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 GREGORY FARTHING

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 GREGORY FARTHING, LPN #42606, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted at the offices of the College of Licensed Practical Nurses of Alberta ("CLPNA") in Edmonton, Alberta on August 21, 2019 with the following individuals present:

Hearing Tribunal:
Nancy Brook, Public Member and Chair
Christine Buck, Licensed Practical Nurse ("LPN")
Alan Naranin, LPN

Staff:
Jason Kully, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
Gregory Farthing, LPN ("Mr. Farthing" or "Investigated Member")

(2) Preliminary Matters

The hearing was open to the public.

Gregory Farthing was unable to attend in person and agreed to have the Hearing proceed in his absence indicating he would be available by phone should the Hearing Tribunal Panel have any questions.

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

Gregory Farthing 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. Gregory Farthing was initially licensed as an LPN in Alberta on July 11, 2016.

On December 14, 2017, the CLPNA received a letter dated November 24, 2017, from Carmen Peterson, Site Manager at The Good Samaritan Society, Park Meadows Village and Cottages ("Park Meadows") in Lethbridge, Alberta, pursuant to s. 57 of the Act. The letter was notification that Mr. Farthing, LPN, was terminated for his unprofessional conduct.

On December 14, 2017, Ms. Peterson, Site Manager, also provided the CLPNA with a letter dated September 18, 2017, which was notification of Mr. Farthing's suspension. This letter included a copy of a Disciplinary Memo, dated September 15, 2017, and a copy of a letter Mr. Farthing, LPN, received from Park Meadows, dated November 24, 2017.

By way of letter dated December 15, 2017, Sandy Davis, Complaints Director, notified Mr. Farthing the Complaint was received and that Philip Northrup, Investigator for the CLPNA (the "Investigator"), was appointed to conduct an investigation in accordance with s. 55(2)(d) of the Act.

By way of letter dated December 15, 2017, Sandy Davis, Complaints Director, notified Ms. Peterson, Site Manager, the complaint was received and Philip Northrup, Investigator for the CLPNA was appointed to conduct an investigation in accordance with s. 55(2)(d) of the Act.

On April 26, 2018, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to CLPNA.

Following the receipt of the Investigation Report, the Complaints Director determined there was sufficient evidence the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Mr. Farthing was notified the matter was referred to a hearing and was provided with a copy of the Investigation Report and the Statement of Allegations, via registered mail under cover of letter dated December 19, 2018.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Mr. Farthing under cover of letter dated January 22, 2019, via registered mail.

(4) Allegations

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

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

1. On or about August 24, 2017:
    a. Signed resident MK's Medication Administration Record as administering Eliquis 5 mg at 1700 hours as per Physician's order; however, failed to administer the medication; and

b. Placed resident MK at an increased risk of stroke, deep vein thrombosis, or pulmonary embolism by failing to administer Eliquis 5 mg.

2. On or about August 25, 2017 failed to administer Apo-Sulfatrim DS 800/160 mg to resident VR at 1700 hours as per Physician's order.

3. On or about August 25, 2017, placed resident PW at potential risk of harm by incorrectly transcribing the Physician's order for Amlodipine 5 mg as "hold if BP> 120/80" rather than "hold if <120/80".

4. On or about August 25, 2017, did one or more of the following :
   a. Failed to arrange medical transportation to the Chinook Regional Hospital for resident DE for a medical procedure, insertion of a new pacemaker;
   b. Failed to arrange for a volunteer to accompany resident DE to the Chinook Regional Hospital;
   c. Failed to assess resident DE upon return to facility; and
   d. Failed to transcribe new orders for resident DE in a timely manner.

5. On or about August 29, 2017, failed to administer Risperidone 0.25 mg at 1200 hour to resident SB as per Physician's order.

6. On or about September 7, 2017, did one or more of the following to JNP:
   a. Failed to administer Xarelto at 1700 hours as per Physician's order; and
   b. Failed to document NP refused the medication.

7. On or about September 12, 2017, did one or more of the following in regards to resident JK:
   a. Administered Morphine 0.2 ml (2 mg) instead of Morphine 0.25 ml (2.5 mg) as per Physician's order;
   b. Pre-poured Morphine contrary to accepted practice;
   c. Failed to label the syringe containing Morphine; and
   d. Failed to document the initiation of a subcutaneous line.

8. On or about October 18, 2017, did one or more of the following in regards to resident AT:
   a. Failed to administer Loperamide 2 mg following each loose bowel movement as per Physician's orders;
   b. Failed to document resident's bowel movements on the Bowel Elimination Summary; and
   c. Placed resident AT at risk of dehydration and electrolyte imbalance by failing to administer Loperamide.

9. On or about October 21, 2017, failed to retrieve the old subcutaneous set after determining resident WP "ripped sub Q Line" out placing both resident and staff at risk of harm.

10. On or about October 21, 2017 did the following in regards to resident WP:

    a. Initiated a subcutaneous line to left upper tricep with an 18G needle instead of the correct size set up; and

    b. Failed to remove the needle after the insertion of the subcutaneous line.

11. On or about November 3, 2017, incorrectly transcribed a Physician's order for Colchicine 0.6 mg for resident OS, by stating that a Health Care Aide was to administer the medication instead of a nurse.

12. On or about November 5, 2017 demonstrated a lack of leadership by inappropriately directing a Health Care Aide to obtain coffee for him and coworkers off site."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits a 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. Farthing pled guilty to all the Allegations as evidenced by his signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. This non-verbal admission of guilt was accepted by the Hearing Tribunal Panel.

Legal Counsel for the Complaints Director 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:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #2:	Statement of Allegations
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. Farthing'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. Farthing.

Allegation 1

Gregory Farthing admitted that on or about August 24, 2017, he:

a. **Signed resident MK's Medication Administration Record as administering Eliquis 5 mg at 1700 hours as per Physician's order; however, failed to administer the medication; and**

b. **Placed resident MK at an increased risk of stroke, deep vein thrombosis, or pulmonary embolism by failing to administer Eliquis 5 mg.**

On August 24, 2017, Mr. Farthing worked from 1500 to 2300 hours. During this time, Mr. Farthing provided care for Resident MK.

The Care Organizer and the Medication Administration Record ("MAR") indicated that Resident MK required Eliquis 5 mg twice daily at 0800 hours and 1700 hours (**in Exhibit #1**).

On August 24, 2017, Mr. Farthing charted that he had administered Eliquis 5mg to Resident MK at 1700 hours on Resident MK's MAR (**in Exhibit #1**)

On August 26, 2017 at approximately 1600 hours, Joanna Corey, LPN was preparing a medication, Warfarin, for one of her patients and during this process she found the pre-labeled package of Eliquis 5 mg for the 1700 hours medication for Resident MK in the Medical Administration Binder. Upon checking the MAR (**Exhibit #1**), it was determined the medication had not been administered but had been signed off.

The incident was reported by Ms. Corey as required on the Park Meadows Event Reporting System (ERS) in **Exhibit #2**.

It is important to note that Eliquis is considered a "high alert medication". This drug is an anticoagulant, used to lower the risk of stroke, and it blocks certain blood clotting substances which treat deep vein thrombosis or pulmonary embolisms. Without this medication, Resident MK was in serious risk of a potential blood clot.

Mr. Farthing inaccurately signed that he had administered Resident MK's Eliquis 5mg, despite failing to administer the medication and this omission put Resident MK at increased risk of stroke or deep vein thrombosis and/or pulmonary embolism.

Mr. Farthing's failure to administer a "high alert medication" such as Eliquis and then charting this medication as being given is a failure of basic nursing skills. In addition, this left the patient in serious risk of having a blood clot. This was clearly a lack of skill and judgement, as well as a breach of CLPNA's Code of Ethics ("Code of Ethics") and CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("Standards of Practice") as set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 2

Gregory Farthing admitted that on or about August 25, 2017, he failed to administer Apo-Sulfatrim DS 800/160 mg to resident VR at 1700 hours as per Physician's order.

On August 25, 2017, Mr. Farthing worked from 1500 to 2300 hours and during this time he provided care for 94 year-old Resident VR. Resident VR was prescribed one tablet of APO-Sulfatrin DS 800/160 mg on August 22, 2017 twice daily for 5 days. (**Exhibit #1**)

Mr. Farthing failed to administer the 1700 hours dose of APO-Sulfatrin DS 800/160 mg to Resident VR on August 25, 2017.

On August 26, 2017 at approximately 0800 hours, Kelcee Kleiner, LPN, was preparing to administer a dose of APO-Sulfatrin when she found a pre-packaged dose of APO-Sulfatrin DS 800/160 mg that was supposed to have been administered on August 25, 2017 at 1700 hours. After reviewing Resident VR's MAR, it was determined that the medication had not been administered or signed for (**Exhibit #1).** The APO-Sulfatrin DS 800/160 mg was still attached to the medication roll with the date of August 25, 2017, 1700 hours (**Exhibit #1**).

After confirming that Mr. Farthing had not administered the dose or documented such, Ms. Kleiner gave the next prescribed dose to Resident VR as ordered. Ms. Kleiner then reported the missed medication on the Event Report System (**Exhibit #1**). The missed dose was put in the "return to pharmacy" bin.

Proper administration of medication is a basic and fundamental nursing skill. Failure to exercise proper medications according to Doctor's orders and procedures can cause harm to a patient, and can interrupt a patient's continuity of care. Failing to administer medication according to a Physician's order is a clear lack of skill and knowledge, and it demonstrates poor judgment. It also constitutes a breach of the Code of Ethics and Standards of Practice as set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 3

Gregory Farthing admitted that on or about August 25, 2017, he placed resident PW at potential risk of harm by incorrectly transcribing the Physician's order for Amlodipine 5 mg as "hold if BP> 120/80" rather than "hold if <120/80".

On August 25, 2017, Mr. Farthing worked from 1500 to 2300 hours; during this time, Mr. Farthing provided care to Resident PW.

Resident PW was a new resident to Park Meadows and was processed by Mr. Farthing. Resident PW suffered from high blood pressure. The Care Organizer indicated that she required "Amlodipine 5 mg one tab by mouth once daily (hold if BP< (*less than*) 120/80)" (**Exhibit #1**).

On August 25, 2017 on or around 1949 hours, when documenting the admission of Resident PW, he transcribed the medication, "Amlodipine 5 mg QD @0800 **Hold if BP greater than 120/80" (**Exhibit #1**).

On the morning of August 26, 2017, Ms. Kleiner, LPN, was in Cottage 7, a dementia care cottage, completing her 0800 hour rounds according to her to-do list. Ms. Kleiner went to administer the Amlodipine 5mg to Resident PW. Amlodipine is used to treat high blood pressure. Ms. Kleiner questioned why the MAR would state to hold the medication if the blood pressure is higher than 120/80 mmHG (high blood pressure is greater than 120/80 and would be treated with medication such as Amlodipine). With this knowledge of medications and understanding of their usage, Ms. Kleiner checked the resident's Physician's Order and saw that it had been incorrectly transcribed. Ms. Kleiner corrected the Care Organizer on or around 0924 hours to state, "hold if BP < (less than) 120/80". Ms. Kleiner then administered the medication to Resident PW.

Ms. Kleiner determined Mr. Farthing had transcribed the order and the parameters incorrectly.

Mr. Farthing failed to properly transcribe and process Resident PW's Amlodipine order, placing Resident PW at risk of harm.

LPNs are responsible for the appropriate transcribing and processing of Physician's orders. The CLPNA Competency Profile, "U: Medication Administration", "Medication Preparation and Administration" requires LPNs to demonstrate knowledge and ability to accept, process, verify and initiate written, verbal, telephone or electronic medication orders (**Exhibit #1**). Failing to do so in this case put a patient at risk of serious harm; it demonstrates a lack of skill and care in providing professional services but also breached the Code of Ethics and Standards of Practice in accordance with the discussion below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 4

Gregory Farthing admitted that on or about August 25, 2017, he did one or more of the following:

a. Failed to arrange medical transportation to the Chinook Regional Hospital for resident DE for a medical procedure, insertion of a new pacemaker;

b. Failed to arrange for a volunteer to accompany resident DE to the Chinook Regional Hospital;

c. Failed to assess resident DE upon return to facility; and

d. Failed to transcribe new orders for resident DE in a timely manner.

On August 24, 2017, Mr. Farthing worked from 1500 to 2300 hours; during this time, Mr. Farthing provided care to Resident DE.

On August 25, 2017, Resident DE was scheduled to attend an appointment at the Chinook Regional Hospital in Lethbridge, Alberta to have his pacemaker replaced.

As Mr. Farthing was providing care to Resident DE, it was his responsibility to arrange transportation and volunteer service for Resident DE. Resident DE had dementia and was unable to travel alone.

Leanne Kogler, LPN, arrived for her shift on the morning of August 25, 2017. She noted that Resident DE's transport and volunteer service had not been arranged. After significant effort, she managed to get transport from Access Lethbridge and found a volunteer on very short notice. A copy of the Progress Notes outlining the incident is attached in **Exhibit #1.**

At around 1500 hours on August 25, 2017, Resident DE returned from Chinook Regional Hospital, Lethbridge to Park Meadows. Resident DE returned with a green sleeve (information sent by hospital with patient following a procedure or discharge) that required follow up and document processing.

As Resident DE's nurse, it was Mr. Farthing's responsibility to assess him, and to accept and transcribe orders that were sent back with the Resident regarding the new pacemaker and dressings change orders.

Mr. Farthing failed to complete an assessment of Resident DE upon his return from his medical appointment (**Exhibit #1**).

Despite Resident DE returning to Park Meadows around 1500 hours, Mr. Farthing did not complete charting or process orders for the resident until 2121 hours (**Exhibit #1**).

Despite being the nurse responsible for Resident DE, Mr. Farthing failed to organize transportation and a volunteer for Resident DE's hospital appointment. Upon his return, Mr. Farthing failed to assess Resident DE and failed to transcribe his new orders in a timely way. These admitted to and demonstrated failures to perform expected routine duties, and in not following routine procedures in charting and assessment, show a lack of skill, judgement, and knowledge from Mr. Farthing. They also breach the Code of Ethics and Standards of Practice as set out below.

Therefore, the Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 5

Gregory Farthing admitted that on or about August 29, 2017, he failed to administer Risperidone 0.25 mg at 1200 hour to resident SB as per Physician's order.

On August 29, 2017, Mr. Farthing worked from 0700 to 1500 hours; during this time, he provided care for Resident SB.

Resident SB was prescribed Risperidone 0.25 mg twice daily, at 1200 hours and 2100 hours (**Exhibit#1**).

On August 29, 2017, Mr. Farthing was to administer Risperidone 0.25 mg to Resident SB at 1200 hours.

Later the same day at 1600 hours, Theresa Swanson, LPN was doing supper rounds. Ms. Swanson found Resident SB's Risperidone 0.25 mg in the medication cupboard and noted that Mr. Farthing had not signed it off as administered on the MAR and Care Organizer record (**Exhibit#1**).

Risperidone is an antipsychotic medication that works by changing the effects of chemicals in the brain, used mainly to treat schizophrenia and bipolar disorder. Ms. Swanson administered the medication at 1700 hours to avoid an adverse effect and behavioural change to the resident.

Mr. Farthing failed to report the incident as required. The event was reported instead by Ms. Swanson. A copy of the Event Reporting System entry is in **Exhibit #1.**

Failure to administer a patient's medication is a serious neglect of duties. In this case, it put the resident SB at risk of experiencing a schizophrenic episode that could have been harmful to the resident or others around him. Compounding the seriousness of this event is Mr. Farthing's failure to report the incident as required by the Facility's procedures. This is plainly a lack of skill, knowledge, and judgement as well as a breach of the Code of Ethics and Standards of Practice.

For these reasons, the Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 6

Gregory Farthing admitted on or about September 7, 2017, he did one or more of the following to JNP:

a. Failed to administer Xarelto at 1700 hours as per Physician's order; and

b. Failed to document NP refused the medication.

On September 7, 2017, Mr. Farthing worked from 1500 to 2300 hours; during this time Mr. Farthing provided care to Resident JNP.

Resident JNP was prescribed Xarelto to be taken at 1700 hours.

As Mr. Farthing was on duty, it was his responsibility to administer the Xarelto at 1700 hours to Resident JNP.

Ms. Corey, LPN, was on shift later that same day. When preparing the next doses for administration, she noticed that the medication pouch was still attached to the medication roll. Ms. Corey checked the MAR and noted that the medication had a "1" written, indicating that the resident had refused the medication. No computer charting had been done by Mr. Farthing to support the resident's refusal of the medication.

After discovering the same, Ms. Corey completed an Event Reporting System entry documenting the incident (**Exhibit #1**).

Although it is an acceptable practice to note a resident's refusal of medication, it is necessary to provide rationale and documentation as to why the medication was refused and what was done next, such as notifying the Physician.

The CLPNA Competency Profile, "Legal Protocols, Documenting and Reporting" requires LPNs to demonstrate professional accountability and responsibility to ensure adherence to legal protocols and documenting and reporting guidelines (D-5-1) and to ensure accurate, concise and complete documentation (D-5-2) (**Exhibit #1**).

Documentation of incidents such as those involving a patient's refusal to take medication is a critical practice for the maintenance of continuity of care and essential communication between caregivers (doctors, nurses and others) who need to know what transpired.

Mr. Farthing admits to forgetting to chart Resident JNP's refusal of the medication.

The failure to properly document Resident JNP's refusal of medication demonstrates a lack of skill and constitutes a breach of the Code of Ethics and Standards of Practice. The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 7

Gregory Farthing admitted that on or about September 12, 2017, he did one or more of the following in regards to resident JK:

a. Administered Morphine 0.2 ml (2 mg) instead of Morphine 0.25 ml (2.5 mg) as per Physician's order;

b. Pre-poured Morphine contrary to accepted practice;

c. Failed to label the syringe containing Morphine; and

d. Failed to document the initiation of a subcutaneous line.

On September 12, 2017, Mr. Farthing worked from 1500 to 2300 hours; during this shift he provided care to Resident JK.

Resident JK is now deceased. The MAR and Physician's Order are, therefore, unavailable. Mr. Farthing admits to administering the incorrect dose and failing to follow procedure.

Resident JK was ordered Morphine 2.5 mg as per Physician's Order.

On September 12, 2017 Resident JK was in pain. Mr. Farthing administered Morphine 2.0 mg. This was contrary to Resident JK's Physician's Order which was Morphine 2.5 mg, as outlined in the Progress Notes (**Exhibit #1**).

Mr. Farthing had pre-poured the Morphine against procedure. Mr. Farthing failed to label the medication correctly, labeling the syringe with the time or date, causing a potential medication error (**Exhibit #1**).

A subcutaneous line ("SC") was initiated by Mr. Farthing to administer the Morphine to Resident JK (**Exhibit #1** Progress Notes). However, he failed to properly document the same. Mr. Farthing did not document the initiation of the SC on the to-do list to let other healthcare providers know and ensure monitoring of the site.

The CLPNA Competency profile Medication Administration requires that LPNs are able to appropriately prepare medications for administration according to agency policy (U-2-4) and demonstrate their knowledge and ability to apply the "rights" and "checks" of medication administration to reduce the risk of medication error and ensure client safety, such as ensuring the correct dose is administered (**Exhibit #1**).

In addition to failing the CLPNA Competency profile, Mr. Farthing did not properly document the SC, so that it could be properly monitored by other health care people working with resident JK. This is undoubtedly a reckless practice and it shows a lack of skill, judgement, and knowledge. It is also a breach of the Code of Ethics and Standards of Practice.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

<u>Allegation 8</u>

Gregory Farthing admitted that on or about October 18, 2017, he did one or more of the following in regards to resident AT:

a. **Failed to administer Loperamide 2 mg following each loose bowel movement as per Physician's orders;**

b. **Failed to document resident's bowel movements on the Bowel Elimination Summary; and**

c. **Placed resident AT at risk of dehydration and electrolyte imbalance by failing to administer Loperamide.**

On October 18, 2017, Mr. Farthing worked from 1100 to 1500 hours; during this time he provided care to 92 year old Resident AT.

Resident AT had a history of loose bowel movement. As a result, on October 18, 2017, Resident AT was started on a trial of Loperamide; 2 tablets each were to be administered and then one tablet after each loose stool for two days as per the MAR (**TAB 26**). The Loperamide trial required that the responsible health care provider complete the Bowel Elimination Summary for Resident AT.

On the same day at around 0800 hours, Leanne Kogler, LPN, administered the initial dose of Loperamide (**Exhibit #1,** Progress Notes).

On October 30, 2017, Karessa Bannerman, LPN, investigated Resident AT's ongoing history of loose stools. Ms. Bannerman discovered that after the initial dose, Mr. Farthing failed to administer Loperamide as ordered after each loose bowl movement. A copy of the resident's MAR is in Exhibit #1 and shows that Resident AT did not receive Loperamide after the initial dose.

Mr. Farthing was also supposed to record whether or not Resident AT was still suffering from loose bowels after the administration of Loperamide. This was in order to track the efficiency of the Lopermide. Mr. Farthing failed to follow-up and document the resident's bowel movement every time the resident had a loose movement after the start of the trial on the Bowel Elimination Summary (**Exhibit #1**).

Mr. Farthing admits to failing to chart the bowel movements for Resident AT.

As a result of Mr. Farthing's lack of administration of Loperamide and failure to document Resident AT's bowl movement, the trial needed to be restarted on October 31, 2017.

Loperamide is used to treat loose stools (diarrhea). Dehydration and electrolyte problems can happen in people who have diarrhea. Mr. Farthing placed Resident AT at risk by not administering the Loperamide as ordered after each loose bowel movement as ordered.

Failing to administer medication and chart effectiveness of the medication is a basic and foundational nursing skill. Such failure demonstrates a lack of skill in the provision of professional services and is a breach of the Code of Ethics and Standards of Practice.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 9

Gregory Farthing admitted that on or about October 21, 2017, he failed to retrieve the old subcutaneous set after determining resident WP "ripped sub Q Line" out placing both resident and staff at risk of harm.

On October 21, 2017, Mr. Farthing was working from 0700 to 1500 hours; during this time, he provided care for Resident WP.

Resident WP was an 89 year old palliative care resident. She was ordered Hydromorphone via SC line every two (2) hours. Hydromorphone is an opioid pain medication that is used to treat moderate to severe pain (**Exhibit # 1**).

On October 21, 2017 at 1026 hours, Mr. Farthing initiated a new SC line in Resident WP's left upper tricep after the resident had "pulled out" the existing line that was in resident's right thigh **(Exhibit # 1).**

On October 21, 2017 during the 1900-0700 hours shift, while turning Resident WP, Ms. Bannerman found a used SC site that had no date but paper tape on it that said "hydro". It was incorrectly labelled over the injection site which was supposed to be monitored for infection.

The resident's left hip had light signs of pressure. Ms. Bannerman checked the charting and saw that Mr. Farthing had removed the site from the right thigh and put a new site in the left arm.

Mr. Farthing failed to dispose of the old SC, leaving it underneath the resident and potentially causing a pressure ulcer. Ms. Bannerman found the SC, removed it, and disposed of it in the sharps container, as outlined in the Progress Notes in **Exhibit #1**. Ms. Bannerman reported the incident in an email to Ms. Peterson on October 22, 2017 (**Exhibit # 1**).

Mr. Farthing placed Resident WP and staff at risk by leaving the subcutaneous needle exposed.

Failing to label the old SC site properly and failing to remove the subcutaneous needle and tubing is reckless and sloppy practice. This puts the patient at risk for infection and pressure sores, while putting other staff members at risk of being exposed to potential puncture by needle. This is basic nursing care and proper practice. This is a serious lack of skill, knowledge and judgement, as well as a contravention of Standards of Practice.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 10

Gregory Farthing admitted that on or about October 21, 2017, he did the following in regards to resident WP:

a. Initiated a subcutaneous line to left upper tricep with an 18G needle instead of the correct size set up; and

b. Failed to remove the needle after the insertion of the subcutaneous line.

On October 21, 2017, Mr. Farthing was working from 0700 to 1500 hours. During this time, he provided care for Resident WP.

Resident WP was ordered Hydromorphone via indwelling SC butterfly line every two (2) hours. Hydromorphone is an opioid pain medication that is used to treat moderate to severe pain (**Exhibit #1**).

On October 21, 2017 at 1026 hours, Mr. Farthing initiated a new SC line in Resident WP's left upper tricep after the resident had "pulled out" the existing line that was in resident's right thigh (**Exhibit # 1**). The purpose of indwelling SC line is to provide optimum symptom control with only one injection; the indwelling SC line can be left in place for a maximum of seven days. The site was used for additional medication by Mr. Farthing and John Jurcak, LPN (**Exhibit #1**).

On October 24, 2017, Teresa Halcro, LPN, prepared a new line for resident WP, after reports from a Co-LPN that the resident's SC site had started leaking (Progress Notes**, Exhibit #1**). At approximately 1915 hours, following report, Ms. Halcro prepared a new line and attended Cottage 5, a dementia care cottage, to insert the new line. When she started to remove the site, she found that an 18 gauge needle was in the arm of the resident, attached to a plastic cannula. Ms. Halcro removed it, took a photo (**Exhibit #1**) and disposed of it in a sharps container.

Ms. Halcro confirmed that Mr. Farthing installed the SC into Resident WP on October 21, 2017 at 1026 hours after reviewing the Progress Notes (**Exhibit # 1**), where Mr. Farthing had charted the insertion. An 18 gauge needle is not the correct needle to have been used for this type of SC butterfly line.

After the insertion of the SC line, the needle should be removed and the cannula left in place. Instead of removing the needle, Mr. Farthing incorrectly left the needle in the patient, causing both potential patient harm as well as a risk of a needle stick injury.

Failing to remove the needle after insertion of the SC line, in addition to using the wrong size needle and set up for the SC line, is a lack of skill, knowledge, and judgement, that had the potential of harming the patient as well as exposing other staff members to potential needle stick injury. It further constitutes a breach of the Code of Ethics and Standards of Practice.

For these reasons, the Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 11

Gregory Farthing admitted that on or about November 3, 2017, he incorrectly transcribed a Physician's order for Colchicine 0.6 mg for resident OS, by stating that a Health Care Aide was to administer the medication instead of a nurse.

On November 3, 2017, Mr. Farthing worked from 1500 to 2300 hours; during that time he provided care for Resident PS.

Resident PS was ordered Colchicine 0.6 mg twice daily (at 0800 hours and 2100 hours) for five days starting on November 3, 2017 (copy of Resident PS's prescription is in **Exhibit #1)** Colchicine is used to treat and prevent gout attacks; gout is a form of inflammatory arthritis causing pain, redness, heat and swelling at the site of inflammation.

The initial dose was to be administered at 2100 hours on November 3, 2017 (**Exhibit #1**). Mr. Farthing received and entered the medication administration in the Care Organizer System at 1551 hours (**Exhibit #1**), indicating the times, dates and dose of the required medication administration.

During transcription, Mr. Farthing entered that the medication was to be administered by a Health Care Aide. The medication actually required administration by a nurse.

Due to the transcription error, the medication did not show up on the medication schedule for an LPN to administer, and the medication was not administered to Resident PS at 2100 hours on November 3, 2017 or 0800 hours on November 4, 2017. This resulted in two medication administration errors.

The error was caught by Ms. Halcro on November 4, 2017 at 1021 hours. The Care Organizer chart was then modified accordingly (**Exhibit #1**).

LPNs are responsible for the appropriate transcribing and processing of medical orders. The CLPNA Competency profile Medication Administration requires that LPNs are able to demonstrate knowledge and ability to accept, process, certify and initiate written, verbal, telephone or electronic medication orders, including ensuring the order is accurate, appropriate and complete (U-2-1) (**Exhibit # 1**).

Failure to appropriately transcribe medication instructions, as well as, failing to administer medication correctly is clearly a display of a lack of skill, judgement and knowledge. It is also a breach of the Code of Ethics and Standards of Practice and for these reasons the Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Allegation 12

Gregory Farthing admitted that on or about November 5, 2017, he demonstrated a lack of leadership by inappropriately directing a Health Care Aide to obtain coffee for him and coworkers off site.

On November 5, 2017, Mr. Farthing worked from 0700 to 1900 hours.

On November 5, 2017, Brandy Fuchs was under Mr. Farthing's delegation as a Health Care Aide. During their day shift, Mr. Farthing instructed Ms. Fuchs to go to Tim Hortons for coffee for himself and their co-workers, and indicated that he would pay.

Ms. Fuchs was responsible for residents during this time and it is against Park Meadows Policy to leave property unless on lunch break.

LPNs at Park Meadows are supervisors to Health Care Aides. The CLPNA Competency Profile "X: Leadership" requires LPNs to demonstrate knowledge and ability to apply critical thinking throughout decision making in nursing practice (X-1-1). They must demonstrate knowledge and ability to model professionalism and assign, educate and supervise health care aides (X-1-6) (**Exhibit #1**).

Mr. Farthing's instruction for Ms. Fuchs to go off-site and purchase coffee was inappropriate; during this time, she was assigned residents to whom she was responsible for providing care. Mr. Farthing failed to demonstrate the required leadership competencies for LPNs when

directing a Health Care Aide under his supervision to leave the facility premises. Mr. Farthing admitted to directing Ms. Fuchs to leave facility property to get coffee for staff.

Clearly sending a Health Care Aide off the premise to procure coffee for the staff was against company policy and amply demonstrated a lack of judgement on Mr. Farthing's part and is a breach of the Code of Ethics and Standards of Practice; therefore, the Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

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

Breaches of the Code of Ethics and Standards of Practice

Mr. Farthing's conduct breached the principles set out in CLPNA's Code of Ethics 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 to 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:

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

    - 2.9 Identify and minimize risks to clients.

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

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

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

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

d. Principle 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.

A copy of the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 is in **Exhibit #1.**

2. Mr. Farthing acknowledges that his conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which state as follows:

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

- 1.1. Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies;

- 1.2. Engage in ongoing self-assessment of their professional practice and competence, and seek opportunities for continuous learning;

- 1.4. Recognize their own practice limitations and consult as necessary;

- 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised;

- 1.7. 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:

    - 2.1. Possess current knowledge to support critical thinking and professional judgement;

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

    - 2.11. Use critical inquiry to assess, plan and evaluate the implications of interventions that impact client outcomes.

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; 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.

A copy of the Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 is in **Exhibit #1.**

(9) Joint Submission on Penalty

The Complaints Director and Mr. Farthing made a joint submission with respect to penalty, which was entered as Exhibit #3. The parties jointly submitted the following proposal to the Hearing Tribunal for consideration:

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

Prior to reinstatement:

2. Mr. Farthing shall pay 25% of the costs of the hearing to a maximum of $3,000.

3. Mr. Farthing shall read and reflect the following CLPNA documents located on the CLPNA's website http://www.clpna.com/ under "Governance". Mr. Farthing is required to provide the Complaints Director with a written reflection paper of 500 – 750 words (typed) on how the CLPNA documents will impact his professional practice:

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

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

   (c) CLPNA Practice Policy: Professional Responsibility & Accountability;

   (d) CLPNA Practice Policy: Documentation;

   (e) CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

   (f) CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

   (g) CLPNA Competency Profile U: Medication Administration;

   (h) Decision-Making Standards for Nurses in the Supervision of Health Care Aides; and

   (i) CLPNA Competency Profile W: Professionalism.

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

   In the event the reflective paper is not satisfactory to the Complaints Director, Mr. Farthing shall do the following:

      i. Within two (2) weeks of being notified by the Complaints Director the reflective paper is not satisfactory, or such longer period as determined by the Complaints Director at her sole discretion, submit a revised paper that is acceptable to the Complaints Director.

4. Mr. Farthing shall complete the LPN Ethics Course available online at http://www.learninglpn.ca/index.php/courses. Mr. Farthing shall provide the Complaints Director with a certificate confirming successful completion of the course.

5. Mr. Farthing shall complete, at his own cost, NURSO 161 Medication Management offered on-line by MacEwan University. Mr. Farthing shall provide the Complaints Director with a certificate confirming successful completion of the course.

6. Mr. Farthing shall complete, at his own cost, Transcribing Physician Orders (HLTH 1118) offered on-line by Vancouver Community College. Mr. Farthing shall provide the Complaints Director with a certificate confirming successful completion of the course.

7. Mr. Farthing shall provide the CLPNA with his contact information, including his home mailing address, home and cellular telephone numbers, current e-mail address and his current employment information after he has an active permit. Mr. Farthing will keep his contact information current with the CLPNA on an ongoing basis.

Legal Counsel for the Complaints Director 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.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Mr. Farthing and the Complaints Director.

(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. Farthing 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

The nature and gravity of the proven allegations
Mr. Farthing has numerous failings to document information correctly, administer medications correctly, and to employ proper care of SC lines. These are errors that are key nursing skills and basic knowledge. These errors could put patients, as well as, other staff members in danger.

The age and experience of the investigated member
Mr. Farthing graduated in 2016, and his unprofessional conduct occurred in 2017, so he was a relatively new graduate; however, the skills, knowledge, and judgment exhibited by Mr. Farthing was in the area of basic skills and standard practice that would be an expected part of a new graduate's abilities.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
No evidence of previous complaints was presented to the Hearing Tribunal.

The age and mental condition of the victim, if any
The patients/residents who were in Mr. Farthing's care were elderly, and were a very vulnerable and dependent group of people. They were dependent on Mr. Farthing carrying out his duties safely and correctly for their safety.

The number of times the offending conduct was proven to have occurred
Over a two month period, Mr. Farthing had 12 proven allegations of unprofessional conduct. The Hearing Tribunal finds these proven allegations of misconduct to be numerous over a short period of time, demonstrating that Mr. Farthing's practice was reckless and sloppy.

The role of the investigated member in acknowledging what occurred
The Hearing Tribunal commends Mr. Farthing for his role in admitting to his misconduct and working with the college to come to an Agreed Statement of Fact and a Joint Submission on

Penalty. The Hearing Tribunal recognizes this cooperation on Mr. Farthing's part as a positive step forward in working on improving his practice.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made

Mr. Farthing was terminated from his job after his misconduct. This constitutes a significant financial loss.

The impact of the incident(s) on the victim

The Hearing Tribunal was not given any evidence of impact on any of the residents as a result of Mr. Farthing's misconduct. However this was a particularly vulnerable population of elderly people, so the misconduct could have lead, in some of the situations, to some serious and dangerous outcomes. 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 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 decision (the "Decision") shall serve as a reprimand.

Prior to reinstatement:

2. Mr. Farthing shall pay 25% of the costs of the hearing to a maximum of $3,000.

3. Mr. Farthing shall read and reflect the following CLPNA documents located on the CLPNA's website http://www.clpna.com/ under "Governance". Mr. Farthing is required to provide the Complaints Director with a written reflection paper of 500 – 750 words (typed) on how the CLPNA documents will impact his professional practice:

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

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

(c) CLPNA Practice Policy: Professional Responsibility & Accountability;

(d) CLPNA Practice Policy: Documentation;

(e) CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

(f) CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

(g) CLPNA Competency Profile U: Medication Administration;

(h) Decision-Making Standards for Nurses in the Supervision of Health Care Aides; and

(i) CLPNA Competency Profile W: Professionalism.

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

In the event the reflective paper is not satisfactory to the Complaints Director, Mr. Farthing shall do the following:

i. Within two (2) weeks of being notified by the Complaints Director the reflective paper is not satisfactory, or such longer period as determined by the Complaints Director at her sole discretion, submit a revised paper that is acceptable to the Complaints Director.

4. Mr. Farthing shall complete the LPN Ethics Course available online at http://www.learninglpn.ca/index.php/courses. Mr. Farthing shall provide the Complaints Director with a certificate confirming successful completion of the course.

5. Mr. Farthing shall complete, at his own cost, NURSO 161 Medication Management offered on-line by MacEwan University. Mr. Farthing shall provide the Complaints Director with a certificate confirming successful completion of the course.

6. Mr. Farthing shall complete, at his own cost, Transcribing Physician Orders (HLTH 1118) offered on-line by Vancouver Community College. Mr. Farthing shall provide the Complaints Director with a certificate confirming successful completion of the course.

7. Mr. Farthing shall provide the CLPNA with his contact information, including his home mailing address, home and cellular telephone numbers, current e-mail address and his current employment information after he has an active permit. Mr. Farthing will keep his contact information current with the CLPNA on an ongoing basis.

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 16th DAY OF SEPTEMBER 2019 IN THE VILLAGE OF RYLEY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Nancy Brook, Public Member
Chair, Hearing Tribunal