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 EDWARD NDE

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 EDWARD NDE, LPN #30809, 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 on October 28, 2020 with the following individuals present:

Hearing Tribunal:
Marg Hayne, Public Member, Chairperson
Noreen Mills, Licensed Practical Nurse ("LPN")
Verna Ruskowsky, LPN

Staff:
Ayla Akgungor, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Edward Nde, LPN ("Mr. Nde 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

Mr. Nde was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Mr. Nde was initially licensed as an LPN in Alberta on January 1, 2008.

On January 24, 2020, the College of Licensed Practical Nurses of Alberta ("CLPNA") received a complaint from Marie Rusk, Director of Care at Extendicare – Michener Hill in Red Deer, Alberta (the "Complaint"). The Complaint, made pursuant to s. 57 of the Act, indicated that Mr. Nde, LPN made errors related to medication administration, failed to follow up on resident condition, failed to follow wound care protocols and engaged in unprofessional conduct in requesting that a staff member not complete an incident report. Mr. Nde received a two-day suspension from his employment at Extendicare – Michener Hill as a result of these errors.

Ms. Sandy Davis, Complaints Director for the CLPNA, appointed Ms. Katie Emter to investigate the Complaint.

Mr. Nde received notice of the Complaint and the investigation by letter dated January 29, 2020.

On April 13, 2020, Ms. Emter concluded the investigation and submitted the Investigation Report to the CLPNA.

Ms. Davis 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.

On review of 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. Mr. Nde 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 June 24, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Mr. Nde under cover of letter dated September 14, 2020.

(4) Allegations

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

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

1. On or about October 31, 2019 failed to administer Advair 250/50 mcg, Inspiolto Respimat 2.5 mg, Perindopril Erbumine 8 mg, Quetiapine 12.5 mg and Vitamin B12 1000 mcg to client JS at 0800 hours but documented on the Medication Administration Record as having administered the medications at 0800 hours.

2. On or about November 2, 2019 failed to administer Metonia 10 mg to client DW at 1200 hours but documented on the Medication Administration Record as having administered the Metonia 10 mg at 1200 hours.

3. On or about November 14 and/or 15, 2019 did one or more of the following:
    a) Failed to administer Calcium 500 mg at 1200 hours to client EN but documented on the Medication Administration Record as having administered the Calcium 500 mg at 1200 hours;
    b) Asked Geneviene Matagay, LPN not to complete an incident report for the failure to administer Calcium 500 mg to client EN at 1200 hours.

4. On or about November 23 and November 24, 2019 failed to compare the label on resident DC's eye ointment cream to the Medication Administration Record and thus incorrectly administered Muro 128 eye ointment at 0800 hours and 1200 hours instead of the ordered Muro 128 eye drops.

5. On or about November 25, 2019 did one or more of the following with regard to client LJ's low blood glucose level of 3.6 at 0900 hours:
    a) Failed to reassess LJ's blood glucose level during his shift;
    b) Failed to assess and/or document an assessment of LJ after obtaining the low blood glucose level of 3.6.

6. On or about December 24, 2019 during a Medication Pass Audit failed to do one or more of the following:
    a) Wash hands between residents after more than casual contact;
    b) Use two resident identifiers;
    c) Maintain privacy of Medication Administration Record when unattended.

7. On or about January 2, 2020 during a Medication Pass Audit failed to do one or more of the following:
    a) Wash hands between residents after more than casual contact;
    b) Use two resident identifiers;
    c) Measure liquid medication accurately;
    d) Check expiry dates of medications.

8. On or about January 21, 2020 during a Medication Pass Audit failed to do one or more of the following:
    a) Wash hands between residents after more than casual contact;

b) Maintain privacy of Medication Administration Record when unattended.

9. On or about January 29, 2020 during a Medication Pass Audit failed to do one or more of the following:
    a) Wash hands between residents after more than casual contact;
    b) Use two resident identifiers;
    c) Ensure right dose administered;
    d) Ensure ingestion of medication;
    e) Prepare medication at time of administration (pre-poured).

10. On or about February 3, 2020 left the medication cart unsecured and unattended.

11. On or about February 6, 2020 during a Medication Pass Audit failed to do one or more of the following:
    a) Wash hands between residents after more than casual contact;
    b) Perform Medication Administration right "right medication;"
    c) Check expiry dates of medication;
    d) Ensure documentation has been completed after medication administration."

(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.

Mr. Nde acknowledged unprofessional conduct to all the allegations as evidenced by his 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 Mr. Nde'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 Mr. Nde.

Allegation 1

Mr. Nde admitted that on or about October 31, 2019, he failed to administer Advair 250/50 mcg, Inspiolto Respimat 2.5 mg, Perindopril Erbumine 8 mg, Quetiapine 12.5 mg and Vitamin B12 1000 mcg to client JS at 0800 hours but documented on the Medication Administration Record as having administered the medications at 0800 hours.

On October 31, 2019, Mr. Nde worked a shift at Extendicare. During this shift, he provided care to client JS.

At 0800 hours, Mr. Nde failed to administer the following medications to client JS: Advair 250/50 mcg, Inspiolto Respimat 2.5 mg, Perindopril Erbumine 8 mg, Quetiapine 12.5 mg and Vitamin B12

1000 mcg. The unopened medication packet was found by Ms. Geneviene Matagay, an LPN working the evening shift.

Mr. Nde signed the Medication Administration Record ("MAR") for client JS indicating that he had administered these medications.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Medication administration and medication management are integral to the work of an LPN. Not only did Mr. Nde fail to provide medication to a client under his care but then falsely indicated in the MAR that he had done this. Thus, not only did the client not receive necessary medications but the MAR did not reflect this reality and introduced risk into the client's care. Thus, Mr. Nde displayed a lack of skill and knowledge in his practice by failing to practice in accordance with skills which are central to an LPN's practice.

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

CLPNA Code of Ethics:

Mr. Nde further acknowledges that his conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

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 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.

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:

- 2.4 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.

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; and

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

d. 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:

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:

    - 1.6. 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.

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:

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

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;

    - 3.4 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.

d. 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.

This conduct has breached the Code and the Standards because Mr. Nde did not maintain the high standards of his profession or provide care that was in furtherance of the safety and well-being of a client under his care. He did not act to minimize risk to this client. By signing off on the MAR that medication had been administered when this was not true, Mr. Nde was not acting with integrity or in a manner reflective of the privilege of self-regulation. It also had the impact of leaving an incorrect record for all those who would rely on the record in the future in order to make decisions about that client's care. These are all factors in this conduct which leads the Hearing Tribunal to conclude Mr. Nde breached the Code and the Standards.

<u>Allegation 2</u>

Mr. Nde admitted that on or about November 2, 2019, he failed to administer Metonia 10 mg to client DW at 1200 hours but documented on the Medication Administration Record as having administered the Metonia 10 mg at 1200 hours.

On November 2, 2019, Mr. Nde a shift at Extendicare. In the course of this shift, Mr. Nde provided care to client DW.

At 1200 hours, Mr. Nde failed to administer Metonia 10 mg to client DW. The unopened medication packet was found by Ms. Matagay on the evening shift.

Mr. Nde signed the MAR for client DW indicating that he had administered this medication.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

As described with regard to Allegation #1, not only did Mr. Nde put a client at risk by failing to administer medication, but he compounded that risk and acted without integrity by signing the MAR indicating the medication had been administered. In this way he demonstrated a lack of skill and a lack of judgment.

Mr. Nde's conduct in regard of this allegation also breached the Code and Standards for the same reasons articulated in the Allegation# 1.

<u>Allegation 3</u>

Mr. Nde admitted that on or about November 14 and/or 15, 2019, he did one or more of the following:

a) Failed to administer Calcium 500 mg at 1200 hours to client EN but documented on the Medication Administration Record as having administered the Calcium 500 mg at 1200 hours;

b) Asked Geneviene Matagay, LPN not to complete an incident report for the failure to administer Calcium 500 mg to client EN at 1200 hours.

On November 14 and/or 15, 2019 Mr. Nde worked a shift at Extendicare. During these shifts Mr. Nde provided care to client EN.

At 1200 hours on November 14, 2019, Mr. Nde failed to administer Calcium 500mg to client EN. The unopened medication packet was found by Ms. Matagay on the evening shift.

Mr. Nde signed the MAR for client EN indicating that he had administered this medication.

On November 14 or 15, 2019, Mr. Nde asked Ms. Matagay, who had discovered the medication administration error, not to complete an incident report as he was concerned about already having committed previous similar errors.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

As with Allegations #1 and #2, Mr. Nde demonstrated a lack of judgment and skill in regard of his failure to administer medications but signed off that he had done this. The conduct in Allegation #3 is further compounded by the effort of Mr. Nde to dissuade his colleague from reporting this incident in light of his prior failures.

Mr. Nde's conduct in regard of this allegation also breached the Code and Standards for the same reasons articulated in the Allegation #1 and adopted in Allegation #2.

Allegation 4

Mr. Nde admitted that on or about November 23 and November 24, 2019, he failed to compare the label on resident DC's eye ointment cream to the Medication Administration Record and thus incorrectly administered Muro 128 eye ointment at 0800 hours and 1200 hours instead of the ordered Muro 128 eye drops.

On November 23 and/or November 24, 2019, Mr. Nde worked a shift at Extendicare. During these shifts Mr. Nde provided care to client DC.

At 0800 hours and 1200 hours on these days, Mr. Nde failed to compare the label on client DC's eye ointment cream to the MAR and as a result incorrectly administered Muro 128 eye ointment instead of Muro 128 eye drops.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

A particular form of medication is ordered over another because it would be expected to address a health concern in a more effective manner. By failing to ensure he administered the correct form of medication, Mr. Nde demonstrated a lack of care in his work and introduced risk into the

client's health outcomes. LPNs are expected to take care in administering medication and meet the "Rights" of medication administration. For these reasons, Mr. Nde displayed a lack of skill and judgment in administering medication and in engaging in his practice.

Mr. Nde's conduct in regard of this allegation also breached the Code and Standards for the same reasons articulated in the Allegation #1 and adopted in Allegations #2 and #3.

Allegation 5

Mr. Nde admitted that on or about November 25, 2019, he did one or more of the following with regard to client LJ's low blood glucose level of 3.6 at 0900 hours:

a) Failed to reassess LJ's blood glucose level during his shift;

b) Failed to assess and/or document an assessment of LJ after obtaining the low blood glucose level of 3.6.

On November 25, 2019 Mr. Nde worked a shift at Extendicare. During this shift Mr. Nde provided care to client LJ.

At 0900 hours, Mr. Nde tested client LJ's blood glucose level and it measured 3.6. Despite this low blood glucose level, Mr. Nde conducted no subsequent blood glucose tests on client LJ during this shift.

During this shift, Mr. Nde also failed to conduct an assessment, and/or document an assessment, of client LJ.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Neglecting to follow a test revealing a client's low blood glucose put that client at risk which was compounded by the failure to perform any assessment of that client. Low blood glucose can have serious consequences and must be monitored with care in order that appropriate steps might be taken to respond to low blood glucose. Mr. Nde did not follow these important steps and so demonstrated a lack of knowledge, skill, and judgment in his practice. Placing a client at risk is conduct opposed to the purposes of LPNs as a regulated profession.

Mr. Nde did not monitor nor did he assess a client under his care as one would have expected. This conduct resulted in the breach of multiple aspects of the Code and the Standards for reasons similar to those already discussed with regard to the prior allegations. It is a serious thing not to assess clients and not to follow up after determining a client is experiencing low blood glucose.

Low blood glucose levels can rapidly become critical; careful monitoring and treatment at an early stage is very important to protect the health of the client. Rather than avoiding harm for his client, Mr. Nde placed the client in harm's way. Rather than reducing risk to the client, Mr. Nde introduced risk for the client. This is not in keeping with the obligations of a regulated professional, does not reflect the privilege of self regulation, and does not accord with the standards of service to others or with safe and ethical practice.

Allegation 6

Mr. Nde admitted that on or about December 24, 2019, during a Medication Pass Audit, he failed to do one or more of the following:

a) Wash hands between residents after more than casual contact;

b) Use two resident identifiers;

c) Maintain privacy of Medication Administration Record when unattended.

On December 24, 2019, Mr. Nde worked a shift at Extendicare on DAL Units 3500/3600.

On December 24, 2019, Ms. Fife-Zayak, LPN, conducted an audit on DAL Units 3500/3600.

During the audit, Mr. Nde failed to wash his hands between clients after more than casual contact; failed to use two client identifiers when administering medication and failed to close the MAR when he left the medication cart.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Hand washing is a simple act which can have profound impacts on the health of a client. There can be no doubt that failing to follow proper hand washing procedures can spread pathogens. It is also important to use more than one checkpoint to ensure medication is being given to the correct client. What can be life saving for one client can cause significant and long-term harm or even death to another. Finally, leaving a client's health care information open for all to see is a failure to safeguard that client's privacy as they are entitled to expect and as an LPN is required to do under the *Health Information Act*. In all of these ways, Mr. Nde demonstrated a lack of skill, knowledge and judgment in carrying out his functions as a regulated professional.

This conduct also breached the Code and Standards. Again, where a regulated professional's behaviours introduce risk to clients under their care, they necessarily undermine the values of safety, risk reduction, contributing to positive health outcomes, and applying the skills and knowledge of their profession. As such, Mr. Nde's conduct also breached the Code and the

Standards because it is largely opposed to the trust placed in an LPN as a health professional and shows a disregard for the responsibility of being a regulated health professional.

Allegation 7

Mr. Nde admitted that on or about January 2, 2020, during a Medication Pass Audit, he failed to do one or more of the following:

a) Wash hands between residents after more than casual contact;

b) Use two resident identifiers;

c) Measure liquid medication accurately;

d) Check expiry dates of medications.

On January 2, 2020, Mr. Nde worked a shift at Extendicare on LTC Units 3500/3600.

On January 2, 2020, Ms. Fife-Zayak, LPN, conducted an audit on LTC Units 3500/3600.

During the audit, Mr. Nde failed to wash his hands between clients after more than casual contact; failed to use two client identifiers when administering medication, failed to measure liquid medication according to protocol and failed to check the expiry dates of medication.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Again, for many of the same reasons discussed in relation to Allegation #6, Mr. Nde put clients at risk by not washing his hands, failing to ensure medication is being administered to the correct client and by not dealing with the medications as he was required to do. Again, where a health professional acts in a manner which causes unnecessary risk to their client they have acted in a manner which displays a lack of knowledge, skill and judgment. As noted above, medication administration is a core competency for an LPN and, where they fail to demonstrate that competency, they have acted in a manner which demonstrates a lack of skill and judgment.

The Code and Standards were also breached by this conduct for substantially the same reasons articulated with regard to the prior Allegations.

Allegation 8

Mr. Nde admitted that on or about January 21, 2020, during a Medication Pass Audit, he failed to do one or more of the following:

a) Wash hands between residents after more than casual contact;

b) Maintain privacy of Medication Administration Record when unattended.

On January 21, 2020, Mr. Nde worked a shift at Extendicare. At 0800 hours, Ms. Briana Gaudry, LPN, conducted a Medication Pass Audit on Mr. Nde.

During this audit, Mr. Nde failed to wash hands between clients after more than casual contact and failed to close the MAR when he walked away from the medication cart.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

As with Allegation #6, Mr. Nde's behaviour introduced risk to his clients. Handwashing is an important aspect of infection prevention and it is a simple act which can have significant consequences --- positive or negative. It is hard to overstate the importance of a patient's privacy. Failing to safeguard a patient's health information is very serious. The conduct in this allegation demonstrates a failure to apply the skill and judgment of an LPN.

For the reasons outlined in relation to the Allegations previously discussed, this conduct also breaches the Code and the Standards of Practice.

Allegation 9

Mr. Nde admitted that on or about January 29, 2020, during a Medication Pass Audit, he failed to do one or more of the following:

a) Wash hands between residents after more than casual contact;

b) Use two resident identifiers;

c) Ensure right dose administered;

d) Ensure ingestion of medication;

e) Prepare medication at time of administration (pre-poured).

On January 29, 2020, Mr. Nde worked a shift at Extendicare. At 1125 hours, Ms. Ramona Kowch, RN, conducted a Medication Pass Audit on Mr. Nde.

During the audit, Mr. Nde failed to wash hands between clients after more than casual contact and failed to use two client identifiers when administering medication.

During the audit, Mr. Nde prepared medications, mixed them with pudding and administered the pudding to the resident. When the resident was noticeably challenged with swallowing, Mr. Nde returned to the med cart and poured the medication again as he was not sure if he had administered the medication.

During the audit, Mr. Nde left a resident's Resource at her bedside and did not ensure that she had consumed it.

Also during the audit, Mr. Nde pre-poured a narcotic and placed it in the resident's box and then left the area to get pudding.

A copy of the audit conducted by Ms. Kowch is attached at TAB 20 of Exhibit #2.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Once again, Mr. Nde did not follow proper hand washing protocols which is problematic for reasons previously discussed. He neglected the "Rights" of medication administration and did not safeguard medications which he had dispensed for administration including a narcotic. Again, this conduct fails to meet the basic competency requirements of an LPN in relation to infection prevention and medication administration which are both integral to the profession. In this way, Mr. Nde did not display the appropriate skill, knowledge and judgment expected of an LPN.

The conduct in regard of Allegation #9 also breached the Code and the Standards for the reasons previously discussed in relation to the Allegations above.

<u>Allegation 10</u>

Mr. Nde admitted that on or about February 3, 2020, he left the medication cart unsecured and unattended.

On February 3, 2020, Mr. Nde worked a shift at Extendicare. On this day Ms. Jennifer Goodman, RN and OH&S Coordinator, conducted an OH&S inspection.

When Ms. Goodman arrived to conduct the inspection, Mr. Nde was in a resident's room and the medication cart was unattended in the hallway.

The MAR was visible and open on the top of the cart. The drawer containing medication was not locked. Ms. Goodman waited by the cart for two or three minutes for Mr. Nde to return. On his

return to the cart, Ms. Goodman confirmed with Mr. Nde that the lock on the medication cart was working.

Ms. Goodman's email to management about this incident is attached at TAB 21 of Exhibit #2.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Medications can have significant impacts when taken improperly or in incorrect doses. Moreover, many medications are addictive in nature and can lead to dependencies. Locking medication away ensures it is secured from theft or from tampering or misplacement. A MAR contains detailed health information about a client which must be safeguarded in order to ensure that client's privacy. Leaving the medication cart unlocked and unattended left both the medications and the private health information exposed. As a result, Mr. Nde demonstrate a lack of judgment in leaving this medication unsecured and a lack of skill in administering medications improperly.

Mr. Nde's conduct also breached the Code and Standards for substantially the same reasons discussed with regard to the prior Allegations.

Allegation 11

Mr. Nde admitted that on or about February 6, 2020, during a Medication Pass Audit, he failed to do one or more of the following:

a) Wash hands between residents after more than casual contact;

b) Perform Medication Administration right "right medication";

c) Check expiry dates of medication;

d) Ensure documentation has been completed after medication administration.

On February 6, 2020, Mr. Nde worked a shift at Extendicare. At 1400 hours, Ms. Briana Gaudry, LPN, conducted a Medication Pass Audit on Mr. Nde.

During the Medication Pass Audit, Mr. Nde failed to wash hands between clients after more than casual contact, failed to cross-check medication labels against the client's MAR; and failed to check expiry dates for insulin.

Ms. Gaudry was observing Mr. Nde administer medications around 11:30 a.m. At that point, Mr. Nde had not yet signed off on the administration of his 0800 hour medications.

A copy of the audit conducted by Ms. Gaudry is attached at TAB 22 of Exhibit #2.

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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

For the reasons stated previously, proper hand washing is an important piece of providing health care as it can prevent the spread of infection. An LPN who does not engage in appropriate hand washing techniques is introducing risk to the clients under their care and in doing so displaying a lack of judgment in the course of their practice. Again, medication administration must be done with care and in accordance with the principles of medication administration. Failing to do so, as Mr. Nde did, demonstrates a lack of skill and judgment in one's practice.

Finally, this conduct also breached the Code and Standards of Practice for the same reasons as have already been discussed with regard to the previous Allegations.

(9) Joint Submission on Penalty

The Complaints Consultant and Mr. Nde 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. Mr. Nde shall pay 25% of the costs of the investigation and hearing to be paid over a period of 48 months from service of letter advising of final costs. A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Mr. Nde shall read and reflect on how the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Mr. Nde shall provide the Complaints Consultant with a signed written declaration within **60 days** of service of the Decision, attesting that he has reviewed the following CLPNA documents:

   (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 Competency Profile A1: Critical Thinking;

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

(f) CLPNA Competency Profile B1: Assessment;

(g) CLPNA Competency Profile B3: Planning;

(h) CLPNA Competency Profile C4: Professional Ethics;

(i) CLPNA Competency Profile D3: Legal Protocols, Documenting and Reporting;

(j) CLPNA Competency Profile F2: Infection Prevention and Control; and

(k) CLPNA Competency Profile U2: Medication Preparation and Administration.

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

4. Mr. Nde shall, complete the following nursing quizzes located on website http://www.learningnurse.org/. Mr. Nde shall provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within **60 days** of service of the Decision:

a) 8.1 Health Assessment; and

b) 16.1 Nursing Ethics.

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

5. Mr. Nde shall complete, at his own cost, the following course: **NURS 0161 Medication Management** offered on-line at www.macewan.ca. Mr. Nde shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **nine (9) months** of service of the Decision.

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

6. Mr. Nde shall complete, at his own cost, the following course: **Patient Privacy** offered on-line at www.ncsbn.org. Mr. Nde shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **90 days** of service of the Decision.

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

7. Mr. Nde shall complete, at his own cost, the following course: **Hand Hygiene** offered on-line www.coursepark.com. Mr. Nde shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **90 days** of service of the Decision.

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

8. The orders set out above at paragraphs 2-7 will appear as conditions on Mr. Nde's practice permit and the Public Registry subject to the following:

   (a) The requirement to complete the remedial activities outlined at paragraphs 2-7 will appear as "CLPNA Monitoring Orders (Conduct)", on Mr. Nde's practice permit and the Public Registry until the below orders have been satisfactorily completed;

      i. Read and Review of CLPNA documents;

      ii. 8.1 Health Assessment;

      iii. 16.1 Nursing Ethics;

      iv. NURS 0161 Medication Management;

      v. Patient Privacy; and

      vi. Hand Hygiene.

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

9. The conditions on Mr. Nde's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraph 8.

10. Mr. Nde shall provide the CLPNA with his contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current

employment information. Mr. Nde will keep his contact information current with the CLPNA on an ongoing basis.

11. Should Mr. Nde 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.

12. Should Mr. Nde 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 Mr. Nde'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 Mr. Nde'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.

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 Mr. Nde 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 Mr. Nde 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:

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

1. **The nature and gravity of the proven allegations:** These are serious allegations with the potential of introducing significant risk to clients.

2. **The age and experience of the investigated member:** Mr. Nde has been registered with the CLPNA since 2008 and as such, he is neither a novice nor a senior LPN. In any event, the age and experience are considered to have limited impact where the conduct in question relates to some of the most basic aspects of an LPN's work: hand washing, safeguarding privacy, and appropriate medication administration.

3. **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** The Hearing Tribunal was advised there were no previous complaints.

4. **The age and mental condition of the victim, if any**: The Hearing Tribunal did not receive information with regard to the age or mental condition of any of the clients impacted by the conduct in question.

5. **The number of times the offending conduct was proven to have occurred:** Mr. Nde repeated the same errors over and over again. As previously noted, the issues with his conduct relates to basic skills for an LPN – this is conduct which should not have occurred at all, let alone multiple times over.

6. **The role of the investigated member in acknowledging what occurred:** Mr. Nde acknowledged his conduct.

7. **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Mr. Nde experienced a brief suspension of his employment which is not considered to be serious.

8. **The impact of the incident(s) on the victim, and/or:** The Hearing Tribunal was not made aware of any impacts on any of the clients in question.

9. **The presence or absence of any mitigating circumstances:** There were no mitigating circumstances of note.

10. **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** Where unprofessional conduct arises from such basic aspects of practice, it must be clear to Mr. Nde that such conduct cannot occur again. It must also be clear to other LPNs they must take care to avoid similar allegations – or worse, harm to a client.

11. **The need to maintain the public's confidence in the integrity of the profession:** The public must feel assured that where there are issues with an LPN's conduct, it will be addressed quickly and appropriately. Sanctions must address the conduct but also place the LPN in a position so as to avoid further issues in the future.

12. **The range of sentence in other similar cases:** The Hearing Tribunal was not made aware of the range of sentences in any other 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) Orders of the Hearing Tribunal

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. Mr. Nde shall pay 25% of the costs of the investigation and hearing to be paid over a period of 48 months from service of letter advising of final costs. A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Mr. Nde shall read and reflect on how the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Mr. Nde shall provide the Complaints Consultant with a signed written declaration within **60 days** of service of the Decision, attesting that he has reviewed the following CLPNA documents:

    (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 Competency Profile A1: Critical Thinking;

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

    (f) CLPNA Competency Profile B1: Assessment;

    (g) CLPNA Competency Profile B3: Planning;

    (h) CLPNA Competency Profile C4: Professional Ethics;

    (i) CLPNA Competency Profile D3: Legal Protocols, Documenting and Reporting;

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    (k) CLPNA Competency Profile U2: Medication Preparation and Administration.

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

4. Mr. Nde shall, complete the following nursing quizzes located on website http://www.learningnurse.org/. Mr. Nde shall provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within **60 days** of service of the Decision:

   a) 8.1 Health Assessment; and

   b) 16.1 Nursing Ethics.

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

5. Mr. Nde shall complete, at his own cost, the following course: **NURS 0161 Medication Management** offered on-line at www.macewan.ca. Mr. Nde shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **nine (9) months** of service of the Decision.

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

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   (a) The requirement to complete the remedial activities outlined at paragraphs 2-7 will appear as "CLPNA Monitoring Orders (Conduct)", on Mr. Nde's practice permit and the Public Registry until the below orders have been satisfactorily completed;

i. Read and Review of CLPNA documents;

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iv. NURS 0161 Medication Management;

v. Patient Privacy; and

vi. Hand Hygiene.

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

9. The conditions on Mr. Nde's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraph 8.

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

11. Should Mr. Nde 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.

12. Should Mr. Nde 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:

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

(e) Treat Mr. Nde's non-compliance as information for a complaint under s. 56 of the Act; or

(f) In the case of non-payment of the costs described in paragraph 2 above, suspend Mr. Nde'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.

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 1st DAY OF MARCH 2021 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Marg Hayne, Public Member
Chair, Hearing Tribunal