**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 JANAY (JASPERSON) BENNETT**

# 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 JANAY (JASPERSON) BENNETT, LPN #38818, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

**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 May 9, 2019 with the following individuals present:

**Hearing Tribunal**:
Kelly Annesty, LPN, Chairperson
Koreen Balaban, LPN
Johanne Chicoine, LPN
Nancy Brook, Public Member

**Staff**:
Tessa Gregson, Legal Counsel for the Complaints Director, CLPNA
Susan Blatz, Complaints Consultant, CLPNA ("Complaints Consultant")
Kevin Oudith, Complaints Consultant, CLPNA

**Investigated Member**:
Janay (Jasperson) Bennett, LPN ("Ms. Bennett" or "Investigated Member")
Carol Drennan, AUPE Representative for the member

## (2) Preliminary Matters

The hearing was open to the public in accordance with the *Health Professions Act*, RSA 2000, c H-7 ("*HPA*").

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 a Partial Joint Submission on Penalty.

## (3) Background

Ms. Bennett was an LPN within the meaning of the *HPA* at all material times, and more particularly, was registered with the CLPNA as a Licensed Practical Nurse ("LPN") at the time of the complaint. Ms. Bennett was initially licensed as an LPN in Alberta on July 9, 2014.

On April 23, 2018, the CLPNA received a complaint from Lori Sanford, Site Manager (the "Complainant"), Garden Vista, the Good Samaritan Society (the "Facility") in Magrath, Alberta (the "Complaint"). The Complaint was sent pursuant to s. 57 of the *HPA* notifying that Ms. Janay Jasperson, now Ms. Janay Bennett, LPN had been terminated from her position with the Facility due to numerous medication administration concerns and unprofessional conduct.

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

In accordance with s. 55(2)(d) of the *HPA*, the Complaints Consultant appointed Kathryn Emter, Investigator for the CLPNA (the "Investigator") to conduct an investigation into the Complaint.

On October 10, 2018, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence the matters should be referred to the Hearings Director for a hearing in accordance with s. 66(3)(a) of the *HPA*. Ms. Bennett received notice that the Complaint was referred to a hearing as well as a copy of the Statement of Allegations under cover of letter dated February 28, 2019.

A Notice of Hearing, Notice to Attend, and Notice to Produce was served upon Ms. Bennett under cover of letter dated March 15, 2019.

## (4) Allegations

The Allegations in the Statement of Allegations are:

"It is alleged that JANAY (JASPERSON) BENNETT, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about February 14, 2018 posted a live video on Facebook during her night shift, while at the front desk, contrary to facility policies.
2. On or about March 6, 2018 did one or more of the following with regards to client HR:
    a. Failed to document a verbal doctor's order received in the Progress Notes and/or the Physician's Order sheet;
    b. Incorrectly transcribed an order for Warfarin on the Medication flow sheet by documenting the wrong dates;
    c. Documented administering Warfarin 3 mg on March 1, 2018 at 2100 hours instead of on March 6, 2018 at 2100 hours; and
    d. Failed to clarify an order for Enoxaparin 40 mg/0.4ml, for administration at 2100 hours, with the physician or pharmacy.

3. On or about March 23, 2018 did one or more of the following with regards to client PK:
    a. Failed to process an order for Monurol 3 gm at 2100 hours; and
    b. Failed to document the administration of Monurol 3 gm at 2100 hours on the Medication Administration Record and/or Progress Notes in a timely manner.

4. On or about March 26, 2018 did one or more of the following with regards to client MU:
    a. Failed to monitor client MU's neurovital signs as per policy after MU suffered a fall; and
    b. Removed the battery from MU's phone, restricting MU from calling her daughter without instructions or orders to do so.

5. On or about March 28/29, 2018 did one or more of the following with regards to client GH:
    a. Failed to consult the physician or community nurse, during her twelve hour shift, regarding client GH's inability to void following the removal of his catheter at 1430 hours; and
    b. Failed to reinsert a catheter after GH had gone for a prolonged period of time without voiding."

## (5) Admission of Unprofessional Conduct

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

Ms. Bennett acknowledged unprofessional conduct to all the Allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Legal Counsel on behalf of the Complaints Director argued, where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

## (6) Exhibits

The following exhibits were entered at the hearing:

| | |
|---|---|
| Exhibit #1: | Statement of Allegations |
| Exhibit #2: | Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct |
| Exhibit #3: | Joint Submission on Penalty |
| Exhibit #4: | Additional Order Sought by the Complaints Consultant Regarding Costs |
| Exhibit #5: | Estimated Hearing Costs |

## (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. Bennett's admission of unprofessional conduct based on evidence 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. Bennett.

Allegation 1

Ms. Bennett admitted that on or about February 14, 2018, she posted a live video on Facebook during her night shift, while at the front desk, contrary to facility policies.

On February 14, 2018, Ms. Bennett worked a night shift at the Facility.

During this shift, while at the front desk, Ms. Bennett and Ms. Rae Foote, Health Care Aide ("RF, HCA") recorded and posted a Facebook Live Video regarding a prize draw for Ms. Bennett's side business "Brows by Janay".

This conduct is in contravention of several Facility policies. Specifically, the Facility Personal Calls and Personal Communication Devices Policy, which states that employees "may never use personal communication devices in resident or client care or service areas" and requires employees to store their personal communication devices with their personal belongings (i.e. in their locker), except for during their breaks. Further, the Facility Social Media Policy prohibits the use of social media by employees during work time. Social media is to be limited to breaks and not to interfere with client care responsibilities. Copies of the Facility Personal Calls and Personal Communication Devices Policy and the Social Media Policy were attached to Exhibit 2 at Tab 5.

Ms. Bennett was not on her break at the time she recorded and posted the live video to Facebook.

An LPN is expected to follow the practices and policies of the workplace, failing to do so can undermine the integrity of the profession in the eyes of the public. In this case, Ms. Bennett was using time that should have been devoted to caring for patients to engage in outside business opportunities.

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

(i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; …

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

Allegation 2

Ms. Bennett admitted that on or about March 6, 2018, she did one or more of the following with regards to client HR:

a. Failed to document a verbal doctor's order received in the Progress Notes and/or the Physician's Order sheet;
b. Incorrectly transcribed an order for Warfarin on the Medication flow sheet by documenting the wrong dates;
c. Documented administering Warfarin 3 mg on March 1, 2018 at 2100 hours instead of on March 6, 2018 at 2100 hours; and
d. Failed to clarify an order for Enoxaparin 40 mg/0.4ml, for administration at 2100 hours, with the physician or pharmacy.

Ms. Bennett worked a night shift from March 6-7, 2018. During this shift, she provided care to resident HR who had arrived at the Facility on March 6, 2018.

Resident HR had an order for Warfarin and Enoxaparin administrations at 2100 hours depending on HR's International Normalized Ratio ("INR") results.

Ms. Bennett was unable to locate HR's INR results and therefore called the physician to clarify the order for Warfarin. The physician provided a verbal order that HR receive Warfarin without the INR results. However, Ms. Bennett failed to document the physician's verbal order on the Progress Notes or the Physician's Order sheet.

Ms. Bennett then incorrectly transcribed the verbal order for the Warfarin on the medication flow sheet by documenting the order as having started on March 1, 2018, when client HR did not arrive to the Facility until March 6, 2018. A copy of HR's medication flow sheet was attached to Exhibit #2 at Tab 6.

While Ms. Bennett administered Warfarin 3 mg to client HR on March 6, 2018, at 2100 hours, she incorrectly documented the medication as having been administered on March 1, 2018. This was seen on HR's medication flow sheet which was attached to Exhibit #2 at Tab 6.

Client HR had an order for Enoxaparin 40 mg/0.4 ml at 2100 hours depending on his INR results. A copy of HR's medication order for Enoxaparin 40 mg/0.4 ml was attached to Exhibit #2 at Tab 7.

Ms. Bennett did clarify HR's Warfarin order; however, she failed to clarify the order for Enoxaparin 40 mg/0.4ml with the physician or pharmacy. Rather, Ms. Bennett held the medication and documented that she would instruct the day LPN to inquire into the INR results so that the Enoxaparin 40 mg/0.4 ml could be administered, see Exhibit #2 at Tab 8.

Proper charting and administration of patient medications is an integral part of patient care. These are basic and fundamental skills which all LPNs must possess and exhibit.

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

> (i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; …
>
> (xii) Conduct that harms the integrity of the regulated profession.

Allegation 3

Ms. Bennett admitted that on or about March 23, 2018, she did one or more of the following with regards to client PK:

a. Failed to process an order for Monurol 3 gm at 2100 hours; and
b. Failed to document the administration of Monurol 3 gm at 2100 hours on the Medication Administration Record and/or Progress Notes in a timely manner.

Ms. Bennett worked a night shift on March 23 and 24, 2018 at the Facility and during her shift she provided care to client PK.

On March 23, 2018, the LPN who was working on the day shift, Ms. Melanie Lewis ("ML, LPN"), received an order for a one-time dose of Monurol 3 gm at 2100 hours and faxed it to the pharmacy. A copy of the PK's progress notes was attached to Exhibit #2 at Tab 9.

Ms. Bennett was responsible for processing the order and administering the Monurol once it arrived. While the pharmacy delivered the medication to the Facility later in the evening on March 23, 2018, Ms. Bennett failed to process the order for Monurol once the medication arrived. The order was not processed until the following day by ML, LPN. A copy of the Medication Administration Record ("MAR") Update Communication Form was attached to Exhibit #2 at Tab 10.

Further, Ms. Bennett administered the Monurol 3 gm at 2100 hours, but failed to document the administration on the MAR or Progress Notes following the administration on March 23 at 2100

hours. Instead, Ms. Bennett documented the administration when she returned to work for her next night shift on March 24, 2018. This could be seen at Exhibit #2 at Tab 11.

Again, the proper administration and documentation of patient medication is vitally important and can have significant impact on a patient's well-being. These tasks are central to the knowledge and skills of an LPN.

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

> (i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; …
>
> (xii) Conduct that harms the integrity of the regulated profession.

Allegation 4

Ms. Bennett admitted that on or about March 26, 2018, she did one or more of the following with regards to client MU:

a. Failed to monitor client MU's neurovital signs as per policy after MU suffered a fall; and
b. Removed the battery from MU's phone, restricting MU from calling her daughter without instructions or orders to do so.

Ms. Bennett worked a night shift at the Facility on March 25-26, 2018.

During this shift, on March 26, 2018, client MU suffered a fall at approximately 0049 hours. A copy of MU's fall report was attached to Exhibit #2 at Tab 12.

Ms. Bennett assessed MU after the fall and charted the same on MU's progress notes at 0240 hours. MU's vital signs were taken at 0554 hours on March 26, 2018. In the progress notes, Ms. Bennett charted that MU was on anticoagulants. Despite this, Ms. Bennett failed to monitor MU's neurovital signs following the fall. A copy of MU's progress notes was attached to Exhibit #2 at Tab 13.

The failure to monitor MU's neurovital signs is contrary to the Facility's Post-Fall Algorithm (the "Algorithm"). The Algorithm requires that a resident's neurovital signs be monitored every hour for 4 hours and every 8 hours for 48 hours where the resident is on anticoagulant or antiplatelet therapy. A copy of the Algorithm was attached to Exhibit #2 at Tab 14.

In addition, MU had a cell phone which she used to call her daughter on a frequent basis. However, during her night shift from March 25-26, 2018, Ms. Bennett removed the battery from MU's cell phone without instructions or orders to do so from MU or MU's daughter. Doing so prevented MU from calling her daughter; MU's daughter did not, and would not have, provided such instructions to Ms. Bennett.

Patient well-being is of primary importance to the work of an LPN, failing to follow the appropriate protocols following a fall left this patient vulnerable to adverse health outcomes. Further, arbitrarily taking patient property, especially when it is the patient's means of communication with family and others, shows a disregard for the dignity of the patient. This conduct could have had significant harmful impacts on the patient.

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

> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; …
>
> (xii) conduct that harms the integrity of the regulated profession.

Allegation 5

Ms. Bennett admitted that on or about March 28-29, 2018, she did one or more of the following with regards to client GH:

a. Failed to consult the physician or community nurse, during her twelve hour shift, regarding client GH's inability to void following the removal of his catheter at 1430 hours; and
b. Failed to reinsert a catheter after GH had gone for a prolonged period of time without voiding.

Ms. Bennett worked a night shift from March 28-29, 2018 and during this shift provided care to client GH.

On March 28, 2018, the home care RN instructed that client GH's catheter be removed on a trial basis to determine if GH could void on his own. The day LPN, ML, removed the catheter at 1430 hours. A copy of GH's progress notes was attached to Exhibit #2 at Tab 15.

ML, LPN provided a report to Ms. Bennett that GH's catheter was removed and GH would need to be monitored for output. GH was monitored throughout the shift, but at no time during Ms.

Bennett's 12-hour night shift did GH void. At 0547 hours on March 29, 2018, GH reported discomfort in his bladder: see Exhibit #2, at Tab 15. By 0547 hours on March 29, 2018, GH had gone 15 hours without voiding. Despite GH's inability to void following the removal of the catheter at 1430 hours on March 28, 2018 and GH's report of bladder discomfort, Ms. Bennett failed to reinsert the catheter. The *Clinical Nursing Skills and Techniques* textbook dictates that it is expected that a patient will void at least 150 mls "no more than 6 to 8 hours after [catheter] removal" (emphasis added). An excerpt from *Clinical Nursing Skills and Techniques*, 9th Edition included with Exhibit #2 at Tab 16.

Ms. Bennett further failed to consult the physician or community nurses regarding GH's inability to void after the removal of the catheter.

LPNs are expected to be knowledgeable in their field and to apply that knowledge for the benefit of patients. In this case, Ms. Bennett demonstrated that she did not possess basic knowledge of the need to reinsert the catheter in this case. Moreover, this failure in knowledge could have caused real harm as well as immediate discomfort to this patient.

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

> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; …
>
> (xii) conduct that harms the integrity of the regulated profession.

CLPNA Code of Ethics Breached

Ms. Bennett acknowledges her conduct breached one of more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013. The Hearing Tribunal finds that Ms. Bennett's conduct breached the following principles and standards set out in CLPNA's Code of Ethics:

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.
    - 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:
    - 2.4 – 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.

c) Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:
    - 3.1 – Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
    - 3.3 – Practice in a manner that is consistent with the privilege and responsibility of self-regulation.
    - 3.4 – Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable.

d) Principle 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.

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

Ms. Bennett acknowledges her conduct also breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, and the Hearing Tribunal agrees she has breached one or more of the following Standards, 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.
    - 1.4 – 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 LPNs.
- 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.
   - 2.3 – Access and use relevant and credible information technology and other resources.
   - 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.
   - 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.

d) Standard 4: Ethical Practice – LPNs uphold, promote and adhere to the values and beliefs 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.

As the Hearing Tribunal has already indicated, it finds that Ms. Bennett's conduct breached the Code of Ethics and Standards of Practice. Although there was no evidence of serious patient harm, Ms. Bennett's actions had the potential for real harm to residents under her care and showed a lack of professionalism. LPNs must provide care in accordance with their training, competence, and protocols that are in place as reflected in the Code of Ethics and Standards of Practice. The breaches of the above noted sections of the Code of Ethics and Standards of Practice by Ms. Bennett are serious and constitute unprofessional conduct in accordance with s 1(1)(pp)(ii) of the *HPA*.

## (9) Partial Joint Submission on Penalty

The Complaints Consultant and Janay (Jasperson) Bennett 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. Bennett shall read the following CLPNA documents located on the CLPNA website at www.clpna.com under the "Governance" tab, and provide a written reflection, between 500 – 700 words, to the Complaints Consultant within **30 days** of service of the Decision on how she will incorporate the following readings in her nursing 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 Practice Guideline: Professionalism on Social Media;
    f. CLPNA Competency Profile: B1: Assessment;
    g. CLPNA Competency Profile: D5: Legal Protocols, Documenting and Reporting;
    h. CLPNA Competency Profile D6: Accept, Transcribe and Initiate Orders;
    i. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;
    j. CLPNA Competency Profile E2: Clinical Judgment and Decision Making;
    k. CLPNA Competency Profile U2: Medication Preparation and Administration; and

l. CLPNA Competency Profile W4: Professional Ethics.

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

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

4. Ms. Bennett shall complete the following nursing quizzes located on website http://www.learningnurse.org/. Ms. Bennett shall provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within **30 days** of service of the Decision:

   a) 12.8 Safe Medication Principles; and

   b) 16.3 Professional Practice.

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

5. Ms. Bennett shall complete, at her own cost, the course: **Transcribing Physician Orders (HLTH 1138)** offered on-line at www.vcc.ca by Vancouver Community College. Ms. Bennett shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **4 months** of service of the Decision.

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

6. Ms. Bennett shall complete, at her own cost, the following course: **Bladder Management** offered online at www.coursepark.com. Ms. Bennett 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 Consulant.

7. Ms. Bennett 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. Bennett will keep her contact information current with the CLPNA on an ongoing basis.

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

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

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

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

Legal Counsel for the Complaints Director submitted the primary purpose of orders from the Hearing Tribunal is to protect the public.

While the parties 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 and partial joint submissions 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 carefully considered the Partial Joint Submission on Penalty by Ms. Bennett 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.

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) ("*Jaswal*"), 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 is a significant factor as the allegations deal with the use of social media in violation of a workplace policy, medication documentation, medication administration, transcribing medication orders, failure to monitor a patient's vital signs, and failure to monitor a patient post procedure. These are basic skills and core competencies that a Licensed Practical Nurse should possess regardless of their experience. These are basic requirements for Licensed Practical Nurses upon graduation.

**The age and experience of the investigated member:** Ms. Bennett was initially registered with the CLPNA on July 9, 2014. Ms. Bennett was continuously registered and a regulated member since that time. Ms. Bennett, at the time of the allegations, had four years' experience as a Licensed Practical Nurse.

**The number of times the offending conduct was proven to have occurred:** There were five allegations made that occurred within a two month time period. These allegations relate to a variety of issues which is a concern in regard to lack of knowledge, skill or judgement on Ms. Bennett's part.

**The role of the investigated member in acknowledging what occurred:** Ms. Bennett did acknowledge her actions and cooperated with both the CLPNA and her representative from AUPE in both the investigation procedure as well as providing an Agreed Statement of Facts.

**Whether the investigated member has already suffered other serious financial or other penalties as a result of the Allegations having been made:** Ms. Bennett was terminated from her position at the Facility on April 16, 2018 for reasons related to the issues in this hearing.

**The impact of the incident(s) on the victim:** The Hearing Tribunal did not receive evidence of actual patient harm; however, there was potential for serious harm because of Ms. Bennett's actions.

**The presence or absence of any mitigating circumstances:** The Hearing Tribunal was not made aware 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:** Regarding specific deterrence there is a need to impose sanctions on Ms. Bennett as she should be aware that her behavior is not acceptable and falls below what is expected of a Licensed Practical Nurse.

Regarding general deterrence, the public should also be made aware that this type of behavior will not be tolerated by the CLPNA and such behavior will be dealt with in a serious manner. CLPNA does have a discipline process which helps ensure LPNs are competent and self-regulated professionals and the public needs to be reassured that this standard is upheld.

**The need to maintain the public's confidence in the integrity of the profession:** The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches in the *HPA*, the Code, and Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

**The range of sentence in other similar cases:** The Hearing Tribunal was not presented with any similar cases.

It is important to the profession of LPNs to maintain the Code and Standards of Practice, and in doing so to promote specific and general deterrents and, thereby, to protect the public. The 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 that actions and unprofessional conduct such as this are 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 in the public interest and therefore accepts the parties' proposed penalties.

**(11) <u>Additional Order sought by the Complaints Consultant</u>**

The Complaints Consultant requested the Hearing Tribunal make the following order:

1. Ms. Bennett will be required to pay 25% of the costs of the Investigation and hearing to a maximum of $3500.00. Costs will be payable in equal monthly installments over a period of 24 months from the date of service of the Hearing Tribunal's written decision, or over such other period of time as agreed to by the Complaints Consultant.

This is a request for a partial payment of costs. *Jaswal* offers guidance on sanctioning for costs at para 51:

> It is necessary, therefore to determine the factors and 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 submission of counsel, the following is a non-exhaustive list of factors 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 his financial position has already been affected by other aspects of any penalty that has been imposed.

The Complaints Consultant submitted that the costs of the Hearing are to be a separate consideration as they are not meant to be a penalty. The repayment of costs is designed to recognize that costs have been incurred by the College and its members should not have to

absorb all the costs of a Hearing. Therefore, the College is asking Ms. Bennett to pay back partial costs of 25% of the total cost up to a maximum of $3,500.00. This amount was requested in recognition of Ms. Bennett's cooperation with the College. Further, there are no restrictions presently on Ms. Bennett's license that stop her from working as an LPN, regardless that she was terminated from her employment at the Facility.

Ms. Bennett's representative submitted that Ms. Bennett was unemployed for a period of five months and she is currently working in a walk-in clinic and has a decreased rate of pay and no health benefits. Ms. Bennett's representative stated that they did not feel that 25% of hearing costs to a maximum of $3,500.00 was a satisfactory amount for Ms. Bennett to pay back. Ms. Bennett's representative submitted that they would like to have a set number for the costs to be fair to Ms. Bennett but did not make a specific request at to what that number should be.

Payment of costs is not to be considered a penalty. It is intended to be a fair recovery of costs expended by the College. It should not be expected that the College's membership bears the full burden of costs for hearings. It must also be fair to the member who is being sanctioned.

In this case, Ms. Bennett admitted to the conduct and assisted in the investigation which resulted in cost savings in that process.

Hearing Tribunals are also urged to consider the financial situation of the member. The Hearing Tribunal has considered Ms. Bennett's submissions in this regard.

The Hearing Tribunal determined that the Complaints Consultant's proposed costs are reasonable. Twenty-five (25%) of the costs to a maximum of $3,500.00 with payments spread over 24 months is a reasonable amount for an LPN. The estimated expense for this hearing is $14,002.00 meaning that Ms. Bennett would be required to pay the maximum amount of $3,500.00. The amount of $3,500.00 spread over 24 months is a monthly payment of $145.83 per month. The Hearing Tribunal does not believe this amount represents a crushing financial burden to Ms. Bennett.

Therefore, the Hearing Tribunal orders the additional sanction of costs.

## (11) Orders of the Hearing Tribunal

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

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

2. Ms. Bennett shall pay 25% of the costs of the hearing to a maximum of $3500.00 to be paid in equal monthly installments over a period of 24 months from service of the Decision.

3. Ms. Bennett shall read the following CLPNA documents located on the CLPNA website at www.clpna.com under the "Governance" tab, and provide a written reflection, between 500 – 700 words, to the Complaints Consultant within **30 days** of service of the Decision on how she will incorporate the following readings in her nursing 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 Practice Guideline: Professionalism on Social Media;

    f. CLPNA Competency Profile: B1: Assessment;

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

    h. CLPNA Competency Profile D6: Accept, Transcribe and Initiate Orders;

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

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

    k. CLPNA Competency Profile U2: Medication Preparation and Administration; and

    l. CLPNA Competency Profile W4: Professional Ethics.

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

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

5. Ms. Bennett shall complete the following nursing quizzes located on website http://www.learningnurse.org/. Ms. Bennett shall provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within **30 days** of service of the Decision:

    a) 12.8 Safe Medication Principles; and

    b) 16.3 Professional Practice.

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

6. Ms. Bennett shall complete, at her own cost, the course: **Transcribing Physician Orders (HLTH 1138)** offered on-line at www.vcc.ca by Vancouver Community College. Ms. Bennett shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **4 months** of service of the Decision.

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

7. Ms. Bennett shall complete, at her own cost, the following course: **Bladder Management** offered online at www.coursepark.com. Ms. Bennett 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 Consulant.

8. Ms. Bennett 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. Bennett will keep her contact information current with the CLPNA on an ongoing basis.

9. Should Ms. Bennett 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.

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

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

(b) Treat Ms. Bennett's non-compliance as information for a complaint under s. 56 of the *HPA*; or

(c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Bennett'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 for penalty adequately balances the factors referred to in s. 10 above, and is consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, sections 87(1)(a),(b) and 87(2) of the *HPA*, 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 17th DAY OF JUNE, 2019 IN THE CITY OF EDMONTON, ALBERTA.**

**THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

Kelly Annesty, LPN
Chair, Hearing Tribunal