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 HELEN DJAMASI

REVISED
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 HELEN DJAMASI, LPN #30984, 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 in Edmonton, Alberta on August 23, 2019 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Marie Concepcion, LPN
Angelica de Vera, LPN
Marg Hayne, Public Member

Staff:
Tessa Gregson, Legal Counsel for the Complaints Consultant, CLPNA
Evie Thorne, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA
Kevin Oudith, Complaints Consultant, CLPNA

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

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Djamasi was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Djamasi was initially licensed as an LPN in Alberta on January 2, 2009.

On April 9, 2018, CLPNA received a letter dated April 9, 2018, from Craig Maddess, Advisor, Employee Relations on behalf of Jane Lewis, Client Services Manager at Carewest Sarcee ("Carewest") in Calgary, Alberta pursuant to s. 57 of the Act. The letter was notification that Ms. Helen Djamasi, LPN, received a one day suspension (the "Complaint").

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

The Complaints Consultant appointed Kathryn Emter, Investigator for the CLPNA (the "Investigator") to conduct an investigation into the Complaint in accordance with s. 55(2)(d) of the Act. Ms. Djamasi received notice of the Complaint and notice of the investigation by letter dated April 9, 2018.

On October 19, 2018, the Investigator concluded the investigation into the Complaint and submitted an Investigation Report to the CLPNA.

Following the receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Djamasi 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 April 8, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Djamasi under cover of letter dated May 10, 2019.

(4) Allegations

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

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

1. On or about March 27, 2018, failed to administer Alendronate 70 mg to client EE on or about 0700 hours as ordered.

2. On or about March 27, 2018, failed to administer Spiriva Inhaler 18 mcg and Voltaren Emugel to client EA at 0800 hours as ordered.

3. On or about March 27, 2018, failed to do one or more of the following with regard to client MB:
    a. Take client MB's weight at 0800 hours as ordered; and
    b. Document in the Total Team Record after recording a "10" on the Medication Administration Record for Vitalux TR Multivitamin at 0800 hours.

4. On or about March 27, 2018, failed to document in the Total Team Record after recording a "10" on client MT's Medication Administration Record for Cranberry caps 1000 mg and Multivitamin at 0800 hours.

5. On or about March 27, 2018, failed to administer the following medications to client HC at 0800 hours as ordered: APO Allopurinol 100 mg, Mylan-Baclofen 10 mg, PMS-Carvedilol 25 mg, APO-Gabapentin 300 mg, Synthroid 0.137 mg, Mylan-Pantoprazole T 40 mg, Quetiapine 25 mg, SDX-Telmisartan 80 mg, APO-Acetaminophen 1000 mg, and Loperamide 4 mg.

6. On or about March 27, 2018, failed to do one or more of the following with regard to client DC:

    a. Document on the Medication Administration Record the administration of the following medications at 0800 hours: APO-Allopurinol 200 mg, SDZ-Bisoprolol 5 mg, APO-Clopidogrel 75 mg, Losartan 50 mg, Mylan-Pantoprazole T 40 mg, Relaxa 17 g/dose, and Voltaren Emulgel; and

    b. Document in the Total Team Record after recording a "9" on the Medication Administration Record for Praxis ASA EC 81 mg at 0800 hours.

7. On or about March 7 to March 27, 2018 failed to record her signature on the Medication Administration Records for the following clients: EE, EA, MB, MT, HC and DC."

(5) Admission of Unprofessional Conduct

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

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Statement of Allegations
Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct

Exhibit #3: Partial Joint Submission on Penalty
Exhibit #4: Additional Order Sought by the Complaints Consultant Regarding Costs
Exhibit #5: Estimated Hearing Costs
Exhibit #6: Ms. Djamasi's Finances

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

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

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

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

Allegation 1

Ms. Djamasi admitted on or about March 27, 2018, she failed to administer Alendronate 70 mg to client EE on or about 0700 hours as ordered.

On March 27, 2018, Ms. Djamasi was scheduled to work a day shift at C3 from 0700 hours to 1515 hours. During this shift, Ms. Djamasi provided care to client EE. A copy of Ms. Djamasi's schedule for March 27, 2018 was provided at Tab 5 of the Agreed Statement of Facts.

On this date, client EE was scheduled to receive Alendronate 70mg for osteoporosis, every Tuesday at 0700 hours or 0730 hours. A copy of client EE's CW Patient Profile and Medication Administration Record ("MAR") was provided at Tab 6 of the Agreed Statement of Facts.

Ms. Djamasi failed to administer client EE's morning dose of Alendronate.

Ms. Djamasi was sent home on March 27, 2018 around 0940 hours and Ms. Kim Wright, LPN took over Ms. Djamasi's medication administration. At 1100 hours, Ms. Wright noticed that

Ms. Djamasi failed to administer client EE's Alendronate and therefore administered it herself at 1100 hours.

Ms. Wright then reported this error to Ms. Jane Lewis, Client Services Manager, who completed an Unusual Occurrence Report on March 28, 2019. A copy of the Unusual Occurrence Report was provided at Tab 7 of the Agreed Statement of Facts.

These failures on the part of the Investigated Member display a lack of judgment in the provision of professional services as it demonstrates carelessness toward the accurate charting of medications. Further, the Hearing Tribunal finds that Ms. Djamasi's conduct breached the CLPNA Code of Ethics ("Code of Ethics") and CLPNA's Standards of Practice ("Standards of Practice"), as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

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;
c) Conduct that harms the integrity of the regulated profession.

Allegation 2

Ms. Djamasi admitted on or about March 27, 2018, she failed to administer Spiriva Inhaler 18mcg and Voltaren Emugel to client EA at 0800 hours as ordered.

Ms. Djamasi worked on March 27, 2018 from 0700 hours until 0940 hours; during this shift she provided care for client EA.

Client EA was scheduled to receive Spiriva Inhaler 18mg and Voltaren Emugel at 0800 hours. Ms. Djamasi failed to administer either the Spiriva Inhaler or the Voltaren Emugel as ordered. A copy of client EA's MAR was provided at Tab 8 of the Agreed Statement of Facts.

Ms. Lewis completed an Unusual Occurrence Report regarding the Spiriva Inhaler, which was provided at Tab 9 of the Agreed Statement of Facts.

Again, this conduct displayed a lack of judgment in the provision of professional services as it demonstrates carelessness toward the accurate provision of medications. Further, the Hearing Tribunal finds that Ms. Djamasi's conduct breached the Code of Ethics and Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

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;
c) Conduct that harms the integrity of the regulated profession.

Allegation 3

Ms. Djamasi admitted on or about March 27, 2018, she failed to do one or more of the following with regard to client MB:

a. Take client MB's weight at 0800 hours as ordered; and

b. Document in the Total Team Record after recording a "10" on the Medication Administration Record for Vitalux TR Multivitamin at 0800 hours.

Ms. Djamasi worked on March 27, 2918 from 0700 hours until 0940 hours; during this shift she provided care to client MB.

Client MB was scheduled to receive Vitalux TR Multi-Vitamin and have her body weight recorded at 0800 hours. A copy of client MB's MAR was provided at Tab 10 of the Agreed Statement of Facts.

However, Ms. Djamasi failed to take client MB's weight at 0800 hours on March 27, 2018 as ordered on the MAR.

Ms. Djamasi recorded a "10" on client MB's MAR for the 0800 hours Multi-Vitamin administration; recording a "10" on the MAR indicates "See Nurse's Notes".

Despite indicating the reference to the Nurse's notes from the MAR, Ms. Djamasi failed to document on client MB's Total Team Record ("TTR") an explanation of why she recorded a "10" code on the MAR. A copy of client MB's TTR was provided at Tab 11 of the Agreed Statement of Facts.

The documentation of care given to patients is fundamental to the practice of an LPN. The failure to so document is serious and constitutes unprofessional conduct. The Hearing Tribunal also finds that Ms. Djamasi's conduct breached the Code of Ethics and Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

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;
c) Conduct that harms the integrity of the regulated profession.

Allegation 4

Ms. Djamasi admitted on or about March 27, 2018, she failed to document in the Total Team Record after recording a "10" on client MT's Medication Administration Record for Cranberry caps 1000 mg and Multivitamin at 0800 hours.

Ms. Djamasi worked on March 27, 2018 from 0700 hours until 0940 hours. During this shift, Ms. Djamasi provided care to client MT.

Client MT was scheduled to receive Cranberry Caps 1000mg and a Multivitamin at 0800 hours daily. A copy of client MT's MAR was provided at Tab 12 of the Agreed Statement of Facts.

On March 27, 2018, Ms. Djamasi recorded a "10" for both the Cranberry Caps and Multivitamin 0800 hour doses on client MT's MAR. A "10" on a client's MAR indicates that one should refer to the Nurse's Notes for further information.

Despite recording a "10" for the administration of the Cranberry Caps and Multivitamin, Ms. Djamasi failed to document an explanation on client MT's TTR for the use of the "10" code. A copy of client MT's TTR was provided at Tab 13 of the Agreed Statement of facts.

Again, documentation of care is fundamental to an LPN's work and to ensure proper care for patients. Failing to maintain proper records is serious and can lead to real harm for patients; this failure and carelessness amounts to unprofessional conduct. The Hearing Tribunal also finds that Ms. Djamasi's conduct breached the Code of Ethics and Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

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;
c) Conduct that harms the integrity of the regulated profession.

Allegation 5

Ms. Djamasi admitted on or about March 27, 2018, she failed to administer the following medications to client HC at 0800 hours as ordered: APO Allopurinol 100 mg, Mylan-Baclofen 10 mg, PMS-Carvedilol 25 mg, APO-Gabapentin 300 mg, Synthroid 0.137 mg, Mylan-Pantoprazole T 40 mg, Quetiapine 25 mg, SDX-Telmisartan 80 mg, APO-Acetaminophen 1000 mg, and Loperamide 4 mg.

Ms. Djamasi worked on March 27, 2018 from 0700 hours until 0940 hours. During this shift, Ms. Djamasi provided care to client HC.

Client HC was scheduled to receive the following medications at 0800 hours daily: APO-Allopurinol 100mg; Mylan-Baclofen 10mg; PMS-Carvedilol 25mg; APO-Gabapentin 300mg; Synthroid 0.137mg; Mylan-Pantoprazole T 40 mg; Quetiapine 25mg; SDX-Telmisartan 80mg; APO-Acetaminophen 1000mg; and Loperamide 4mg (collectively referred to as the "Morning Medication"). A copy of client HC's MAR was provided at Tab 14 of the Agreed Statement of Facts.

Despite this, on March 27, 2018, Ms. Djamasi failed to administer the Morning Medication to client HC as ordered.

At around 0930 hours, before Ms. Djamasi went home, she told Ms. Wright that she had failed to administer APO-Acetaminophen 1000mg and Loperamide 4mg to client HC.

Ms. Wright, therefore, administered the APO-Acetaminophen and Loperamide, as well as, the remaining Morning Medications to client HC and documented her initials on client HC's MAR.

Proper administration of medication is central to good patient care and outcomes. Failing to carry out the administration of medication demonstrated a lack of judgment in the provision of profession services and demonstrates carelessness. Such conduct is serious and amounts to unprofessional conduct. The Hearing Tribunal also finds that Ms. Djamasi's conduct breached the Code of Ethics and Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

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;
c) Conduct that harms the integrity of the regulated profession.

Allegation 6

Ms. Djamasi admitted on or about March 27, 2018, she failed to do one or more of the following with regard to client DC:

a. Document on the Medication Administration Record the administration of the following medications at 0800 hours: APO-Allopurinol 200 mg, SDZ-Bisoprolol 5 mg, APO-Clopidogrel 75 mg, Losartan 50 mg, Mylan-Pantoprazole T 40 mg, Relaxa 17 g/dose, and Voltaren Emulgel; and

b. Document in the Total Team Record after recording a "9" on the Medication Administration Record for Praxis ASA EC 81 mg at 0800 hours.

Ms. Djamasi worked on March 27, 2018 from 0700 hours to 0940 hours. During the shift Ms. Djamasi provided care to client DC.

Client DC was scheduled to receive; APO-Allopurinol 200mg; SDZ- Bisprolol 5mg; APO-Clopidogrel 75mg; Losartan 50mg; Mylan-Pantoprazole T 40mg; Relaxa 17g/dose; Praxis ASA EC 81mg; and Voltaren Emulgel at 0800 hours, daily. (Collectively referred to as "Client DC's Medications"). A copy of client DC's MAR was provided at Tab 15 of the Agreed Statement of Facts.

Rather than signing client DC's MAR to indicate the administration of client DC's medications, on March 27, 2018, Ms. Djamasi inappropriately marked client DC's MAR with dots.

In addition, Ms. Djamasi documented a "9" for Praxis ASA EC 81mg at 0800 hours on client DC's MAR. Documenting a "9" indicates that the medication was held. Despite documenting a "9" on client DC's MAR, Ms. Djamasi failed to document the reason that the Praxis ASA EC 81mg was held in client DC's TTR. A copy of DC's TTR was provided at Tab 16 of the Agreed Statement of Facts.

Later, Ms. Wright noticed the dots on the MAR and found that the medication was gone from the medication cart. Ms. Wright also checked with client DC who recalled taking the medication. Ms. Djamasi later confirmed that she placed dots as entries instead of her initials.

Ms. Wright completed an Unusual Occurrence Report regarding Ms. Djamasi's documentation on client DC's MAR on March 28, 2018. A copy of the Unusual Occurrence Report was provided at Tab 17 of the Agreed Statement of Facts.

Patient records serve to allow all members of a patient's health care team to know the care that a patient has received and provide a record for health care decisions to be based upon. Improper recording of patient information can negatively affect patient health and well-being, this conduct constitutes unprofessional conduct. The Hearing Tribunal also finds that Ms. Djamasi's conduct breached the Code of Ethics and Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

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;
c) Conduct that harms the integrity of the regulated profession.

Allegation 7

Ms. Djamasi admitted on or about March 7 to March 27, 2018, she failed to record her signature on the Medication Administration Records for the following clients: EE, EA, MB, MT, HC and DC.

Between March 7 and March 27, 2018, Ms. Djamasi worked dayshifts at C3. During the month of March 2018, Ms. Djamasi provided care to clients EE, EA, MB, MT, HC and DC and administered medications to the clients as ordered.

Staff at Carewest are required to sign the "Nurse's Signature" area at the bottom of the clients' MARs. Despite this requirement, Ms. Djamasi failed to record her signature on the bottom of the MARs of clients EE, EA, MB, MT, HC, and DC for the month of March 2018.

Record keeping is an important aspect of the professional services of an LPN. Failing to keep fulsome and accurate records in this manner amounts to unprofessional conduct. Further, the Hearing Tribunal finds that Ms. Djamasi's conduct breached the Code of Ethics and Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

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:

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;
c) Conduct that harms the integrity of the regulated profession.

As already noted, Ms. Djamasi's conduct breached several provisions of the Code of Ethics and Standards of Practice including those as follows:

Code of Ethics:

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.

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

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

2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities.

2.8 Use evidence and judgement to guide nursing decisions.

2.9 Identify and minimize risks to clients.

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

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

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

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

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

Standards of Practice:

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

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

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

1.7 Incorporate established client safety principles and quality assurance/improvement activities into LPN practice.

1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.

1.10 Maintain documentation and reporting according to established legislation, regulations, laws and employer policies.

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

2.1 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.

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.

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

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

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

Ms. Djamasi's conduct breached the Code of Ethics and Standards of Practice. Ms. Djamasi's actions had potential for real harm to the residents under her care. LPNs must provide care in accordance with their training, competence and protocols that are in place as reflected in the provisions noted above. Care must be provided in a timely manner to ensure that patients are

not put at risk. The breaches of the above noted sections of the Code of Ethics and Standards of Practice by Ms. Djamasi are serious and constitute unprofessional conduct.

(9) Partial Joint Submission on Penalty

The Complaints Consultant and Ms. Djamasi made a partial 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 reasons for decision ("the Decision") shall serve as a reprimand.

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

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

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

    c. CLPNA Practice Policy: Professional Responsibility & Accountability;

    d. CLPNA Practice Policy: Documentation;

    e. CLPNA Practice Guideline: Medication Management;

    f. CLPNA Competency Profile D5: Legal Protocols, Documenting and Reporting;

    g. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

    h. CLPNA Competency Profile E2: Clinical Judgment and Decision Making; and

    i. 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.

3. In the event the reflective paper referred to in paragraph 3 above is not satisfactory to the Complaints Consultant, Ms. Djamasi shall within **two (2) weeks** of being notified by the Complaints Consultant the reflective paper is not satisfactory, or such longer period as determined by the Complaints Consultant at her sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

4. Ms. Djamasi shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses. Ms. Djamasi shall provide the

Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

5. Ms. Djamasi shall complete, at her own cost, the courses available online at http://www.pedagogyeducation.com. Ms. Djamasi shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **60 days** of service of the Decision:

    a. **Critical Thinking in Medication Administration;** and
    b. **Reducing Medication Errors: A Focus on the Med Pass.**

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

6. Ms. Djamasi shall complete **Nursing Documentation 101** available online at http://www.clpna.com. Ms. Djamasi shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **60 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. Ms. Djamasi shall provide the CLPNA with her contact information, including her home mailing address, home and cellular telephone numbers, current e-mail address and her current employment information. Ms. Djamasi will keep her contact information current with the CLPNA on an ongoing basis.

8. Should Ms. Djamasi 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.

9. Should Ms. Djamasi 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; or

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

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 partial 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 Helen Djamasi and the Complaints Consultant.

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Djamasi 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: This was a factor as Ms. Djamasi was failing to meet the minimum requirements of an LPN. Ms. Djamasi displayed lack of skill, knowledge, and judgement based on core competencies which are expected of an LPN. The errors that Ms.

Djamasi made were with regards to both medication administration, as well as, documentation which are basic fundamentals of an LPN.

The age and experience of the investigated member: Ms. Djamasi was initially registered with the CLPNA on January 1, 2009 and has been continually registered since that time. At the time that the Allegations took place Ms. Djamasi was registered for nine (9) years in Alberta and the Hearing Tribunal heard that she worked in Texas prior to moving to Alberta. Due to Ms. Djamasi's experience, she should have known better than to commit these basic errors which are admitted to in the Allegations that were presented.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The CLPNA is not aware of any previous complaints in regard to Ms. Djamasi.

The number of times the offending conduct was proven to have occurred: The Allegations in regard to Ms. Djamasi took place for the most part on one (1) date which was March 27, 2018. Six (6) of the seven (7) allegations presented happened on that date. There is no pattern established as a result of the medication and documentation errors that took place.

The role of the investigated member in acknowledging what occurred: Ms. Djamasi did acknowledge her role in respect to the seven (7) allegations and did provide the Hearing Tribunal with an Agreed Statement of Facts and Admission of Unprofessional Conduct, which she had worked with both the CLPNA and AUPE to provide. Ms. Djamasi has also completed most of the education portion of the sanctions to date, as well as, the education that Carewest asked her to complete for her employment. This shows that Ms. Djamasi is willing to learn from her mistakes.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Djamasi did receive a one (1) day suspension from Carewest as a result of these Allegations, as well as, being placed on administrative leave pending the decision of the Hearing Tribunal. Ms. Djamasi is responsible for covering the costs of two (2) of the courses that she is to take as reprimand, as well as, paying partial hearing costs.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was not presented with any information regarding any mitigating circumstances regarding Ms. Djamasi. The Hearing Tribunal was made aware that Ms. Djamasi was on modified duties at the time of the allegations; however, there was no evidence presented that this would affect her ability to administer medications or document accurately.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: Regarding specific deterrence, there is a need to impose sanctions on Ms. Djamasi. She needs to be aware that this type of behavior is not acceptable of an LPN, nor will it be tolerated by the CLPNA and that this type of behavior is dealt with in a

serious manner. The sanctions that are imposed with regards to Ms. Djamasi will also act as a deterrent to other LPNs by CLPNA acknowledging the seriousness of these breaches of conduct and responding with appropriate orders. These are core duties of an LPN and are a basic skill, knowledge base, and a fundamental responsibility of an LPN.

The need to maintain the public's confidence in the integrity of the profession: Documentation and medication administration are core competencies of LPNs and the public needs to be made aware that the lack of skill in these areas is something that the CLPNA takes seriously. CLPNA deals with the actions of the members when they conduct themselves in a way that is not becoming to the LPN profession. LPNs are trusted caregivers for populations that are often vulnerable and require attentive and careful care. The public's trust must be maintained by demonstrating that the CLPNA will deal with any breaches in the Act, Code Ethics and Standard of Practice in a manner that reflects the seriousness of this conduct.

The range of sentences in other similar cases. The Hearing Tribunal was presented with other similar cases and the proposed sanction is in keeping with those other decisions.

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) Additional Order Sought by Complaints Consultant

In addition to the Partial Joint Submission on Penalty outlined above, the Complaints Consultant sought the following two orders relating to the costs of the hearing:

1. Ms. Djamasi shall pay 25% of the costs of the hearing to a maximum of $3,500.00 to be paid in equal monthly installments over a period of 24 months from service of the Hearing Tribunal's written reasons for decision.

2. In the case of non-payment of the costs described in paragraph 1 above, the Complaints Consultant may suspend Ms. Djamasi's practice permit until such costs are pain 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.

These orders were opposed by Ms. Djamasi.

These requests orders are a request for a partial payment of costs. *Jaswal* offers guidance on sanctioning for costs at paragraph 51:

> It is necessary, therefore to determine the factors appropriate to the proper exercise of the judicial discretion to make an order for payment or partial payment of expenses. In my view, based on the submissions of counsel, the following is a non-exhaustive list of factor which ought to be considered in a given case before deciding to impose an order for payment of expense.

The two factors that pertain to the situation in this decision are as follows:

> …
>
> 5. Whether the [member] cooperated with respect to the investigation and offered to facilitate proof by admission.
>
> 6. The financial circumstances of the [member] and the degree to which [her] financial position has already been affected by other aspects of any penalty that has been imposed.

Ms. Djamasi admitted to the conduct alleged and thereby saved the need to prove the allegations through a full hearing which resulted in efficiencies.

The Hearing Tribunal heard evidence about Ms. Djamasi's financial circumstances from Ms. Djamasi's representative which showed Ms. Djamasi's monthly income as well as her monthly expenses. The Hearing Tribunal heard earlier that Ms. Djamasi was placed on an administrative leave from Carewest pending the decision of the Hearing Tribunal. This administrative leave did not restrict Ms. Djamasi from seeking employment elsewhere. Ms. Djamasi's representative stated that they did not feel that 25% of the hearing costs to a maximum of $3500.00 was a satisfactory amount for Ms. Djamasi to pay to the College.

Decision on costs

Payment of costs is not considered to be a penalty. It is intended to be a fair recovery of the costs that are expended by the College. It should not be expected that the College's membership acquires the full cost of the hearing with regards to Ms. Djamasi. The membership should not be responsible for covering the costs of the hearing or the investigation process with regards to Ms. Djamasi's allegations. However, the payment of cost must also be fair to the member who is being sanctioned. The Hearing Tribunal did feel that the sanction on monetary costs of approximately $145.00 per month is a fair and reasonable amount with regard to the Hearing costs.

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

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

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

    c. CLPNA Practice Policy: Professional Responsibility & Accountability;

    d. CLPNA Practice Policy: Documentation;

    e. CLPNA Practice Guideline: Medication Management;

    f. CLPNA Competency Profile D5: Legal Protocols, Documenting and Reporting;

    g. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

    h. CLPNA Competency Profile E2: Clinical Judgment and Decision Making; and

    i. 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.

3. In the event the reflective paper referred to in paragraph 3 above is not satisfactory to the Complaints Consultant, Ms. Djamasi shall within **two (2) weeks** of being notified by the Complaints Consultant the reflective paper is not satisfactory, or such longer period as determined by the Complaints Consultant at her sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

4. Ms. Djamasi shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses. Ms. Djamasi shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

5. Ms. Djamasi shall complete, at her own cost, the courses available online at http://www.pedagogyeducation.com. Ms. Djamasi shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **60 days** of service of the Decision:

    a. **Critical Thinking in Medication Administration;** and
    b. **Reducing Medication Errors: A Focus on the Med Pass.**

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

6. Ms. Djamasi shall complete **Nursing Documentation 101** available online at http://www.clpna.com. Ms. Djamasi shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **60 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. Ms. Djamasi shall provide the CLPNA with her contact information, including her home mailing address, home and cellular telephone numbers, current e-mail address and her current employment information. Ms. Djamasi will keep her contact information current with the CLPNA on an ongoing basis.

8. Should Ms. Djamasi 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.

9. Should Ms. Djamasi 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:

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

    (d) Treat Ms. Djamasi's non-compliance as information for a complaint under s. 56 of the Act.

10. Ms. Djamasi shall pay 25% of the costs of the hearing to a maximum of $3,500.00 to be paid in equal monthly installments over a period of twenty-four (24) months from service of the Hearing Tribunal's written reasons for decision.

11. In the case of non-payment of the costs described in paragraph 10 above, the Complaints Consultant may suspend Ms. Djamasi'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 11 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 3rd DAY OF OCTOBER 2019 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal