300 (100) mg at 1700 hours for client JW;
i. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Acetaminophen 650 mg, Melatonin 5 mg and Trazodone HCL 75 mg at 2100 hours for client AC;
j. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for medications to be administered at 1700 hours and 2100 hours for client ES.

6. On or about March 28, 2019 failed to appropriately document medication administration to one or more clients as set out below:
   a. Failed to document on the Medication Administration Record for the administration of Acetaminophen 650 mg at 1700 hours for client DM;
   b. Failed to document on the Medication Administration Record for the administration of Clonazepam 0.0625 mg at 1700 hours for client SKL;
   c. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Acetaminophen 650 mg at 2100 hours for client AB (RM2311);
   d. Failed to document on the Medication Administration Record for the administration of Gabapentin 100 mg at 2100 hours for client MB;

e. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for Resource at 2100 hours for client DH.

7. On or about March 29, 2019 failed to appropriately document medication administration to one or more clients as set out below:

   a. Failed to document on the Medication Administration Record the administration of Acetaminophen 650 mg, Artificial Tears and Resource at 1700 hours and Resource and Melatonin at 2100 hours for client JZ;

   b. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for Acetaminophen 650 mg and Resource at 2100 hours for client AB (RM2311);

   c. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for Sennosides at 1700 hours and Resource at 2100 hours for client DH;

   d. Failed to document on the Medication Administration Record for the administration of Magnesium 30 ml at 1700 hours and Acetaminophen 325 mg at 2100 hours for client CSL;

   e. Failed to document on the Medication Administration Record for the administration of Loprox Cream at 2100 hours for client RH.

8. On or about March 30, 2019 failed to appropriately document medication administration to one or more clients as set out below:

   a. Failed to document on the Medication Administration Record for the administration of Acetaminophen 650 mg at 1700 hours for client DM;

   b. Failed to document in the Progress Notes the reason for documenting an “n/a” on the Medication Administration Record for Clonazepam 0.0625 mg at 1700 hours for client SKL;

   c. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for Acetaminophen 650 mg at 2100 hours for client AB (RM2311);

   d. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for Resource at 2100 hours for client DH;

   e. Failed to document on the Medication Administration Record for the administration of HDC at 2000 hours for client DH;

   f. Documented on the Medication Administration Record for the administration of Lax-a-day and Loprox Cream at 0800 hours for client RH when she worked an evening shift on March 30, 2019;

g. Failed to document the reason for the removal of Dilaudid 0.25 mg at 1700 hours from the Daily Narcotic & Controlled Drug record for client HB;

h. Failed to properly document the wastage of the Dilaudid 0.5 mg removed from the Daily Narcotic & Controlled Drug record at 2100 hours for client HB when failed to indicate the dose wasted and failed to obtain a second signature for the wastage.

9. On or about March 31, 2019 failed to appropriately document medication administration to one or more clients as set out below:

   a. Failed to document on the Medication Administration Record for the administration of Acetaminophen 650 mg and Olanzapine 2.5 mg at 1700 hours for client DM;

   b. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Fluticasone/Salmeterol 250/25 mcg, Acetaminophen 650 mg and Trazadone HCL 50 mg at 2100 hours for client DM;

   c. Failed to document on the Medication Administration Record the administration of Olanzapine 2.5 mg at 2100 hours for client AB (RM 2320);

   d. Failed to document on the Medication Administration Record the administration of Acetaminophen 650 mg at 1700 hours for client JZ;

   e. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Acetaminophen 650 mg at 2100 hours for client AB (RM2311);

   f. Failed to document on the Medication Administration Record for the administration of Resource at 1700 hours and Resource at 2100 hours for client DH;

   g. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Magnesium 30 ml and Acetaminophen 650 mg at 1700 hours and Acetaminophen 650 mg at 2100 hours for client CSL;

   h. Failed to document on the Medication Administration Record for the administration of Loprox Cream at 2100 hours for client RH;

   i. Failed to document on the Medication Administration Record for the administration of Metoprolol 25 mg at 1700 hours for client EM.

10. On or about April 4, 2019 failed to appropriately document medication administration to one or more clients as set out below:

   a. Documented on the Pain Flow Record, Tylenol #3 was administered at 1850 hours to client DB when it was not administered;

b. Removed Tylenol #3 from the Daily Narcotic & Controlled Drug record at 1700 hours for a client then documented another client's name over the initial name making the record confusing and illegible;

c. Failed to document on the Medication Administration Record for the administration of Percocet at 1700 hours to client CS.

11. On or about April 5, 2019 failed to appropriately document medication administration to one or more clients as set out below:

    a. Failed to document on the Medication Administration Record for the administration of Valproic Acid 250mg/5ml at 2100 hours for client HT;

    b. Failed to document on the Medication Administration Record for the administration of Hydromorphone 0.5 mg at 2000 hours for client GK;

    c. Failed to document in the Progress Notes a dosage of Hydromorphone administered at 2000 hours to client GK;

    d. Documented in client GK's Progress Notes medications for 1700 hours were refused but documented on the Medication Administration Record Acetaminophen 650 mg and Moxifloxacin 0.5% drops were administered at 1700 hours;

    e. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Isopto Tears at 2100 hours for client GK;

    f. Failed to initiate a Pain Flow Record after administering Hydromorphone 0.5 mg at 2000 hours to client GK."

(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. Corpin 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. Corpin'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. Corpin.

Allegation 1

Carla Corpin admitted on or about December 31, 2018, she administered Hydromorphone 3 mg to client LR without a physician's order.

On December 31, 2018, Ms. Corpin worked the evening shift at Extendicare. During this shift, she provided care to client LR.

Ms. Corpin administered Hydromorphone 3 mg to client LR when LR did not have an order for Hydromorphone. Ms. Corpin failed to perform the necessary checks before administering the Hydromorphone. The Hearing Tribunal was provided with a copy of the Counselling Memorandum and Medication Incident Report in the Agreed Statement of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 1 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication.

Ms. Corpin did not abide by the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Code of Ethics") or the Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Standards of Practice"), as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail below.

The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out below and that such breaches are sufficiently serious to constitute unprofessional conduct.

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

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 standards of practice, professional competence, and conduct; and
- 1.5 Provide care directed toward the health and well-being of the person, family, and community.

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

- 2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities; and
- 2.9 Identify and minimize risks to clients.

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

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

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

CLPNA Standards of Practice:

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;
- 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised;
- 1.7. Incorporate established client safety principles and quality assurance/ improvement activities into LPN practice;
- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses; and
- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

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:

- 2.2. Apply knowledge from nursing theory and science, other disciplines, evidence to inform decision making and LPN practice.

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;
- 3.4 Promote a culture of safety by using established occupational health and safety practices, infection control, and other safety measures to protect clients, self and colleagues from illness and injury;
- 3.5. Provide relevant and timely information to clients and co-workers; and
- 3.6 Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

Standard 4: Ethical Practice – LPNs uphold, promote, and adhere to the values and beliefs as described in the Canadian Council for Practical 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.

<u>Allegation 2</u>

Carla Corpin admitted on or about January 1, 2019, she did one or more of the following:

a. Failed to sign the narcotic shift count at 1500 hours on the Daily Narcotic & Controlled Drug Administration record;
b. Failed to sign for the removal of Tylenol #3 at 1700 hours on the Daily Narcotic & Controlled Drug Administration record for client BI.

On January 1, 2019, Ms. Corpin worked a shift at Extendicare. In the course of this shift, Ms. Corpin administered narcotics to clients. On January 29, 2019, during a routine audit of the Daily Narcotic & Controlled Drug Administration record, Sharon Wharton, Director of Care, discovered that Ms. Corpin failed to sign the Daily Narcotic and Controlled Drug Administration record on January 1, 2019 at 1500 hours.

The audit further revealed that Ms. Corpin failed to sign for Tylenol #3 removed at 1700 hours on the Daily Narcotic & Controlled Drug Administration Record. The Hearing Tribunal was provided with the Daily Narcotic & Controlled Drug Administration Record for January 1, 2019 as well as the Medication Incident Report for January 29, 2019.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 2 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies of the employer.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 3

Carla Corpin admitted on or about March 21, 2019, she made one or more of the following errors relating to medication administration and/or documentation:

a. Administered insulin at 0800 hours to client GG when there was a Physician's Order to hold the insulin;
b. Incorrectly documented on the Medication Administration Record for the administration of Telmisartan 40 mg at 0800 hours for client PT when the medication had been discontinued on February 24, 2019 and was not provided by pharmacy;
c. Failed to document on the Medication Administration Record for the administration of Acetaminophen 650 mg at 1700 hours for client DM.

On March 21, 2019, Jocelyn Copero, RN, notified Ms. Brooks that Ms. Corpin had administered insulin to client GG although there was an order to hold the insulin.

Ms. Brooks determined that at approximately 0800 hours, Ms. Corpin administered insulin to client GG when there was a Physician's Order to hold the insulin. Ms. Corpin appropriately withheld the 1200 hour dose. Ms. Corpin failed to notify the on-duty Physician or Registered Nurse that, contrary to the Physician's Order, insulin had been administered to client GG at 0800 hours. The Hearing Tribunal was provided with a copy of GG's MAR and a copy of the physician's order related to this incident as part of the Agreed Statement of Facts.

Ms. Brooks also noticed that at approximately 0800 hours on March 21, 2019, Ms. Corpin signed the MAR for client PT indicating she had administered Telmisartan 40 mg. This medication had been discontinued on February 24, 2019 and was not included in the medication pouch provided by the pharmacy. The Hearing Tribunal was provided with a copy of PT's MAR and physician's order and Medication Incident Report related to the March 21, 2019 incident.

Following this incident, Ms. Brooks conducted an audit of Ms. Corpin's medication administrations from March 21, 2019 – April 8, 2019. As a result of her audit, Ms. Brooks identified a number of additional errors. As a result of her audit, Ms. Brooks discovered that at approximately 1700 hours, Ms. Corpin failed to document on the Medication Administration Report ("MAR") of client DM the administration of Acetaminophen 650mg. The Hearing Tribunal was provided with a copy of Ms. Brooks investigation summary, Ms. Corpin's schedule from March 21, 2019 to April 8, 2019 as well as the Medication Administration Record for client DM.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 3 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies and procedures of the employer.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 4

Carla Corpin admitted on or about March 22, 2019, she failed to appropriately document medication administration to one or more clients as set out below:

a. Failed to document on the Medication Administration Record for the administration of Saccharomyces and PEG 17 g at 0800 hours and Biotene mouth spray at 1200 hours for client AB (RM 3304);
b. Failed to document the reason for the removal of Hydromorphone 1 mg from the Daily Narcotic & Controlled Drug record at 1300 hours for client AB (RM 3304);
c. Failed to document on the Medication Administration Record for the administration of Hydromorphone 1 mg at 1400 hours for client AB (RM3304);

d. Failed to document on the Medication Administration Record the administration of Almagel, Resource and Beneprotein at 1700 hours for client AB (RM 2320);
e. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for 1700 hours medications for client JZ;
f. Failed to document on the Medication Administration Record for the administration of Acidophilus at 2100 hours for client GC;
g. Failed to properly correct an error on the Medication Administration Record by crossing out her initials for Estrogens at 2000 hours for client SKL.

Ms. Brooks also identified a number of errors made by Ms. Corpin during the shift she worked on March 22, 2019. At approximately 0800 hours, Ms. Corpin failed to document on the MAR of client AB the administration of Saccharomyces and PEG 17g. At approximately 1200 hours, Ms. Corpin failed to document on the MAR of client AB the administration of Biotene mouth spray.

At approximately 1300 hours, Ms. Corpin noted in the Daily Narcotic and Controlled Drug Record the removal of Hydromorphone 1 mg for client AB. However, she failed to document on the MAR the administration of Hydromorphone 1 mg to client AB or the reason for removing the drug.

At approximately 1700 hours, Ms. Corpin failed to document on the MAR of client AB the administration of Almagel, Resource and Beneprotein.

At approximately 1700 hours, Ms. Corpin documented an “R” on the MAR of client JZ. Ms. Corpin then failed to document in the Progress Notes the reason for documenting a “R” on the MAR for 1700 hour medications for client JZ.

At approximately 2100 hours, Ms. Corpin failed to document on the MAR of client GC the administration of Acidophilus.

At approximately 2000 hours, Ms. Corpin initialled the administration of Estrogens but then subsequently crossed out her initials, not following proper procedure for correcting an error.

The Hearing Tribunal was provided with copies of the MARs for all the incidents in this allegation as part of the Agreed Statement of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin’s admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 4 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies and procedures of the employer.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 5

Carla Corpin admitted on or about March 23, 2019, she failed to appropriately document medication administration to one or more clients as set out below:

a. Failed to document on the Medication Administration Record for the administration of Acidophilus at 2100 hours for client GC;
b. Failed to document on the Medication Administration Record for the administration of Lantus 20 units at 2100 hours to client AG;
c. Failed to document on the Medication Administration Record for the administration of Baby Shampoo and Tear Gel Eye Lubricant at 1700 hours for client FG;
d. Failed to document on the Medication Administration Record for the administration of Metoprolol 62.5 mg at 2100 hours for client KH;
e. Failed to document on the Medication Administration Record for the administration of Trazadone 50 mg at 2100 hours for client WL;
f. Failed to document on the Medication Administration Record for the administration of Sennosides, Tobrex Eye Drops, Tums, Diclofenac to back and Diclofenac to joints at 2100 hours for client LR;
g. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Folic Acid at 1700 hours for client EC;
h. Failed to document on the Medication Administration Record for the administration of Ferrous Fumarate 300 (100) mg at 1700 hours for client JW;
i. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Acetaminophen 650 mg, Melatonin 5 mg and Trazodone HCL 75 mg at 2100 hours for client AC;

j. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for medications to be administered at 1700 hours and 2100 hours for client ES.

As a result of her audit, Ms. Brooks also identified a number of medication administration errors that occurred on March 23, 2019 when Ms. Corpin worked her shift at Extendicare, including:

- At approximately 2100 hours, Ms. Corpin failed to document on the MAR of client GC the administration of Acidophilus.
- At approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Lantus 20 units to client AG.
- At approximately 1700 hours, Ms. Corpin failed to document on the MAR for the administration of Baby Shampoo and Tear Gel Eye Lubricant for client FG.
- At approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Metoprolol 62.5 mg for client KH.
- At approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Trazadone 50 mg for client WL.
- At approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Sennosides, Tobrex Eye Drops, Tums, Diclofenac to back and Diclofenac to joints for client LR.
- At approximately 1700 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an “R” on the MAR for Folic Acid at 1700 hours for client EC.
- At approximately 1700 hours, Ms. Corpin failed to document on the MAR for the administration of Ferrous Fumarate 300 (100) mg for client JW.
- At approximately 2100 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an “R” on the MAR for Acetaminophen 650 mg, Melatonin 5 mg and Trazodone HCL 75 mg for client AC.

Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an “R” on the MAR for medications to be administered at 1700 hours and 2100 hours for client ES.

The Hearing Tribunal was provided with copies of the MARs for all of the incidents in this allegation by way of the Agreed Statement of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin’s admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 5 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of Medication Administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies of the employer.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

<u>Allegation 6</u>

Carla Corpin admitted on or about March 28, 2019, she failed to appropriately document medication administration to one or more clients as set out below:

a. Failed to document on the Medication Administration Record for the administration of Acetaminophen 650 mg at 1700 hours for client DM;
b. Failed to document on the Medication Administration Record for the administration of Clonazepam 0.0625 mg at 1700 hours for client SKL;
c. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Acetaminophen 650 mg at 2100 hours for client AB (RM2311);
d. Failed to document on the Medication Administration Record for the administration of Gabapentin 100 mg at 2100 hours for client MB;
e. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Resource at 2100 hours for client DH.

As a result of her audit, Ms. Brooks also identified a number of additional errors relating to Ms. Corpin's administration of medication during her shift at Extendicare on March 28, 2019, including:

- At approximately 1700 hours, Ms. Corpin failed to document on the MAR of client DM the administration of Acetaminophen 650mg.
- At approximately 1700 hours, Ms. Corpin failed to document on the MAR of client SKL the administration of Clonazepam 0.0625mg.

- At approximately 2100 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an "R" on the MAR for Acetaminophen 650 mg for client AB (RM2311).
- At approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Gabapentin 100 mg for client MB.
- At approximately 2100 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an "R" on the MAR for Resource for client DH.

The Hearing Tribunal was provided with copies of the MARs for all of the incidents in this allegation by way of the Agreed Statements of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 6 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies of the employer.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

<u>Allegation 7</u>

Carla Corpin admitted on or about March 29, 2019, she failed to appropriately document medication administration to one or more clients as set out below:

a. Failed to document on the Medication Administration Record the administration of Acetaminophen 650 mg, Artificial Tears and Resource at 1700 hours and Resource and Melatonin at 2100 hours for client JZ;

b. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for Acetaminophen 650 mg and Resource at 2100 hours for client AB (RM2311);
c. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for Sennosides at 1700 hours and Resource at 2100 hours for client DH;
d. Failed to document on the Medication Administration Record for the administration of Magnesium 30 ml at 1700 hours and Acetaminophen 325 mg at 2100 hours for client CSL;
e. Failed to document on the Medication Administration Record for the administration of Loprox Cream at 2100 hours for client RH.

As a result of her audit, Ms. Brooks also discovered a number of medication administration errors during Ms. Corpin’s shift at Extendicare on March 29, 2019, including:

- Ms. Corpin failed to document on the MAR the administration of Acetaminophen 650 mg, Artificial Tears and Resource at 1700 hours and Resource and Melatonin at 2100 hours for client JZ.
- At approximately 2100 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an “R” on the MAR for Acetaminophen 650 mg and Resource for client AB (RM2311).
- Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an “R” on the MAR for Sennosides at 1700 hours and Resource at 2100 hours for client DH.
- Ms. Corpin failed to document on the MAR for the administration of Magnesium 30 ml at 1700 hours and Acetaminophen 325 mg at 2100 hours and for client CSL.
- At approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Loprox Cream for client RH.

The Hearing Tribunal was provided copies of the MARs for all of the incidents in this allegation by way of the Agreed Statements of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin’s admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 7 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies of the employer.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 8

Carla Corpin admitted on or about March 30, 2019, she failed to appropriately document medication administration to one or more clients as set out below:

a. Failed to document on the Medication Administration Record for the administration of Acetaminophen 650 mg at 1700 hours for client DM;

b. Failed to document in the Progress Notes the reason for documenting an "n/a" on the Medication Administration Record for Clonazepam 0.0625 mg at 1700 hours for client SKL;

c. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Acetaminophen 650 mg at 2100 hours for client AB (RM2311);

d. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Resource at 2100 hours for client DH;

e. Failed to document on the Medication Administration Record for the administration of HDC at 2000 hours for client DH;

f. Documented on the Medication Administration Record for the administration of Lax-a-day and Loprox Cream at 0800 hours for client RH when she worked an evening shift on March 30, 2019;

g. Failed to document the reason for the removal of Dilaudid 0.25 mg at 1700 hours from the Daily Narcotic & Controlled Drug record for client HB;

h. Failed to properly document the wastage of the Dilaudid 0.5 mg removed from the Daily Narcotic & Controlled Drug record at 2100 hours for client HB when failed to indicate the dose wasted and failed to obtain a second signature for the wastage.

As a result of her audit, Ms. Brooks identified a number of medication administration errors that occurred on March 30, 2019 during Ms. Corpin's shift at Extendicare, including:

- At approximately 1700 hours, Ms. Corpin failed to document on the MAR of client DM the administration of Acetaminophen 650mg.
- At approximately 1700 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an "n/a" on the MAR for Clonazepam 0.0625 mg for client SKL.
- At approximately 2100 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an "R" on the MAR for Acetaminophen 650 mg for client AB (RM2311).
- At approximately 2100 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an "R" on the MAR for client DH.
- At approximately 2000 hours, Ms. Corpin failed to document on the MAR for the administration of HDC for client DH.

Ms. Corpin documented on the MAR for the administration of Lax-a-day and Loprox Cream at 0800 hours for client RH. However, on March 30, 2019 Ms. Corpin worked from 2300 – 0715. Since she did not work the day shift, she could not have administered medications to client RH at 0800 hours.

At approximately 1700 hours, Ms. Corpin removed Dilaudid 0.25 mg from the Narcotic Count Record for client HB, although the order for Dilaudid had been discontinued earlier that day. Ms. Corpin failed to document the reason for the removal of Dilaudid 0.25 mg.

At approximately 2100 hours, Ms. Corpin removed Dilaudid 0.5 mg from the Narcotic Count Record for client HB. Ms. Corpin then crushed the Dilaudid to put it in HB's juice, but HB refused it, so it was not administered. Ms. Corpin did record an "R" in the MAR for client HB and documented the refusal of Dilaudid 0.5 mg in the Resident Progress Notes. However, Ms. Corpin failed to properly document the wastage of the Dilaudid 0.5 mg on the Daily Narcotic & Controlled Drug Administration record. Specifically, Ms. Corpin failed to indicate the dose wasted and failed to obtain a second signature for the wastage.

The Hearing Tribunal was provided with copies of the MARs, as well as copies of the Daily Narcotic & Controlled Drug Administration records, client progress notes for the incidents in this allegation by way of the Agreed Statement of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 8 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies of the employer. Ms. Corpin failed to properly fill out the Daily Narcotic & Controlled Drug Administration record including failing to sign off the wasted narcotic and getting a second signature for the wasted narcotic.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 9

Carla Corpin admitted on or about March 31, 2019, she failed to appropriately document medication administration to one or more clients as set out below:

a. Failed to document on the Medication Administration Record for the administration of Acetaminophen 650 mg and Olanzapine 2.5 mg at 1700 hours for client DM;
b. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Fluticasone/Salmeterol 250/25 mcg, Acetaminophen 650 mg and Trazadone HCL 50 mg at 2100 hours for client DM;
c. Failed to document on the Medication Administration Record the administration of Olanzapine 2.5 mg at 2100 hours for client AB (RM 2320);
d. Failed to document on the Medication Administration Record the administration of Acetaminophen 650 mg at 1700 hours for client JZ;
e. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Acetaminophen 650 mg at 2100 hours for client AB (RM2311);
f. Failed to document on the Medication Administration Record for the administration of Resource at 1700 hours and Resource at 2100 hours for client DH;
g. Failed to document in the Progress Notes the reason for documenting an "R" on the Medication Administration Record for Magnesium 30 ml and Acetaminophen 650 mg at 1700 hours and Acetaminophen 650 mg at 2100 hours for client CSL;
h. Failed to document on the Medication Administration Record for the administration of Loprox Cream at 2100 hours for client RH;

i. Failed to document on the Medication Administration Record for the administration of Metoprolol 25 mg at 1700 hours for client EM.

Ms. Brooks' audit also identified a number of medication errors by Ms. Corpin during her shift at Extendicare on March 31, 2019, including:

- At approximately 1700 hours, Ms. Corpin failed to document on the MAR of client DM the administration of Acetaminophen 650 mg and Olanzapine 2.5 mg.
- At approximately 2100 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an "R" on the MAR for Fluticasone/Salmeterol 250/25 mcg, Acetaminophen 650 mg and Trazadone HCL 50 mg for client DM.
- At approximately 2100 hours, Ms. Corpin failed to document on the MAR of client AB (RM2320) the administration of Olanzapine 2.5 mg.
- At approximately 1700 hours, Ms. Corpin failed to document on the MAR the administration of Acetaminophen 650 mg for client JZ.
- At approximately 2100 hours, Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an "R" on the MAR for Acetaminophen 650 mg for client AB (RM2311).
- At approximately 1700 hours and again at approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Resource for client DH.
- Ms. Corpin failed to document in the Client Progress Notes the reason for documenting an "R" on the MAR for Magnesium 30 ml and Acetaminophen 650 mg at 1700 hours and Acetaminophen 650 mg at 2100 hours for client CSL.
- At approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Loprox Cream for client RH.
- At approximately 1700 hours, Ms. Corpin failed to document on the MAR for the administration of Metoprolol 25 mg for client EM.

The Hearing Tribunal was provided with copies of the MARs as well as Client Progress Notes for the incidents in the allegation by way of the Agreed Statement of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 9 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies of the employer.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 10

Carla Corpin admitted on or about April 4, 2019, she failed to appropriately document medication administration to one or more clients as set out below:

a. Documented on the Pain Flow Record, Tylenol #3 was administered at 1850 hours to client DB when it was not administered;
b. Removed Tylenol #3 from the Daily Narcotic & Controlled Drug record at 1700 hours for a client then documented another client's name over the initial name making the record confusing and illegible;
c. Failed to document on the Medication Administration Record for the administration of Percocet at 1700 hours to client CS.

As a result of the audit conducted by Ms. Brooks, she identified a number of medication administration errors made by Ms. Corpin during her shift at Extendicare on April 4, 2019.

Ms. Corpin documented on the Pain Flow Record that Tylenol #3 was administered at 1850 hours to client DB. The Tylenol #3 was not administered to client DB at this time. The Tylenol #3 was not removed from the Daily Narcotic & Controlled Drug Administration record until 2100 hours. At approximately 1700 hours, Ms. Corpin removed Tylenol #3 from the Daily Narcotic & Controlled Drug Administration record. She then wrote the last name of client BI over the top of the last name of client DB in the Daily Narcotic & Controlled Drug Administration record. Client BI and client DB were each to receive Tylenol #3 during the evening of April 4, 2019. Ms. Corpin's action rendered the Daily Narcotic & Controlled Drug Administration record confusing and illegible.

At approximately 1700 hours, Ms. Corpin removed Percocet from the Daily Narcotic & Controlled Drug Administration record for client CS. Ms. Corpin then failed to document on the MAR for client CS the administration of Percocet at 1700 hours.

The Hearing Tribunal was provided with copies of the MARs, Pain Flow Records and Daily Narcotic & Controlled Drug Administration record for all incidents in this allegation by way of the Agreed Statement of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 10 did in fact occur.

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 judgement in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of medication administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies of the employer. By failing to properly document on the Daily Narcotic & Controlled Drug Administration record she made the record confusing and illegible.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

<u>Allegation 11</u>

Carla Corpin admitted on or about April 5, 2019, she failed to appropriately document medication administration to one or more clients as set out below:

a. Failed to document on the Medication Administration Record for the administration of Valproic Acid 250mg/5ml at 2100 hours for client HT;
b. Failed to document on the Medication Administration Record for the administration of Hydromorphone 0.5 mg at 2000 hours for client GK;
c. Failed to document in the Progress Notes a dosage of Hydromorphone administered at 2000 hours to client GK;
d. Documented in client GK's Progress Notes medications for 1700 hours were refused but documented on the Medication Administration Record Acetaminophen 650 mg and Moxifloxacin 0.5% drops were administered at 1700 hours;

e. Failed to document in the Progress Notes the reason for documenting an “R” on the Medication Administration Record for Isopto Tears at 2100 hours for client GK;

f. Failed to initiate a Pain Flow Record after administering Hydromorphone 0.5 mg at 2000 hours to client GK.

As a result of the audit conducted by Ms. Brooks, she identified a number of medication errors made by Ms. Corpin during her shift at Extendicare on April 5, 2019.

At approximately 2100 hours, Ms. Corpin failed to document on the MAR for the administration of Valproic Acid 250mg/5ml for client HT.

At approximately 2000 hours, Ms. Corpin removed 0.5 mg Hydromorphone from the Daily Narcotic & Controlled Drug Administration record for client GK. Ms. Corpin then failed to document on the MAR and the Client Progress Notes for client GK the administration of 0.5 mg Hydromorphone. Although Ms. Corpin documented in the Progress Notes “hydromorphone given for leg pain with effect”, she failed to initiate a Pain Flow Record.

At approximately 1700 hours, Ms. Corpin documented in the Client Progress Notes for client GK that medications were refused and, at the same time, documented in the MAR for client GK that Acetaminophen 650 mg and Moxifloxacin 0.5% drops were administered.

At approximately 2100 hours, Ms. Corpin documented an “R” on the MAR for client GK for Isopto Tears. Ms. Corpin then failed to document in the Client Progress Notes for client GK the reason for documenting an “R” for Isopto Tears for client GK.

The Hearing Tribunal was provided with copies of the MARs and Client progress Notes for the incidents in this allegation by way of the Agreed Statement of Facts.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Corpin’s admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 11 did in fact occur.

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.

Ms. Corpin displayed a lack of knowledge, skill, and judgement when she failed to follow the basic principles of Medication Administration including performing the necessary checks prior to administering medication. She also failed to properly document medication administration as per the policies of the employer including initiating a Pain Flow Record.

Ms. Corpin did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

(9) Joint Submission on Penalty

The Complaints Consultant and Ms. Corpin 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. Corpin shall pay 25% of the costs of the investigation and hearing to be paid over a period of **36 months** from service of letter advising of final costs.
    a. A letter advising of the final costs will be forwarded when final costs have been confirmed.
3. Ms. Corpin will not be eligible to apply for registration until she has complied with the following:
    a. Ms. Corpin shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Corpin shall provide a signed written declaration to Susan Blatz, Complaints Consultant, attesting she has reviewed CLPNA's documents:
        i. Code of Ethics for Licensed Practical Nurses in Canada;
        ii. Standards of Practice for Licensed Practical Nurses in Canada;
        iii. CLPNA Practice Policy: Professional Responsibility & Accountability;
        iv. CLPNA Practice Policy: Documentation;
        v. CLPNA Practice Guideline: Medication Management;
        vi. CLPNA Competency Profile A1: Critical Thinking;
        vii. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
        viii. CLPNA Competency Profile A3: Time Management; and
        ix. CLPNA Competency Profile U: Medication Management.

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

b. Ms. Corpin shall complete, at her own cost, the following course: **NURS 0161: Medication Management** offered on-line at www.macewan.ca. Ms. Corpin shall provide the Complaints Consultant, with a certificate confirming successful completion of the course.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

c. Ms. Corpin shall complete the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Ms. Corpin shall provide the Complaints Consultant, with a certificate confirming successful completion of the course.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

4. Once Ms. Corpin has completed the requirements in paragraph #3 above, she will be eligible to apply for registration.

5. If, upon receiving her application for registration, the Registrar determines that Ms. Corpin meets the CLPNA's requirements for registration, Ms. Corpin's practice permit shall be subject to a condition that she engage in supervised practice for a period of 150 hours. During the period of supervised practice, she may practice under indirect supervision, except that medication administration must be under direct supervision, subject to the following:

   a. She must provide any person supervising ("Evaluator") her with a copy of the Medication Administration Competency Skills Evaluation Tool;

   b. Following the completion of 150 hours of supervised practice, she must be deemed knowledgeable and/or competent by the Evaluator in every competency listed in the Medication Administration Competency Skills Evaluation Tool;

   c. Following the completion of 150 hours of supervised practice, she must provide to the Complaints Consultant a completed copy of the Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

6. If, following the completion of 150 hours of supervised medication administration practice, the Evaluator is unable to indicate that Ms. Corpin is deemed knowledgeable or competent as set out above at paragraph 5(b):

a. the condition requiring Ms. Corpin to practice under supervision will remain on Ms. Corpin's practice permit for an additional 150 hours;

b. During the additional 150 hours of supervised practice Ms. Corpin may practice under indirect supervision except that medication administration must be performed under direct supervision; and

c. Following the completion of the additional 150 hours of supervised practice, she must provide proof to the Complaints Consultant that she has successfully completed a second Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

7. In the event that the Evaluator does not deem Ms. Corpin knowledgeable and/or competent in every competency listed in the Medication Administration Competency Skills Evaluation Tool following the additional 150 hours of supervised practice, the matter may be remitted to the Hearing Tribunal for further consideration.

8. The orders set out above at paragraphs 3-6 will appear as conditions on Ms. Corpin's practice permit and the Public Registry subject to the following:

   a. The requirement to complete the remedial activities outlined at paragraph 3 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Corpin's practice permit and the Public Registry until the below orders have been satisfactorily completed;

      i. Read and review CLPNA documents;

      ii. NURS 0161 Medication Management;

      iii. Nursing Documentation 101;

   b. The requirement to practice subject to supervision will continue to appear on Ms. Corpin'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 paragraphs 5-7; and

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

9. The conditions on Ms. Corpin's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraphs 2-6.

10. Ms. Corpin shall provide the CLPNA with her current contact information, including her home mailing address, home and cellular telephone numbers, current e-mail address and

her current employment information. Ms. Corpin will keep her contact information current with the CLPNA on an ongoing basis.

11. Should Ms. Corpin 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 Director.

12. Should Ms. Corpin 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 Director 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. Corpin's 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. Corpin's 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.

13. The parties agree that the Agreed Statement of Facts and Acknowledgement may be signed in any number of counterparts, which taken together shall constitute one and the same Agreement. This Agreement may be delivered by original, facsimile, or by email in portable document format (PDF) and shall be deemed to be an original.

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. Corpin 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. Corpin 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; and
12. The range of sentence in other similar cases.

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

- **The nature and gravity of the proven allegations**: The Hearing Tribunal found that the majority of the allegations were of moderate severity; however, there were multiple medication errors, including several incidents that included narcotics, which we deemed to be more serious. There were also multiple documentation errors. The Hearing Tribunal found due to the significant number of allegations, over a period of time as opposed to one incident, that were proven to be unprofessional conduct cumulatively were concerning.

- **The age and experience of the investigated member:** Ms. Corpin has been an LPN since August 2016. She had been employed by Extendicare as a Health Care Aide ("HCA") initially in January 2014, and in January 2018 she transitioned roles and was hired by Extendicare as an LPN. Ms. Corpin had been in her role as an LPN at Extendicare for almost a year prior to the earliest proven allegations in this Hearing occurred.

- **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** The Hearing Tribunal was provided with previous written "Letters of Expectation" regarding medication administration errors. One dated July 4, 2018 regarding an incident on July 3, 2018 and the other dated February 7, 2019 regarding several medication administration errors between December 16, 2018 and January 1, 2019. These demonstrate that even prior to these Allegations, Ms. Corpin was having medication administration errors.

- **The age and mental condition of the victim:** The Hearing Tribunal was not given specifics about the age or mental conditions of the victims.

- **The number of times the offending conduct was proven to have occurred: There were numerous incidents that the conduct was proven.** There were multiple medication errors and documentation errors proven to be unprofessional conduct, demonstrated by the multiple charges (and sub-charges) set out in the Allegations. Also, these Allegations occurred between December 31, 2018 and April 5, 2019 (about 4 months), demonstrating a consistent pattern over those months of multiple medication errors. This suggests this was not a one-off occurrence but rather a pattern of misconduct on the part of Ms. Corpin.

- **The role of the investigated member in acknowledging what occurred:** The Hearing Tribunal acknowledges and appreciates Mr. Corpin's cooperation throughout the investigation. This includes assisting in the Agreed Statement of Facts as well as the Joint Submission on Penalty.

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Ms. Corpin had an interim condition placed on her practice permit by Ms. Bateman on May 24, 2019 restricting her from medication preparation and administration unless she had direct supervision**.**

- **The impact of the incident(s) on the victim:** The Hearing Tribunal was not made aware of the impact Ms. Corpin's actions had on the clients involved.

- **The presence or absence of any mitigating circumstances:** Ms. Corpin was cooperative throughout the investigation and took ownership of her errors.

- **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** Specific deterrence is required to ensure Ms. Corpin does not repeat the same conduct in the future. The Hearing Tribunal believes that the proposed sanction achieves specific deterrence, as they serve as a reprimand, require the payment of costs, and require Ms. Corpin to complete a number of

educational courses to ensure she knows the errors of her ways and can correct them. General deterrence is required to ensure other members of the CLPNA do not engage in this type of conduct. By including a significant amount of requirements for additional training and education and by the comprehensive nature of the proposed sanction, it is clear that members of the CLPNA will know that this conduct will not be tolerated by CLPNA.

- **The need to maintain the public's confidence in the integrity of the profession:** The CLPNA ensures they deal with any breaches of the CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct. By doing this they ensure they not only protect the public but maintain the public's confidence in the integrity of the profession.

- **The range of sentence in other similar cases:** The Hearing Tribunal was advised that the sentence in this case is similar to the range of sentences in other similar cases.

It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and the CLPNA 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. Corpin shall pay 25% of the costs of the investigation and hearing to be paid over a period of **<u>36 months</u>** from service of letter advising of final costs.
    a. A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Corpin will not be eligible to apply for registration until she has complied with the following:

    a. Ms. Corpin shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Corpin shall provide a signed written declaration to Susan Blatz, Complaints Consultant, attesting she has reviewed CLPNA's documents:

        i. Code of Ethics for Licensed Practical Nurses in Canada;
        ii. Standards of Practice for Licensed Practical Nurses in Canada;
        iii. CLPNA Practice Policy: Professional Responsibility & Accountability;
        iv. CLPNA Practice Policy: Documentation;
        v. CLPNA Practice Guideline: Medication Management;
        vi. CLPNA Competency Profile A1: Critical Thinking;
        vii. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
        viii. CLPNA Competency Profile A3: Time Management; and
        ix. CLPNA Competency Profile U: Medication Management.

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

    b. Ms. Corpin shall complete, at her own cost, the following course: **NURS 0161: Medication Management** offered on-line at www.macewan.ca. Ms. Corpin shall provide the Complaints Consultant, with a certificate confirming successful completion of the course.

        If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

    c. Ms. Corpin shall complete the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Ms. Corpin shall provide the Complaints Consultant, with a certificate confirming successful completion of the course.

        If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

4. Once Ms. Corpin has completed the requirements in paragraph #3 above, she will be eligible to apply for registration.

5. If, upon receiving her application for registration, the Registrar determines that Ms. Corpin meets the CLPNA's requirements for registration, Ms. Corpin's practice permit shall be subject to a condition that she engage in supervised practice for a period of 150 hours. During the period of supervised practice, she may practice under indirect supervision, except that medication administration must be under direct supervision, subject to the following:

    a. She must provide any person supervising ("Evaluator") her with a copy of the Medication Administration Competency Skills Evaluation Tool;

    b. Following the completion of 150 hours of supervised practice, she must be deemed knowledgeable and/or competent by the Evaluator in every competency listed in the Medication Administration Competency Skills Evaluation Tool;

    c. Following the completion of 150 hours of supervised practice, she must provide to the Complaints Consultant a completed copy of the Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

6. If, following the completion of 150 hours of supervised medication administration practice, the Evaluator is unable to indicate that Ms. Corpin is deemed knowledgeable or competent as set out above at paragraph 5(b):

    a. the condition requiring Ms. Corpin to practice under supervision will remain on Ms. Corpin's practice permit for an additional 150 hours;

    b. During the additional 150 hours of supervised practice Ms. Corpin may practice under indirect supervision except that medication administration must be performed under direct supervision; and

    c. Following the completion of the additional 150 hours of supervised practice, she must provide proof to the Complaints Consultant that she has successfully completed a second Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

7. In the event that the Evaluator does not deem Ms. Corpin knowledgeable and/or competent in every competency listed in the Medication Administration Competency Skills Evaluation Tool following the additional 150 hours of supervised practice, the matter may be remitted to the Hearing Tribunal for further consideration.

8. The orders set out above at paragraphs 3-6 will appear as conditions on Ms. Corpin's practice permit and the Public Registry subject to the following:

a. The requirement to complete the remedial activities outlined at paragraph 3 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Corpin's practice permit and the Public Registry until the below orders have been satisfactorily completed;

    i. Read and review CLPNA documents;

    ii. NURS 0161 Medication Management;

    iii. Nursing Documentation 101;

b. The requirement to practice subject to supervision will continue to appear on Ms. Corpin'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 paragraphs 5-7; and

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

9. The conditions on Ms. Corpin's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraphs 2-6.

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

11. Should Ms. Corpin 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 Director.

12. Should Ms. Corpin 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 Director 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. Corpin's 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. Corpin's 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.

13. The parties agree that the Agreed Statement of Facts and Acknowledgement may be signed in any number of counterparts, which taken together shall constitute one and the same Agreement. This Agreement may be delivered by original, facsimile, or by email in portable document format (PDF) and shall be deemed to be an original.

The Hearing Tribunal believes these orders adequately balance 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 2ND DAY OF NOVEMBER 2020 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

M. Stolz LPN

Michelle Stolz
Chair, Hearing Tribunal