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 KINAWA SEANTHAVESOUK

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 KINAWA SEANTHAVESOUK, LPN #30554, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Videoconference using Zoom on November 5, 2020 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Patricia Riopel, LPN
James Lees, Public Member

Staff:
Jason Kully, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Kinawa Seanthavesouk, LPN ("Ms. Seanthavesouk" or "Investigated Member")
Kathie Milne, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Seanthavesouk 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. Seanthavesouk was initially registered with the CLPNA on September 8, 2008. She began working as an LPN at the RAH in 2008.

The CLPNA received a complaint on January 19, 2018 (the "First Complaint") from Tenille Wren, RN, Unit Manager, Patient Care Unit (PCU) 44 at the Royal Alexandra Hospital ("RAH") in Edmonton, Alberta, pursuant to s. 57 of the Act. The First Complaint stated Ms. Seanthavesouk, LPN, had received a three-day suspension of her employment at the RAH for professional misconduct.

Ms. Seanthavesouk is also known by her married name, Kinawa Harrison.

In accordance with s. 55(2)(d) of the Act, Ms. Sandy Davis, the Complaints Director of the CLPNA (the "Complaints Director") appointed Kerry Palyga, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the First Complaint.

By way of letter dated January 31, 2018, the Complaints Director provided Ms. Seanthavesouk with notice of the First Complaint and of the appointment of the Investigator.

On March 12, 2019, the Investigator concluded the investigation into the First Complaint and submitted an Investigation Report to the Complaints Director.

The CLPNA received a further complaint dated April 22, 2019 (the "Second Complaint") from Ms. Wren pursuant to s. 57 of the Act. The Second Complaint stated that Ms. Seanthavesouk had received a five-day suspension of her employment at the RAH as a result of professional misconduct.

In accordance with s. 55(2)(d) of the Act, the Complaints Director appointed the Investigator to conduct an investigation into the Second Complaint. At this time, the Complaints Director delegated her authority and powers under Part 4 of the Act to Susan Blatz, Complaints Consultant for the CLPNA, (the "Complaints Consultant") pursuant to s. 20 of the Act.

By way of letter dated May 8, 2019, the Complaints Director provided Ms. Seanthavesouk with notice of the Second Complaint, notice of the appointment of the Investigator, and notice of the delegation of authority to the Complaints Consultant.

On June 4, 2020, the Investigator concluded the investigation into the Second Complaint and submitted an Investigation Report to the Complaints Consultant.

Following receipt of the Investigation Reports, the Complaints Consultant determined there was sufficient evidence that the issues raised in the First Complaint and the Second Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Seanthavesouk received notice the matters were referred to a hearing, as well as a copy of the Statement of Allegations and the Investigation Reports, on July 27, 2020.

A Notice of Hearing Notice to Attend and Notice to Produce was served upon Ms. Seanthavesouk under cover of letter dated October 5, 2020.

(4) Allegations

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

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

1. On or about September 22, 2017 did one or more of the following with regards to client KR:
    a) Failed to reassess and/or document a reassessment after discovering a low blood glucose level of 3.7;
    b) Failed to clearly document the administration or holding of scheduled insulin in the Medication Log (VAX) at 1700 hours, particulars of which include one or more of the following:
        a. Creating an entry at 1636 hours that the medication was held at 1700 hours and then deleting the entry at 1755 hours;
        b. Creating an entry at 1755 hours that the medication was administered at 1730 hours and then deleting the entry at 2143 hours;
        c. Creating an entry at 2143 hours that the medication was held at 1730 hours.

2. On or about October 3, 2017 failed to follow a physician's order by failing to discontinue the intravenous administration of D5W NS with 20 KCL for client ED as ordered.

3. On or about March 5, 2018 did one or more of the following with regards to client DS:
    a) Failed to document in the Nursing Assessment and Care Record DS's complaint of nausea;
    b) Failed to provide and/or document any intervention to address DS's complaint of nausea;
    c) Failed to document in the Nursing Assessment and Care Record the reason for not administering insulin at the scheduled time of 0730 hours;
    d) Failed to notify the physician of the missed dose of insulin at 0730 hours in a timely manner;
    e) Left an insulin pen on a nurses' tray in DS's room;
    f) Pre-charted the administration of Humalog at 0825 hours on the Insulin and Blood Glucose Monitoring Record prior to the administration of the insulin;

g) Failed to document in the Nursing Assessment and Care Record that DS's physician was notified of high blood glucose level and missed dose of insulin at 0730 hours.

4. On or about March 5, 2018 did one or more of the following with regards to client CB:
    a) Pre-charted the administration of Humalog at 0825 hours on the Insulin and Blood Glucose Monitoring Record prior to the administration of the insulin;
    b) Failed to properly correct documentation of the administration of Humalog on the Insulin and Blood Glucose Monitoring Record by writing over the initial "time administered" and "site" documented and making the documentation illegible.

5. On or about March 5, 2018 did one or more of the following while providing care during a buddy shift:
    a) Pre-poured medications;
    b) Pre-charted the administration of patient medications;
    c) Failed to administer medications in a timely manner;
    d) Demonstrated a lack of medication administration knowledge."

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Statement of Allegations
Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3: Joint Submission on Penalty

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

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

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

The Hearing Tribunal also accepts Ms. Seanthavesouk'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. Seanthavesouk.

Allegation 1

Kinawa Seanthavesouk admitted on or about September 22, 2017, she did one or more of the following with regards to client KR:

a) Failed to reassess and/or document a reassessment after discovering a low blood glucose level of 3.7;
b) Failed to clearly document the administration or holding of scheduled insulin in the Medication Log (VAX) at 1700 hours, particulars of which include one or more of the following:
    a. Creating an entry at 1636 hours that the medication was held at 1700 hours and then deleting the entry at 1755 hours;
    b. Creating an entry at 1755 hours that the medication was administered at 1730 hours and then deleting the entry at 2143 hours;
    c. Creating an entry at 2143 hours that the medication was held at 1730 hours.

Ms. Seanthavesouk worked from 1500 to 2300 hours on September 22, 2017 at the Royal Alexandra Hospital. KR was one of Ms. Seanthavesouk's assigned patients.

KR was scheduled to receive insulin at 1700 hours.

On September 22, 2017 at 1650 hours, Ms. Seanthavesouk documented on KR's insulin and Blood Glucose Monitoring Record "Insulin held 4 apple juice and supper Glucometer 3.7."

At 1800 hours, Ms. Seanthavesouk documented on KR's Nursing Assessment and Care Record "Pt c/s was 3.7 mml/L, pt drank 4 apple juices and ate 100% of supper, will continue to monitor." At 2200 hours, Ms. Seanthavesouk documented "Dr. Drummond found pt unconscious on the floor c/s at 2115 was 0.7 mmol/L. Head to toe done, c/s at 2125 was 10.6 after D5W push."

A blood glucose level below 3.9 mmol/L is low and can cause harm.

Ms. Seanthavesouk failed to reassess or document a reassessment of KR on September 22, 2017 after documenting a blood glucose level of 3.7, which was below 3.9 and a cause for concern. KR was later found unconscious with a very low blood glucose level.

At 1636 hours, Ms. Seanthavesouk documented "Medication Held @ 1700 hours – Notes CS 3.7." She then deleted this documentation at 1755 hours. At 1755 hours, Ms. Seanthavesouk documented that "Medication Administered (KR's left Thigh) at 1730 hours – Notes CS 5.3." Ms. Seanthavesouk then deleted this documentation at 2143 hours. At 2143 hours, Ms. Seanthavesouk "Medication Held @ 1730 hours – Notes CS 3.7."

Ms. Seanthavesouk did not clearly document the administration or holding of the medication to KR and this brings into question what Ms. Seanthavesouk did with KR's scheduled insulin administration at 1700 hours.

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

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

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Seanthavesouk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to reassess and to document the reassessment of KR's blood

glucose after discovering that it was low. Ms. Seanthavesouk also failed to document the administration or the holding of KR's insulin clearly on the Medication log.

Ms. Seanthavesouk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Seanthavesouk in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail below. The Hearing Tribunal finds the conduct breached by the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out below and that such breaches are sufficiently serious to constitute unprofessional conduct.

Ms. Seanthavesouk's conduct harms the integrity of the regulated profession in that Ms. Seanthavesouk did not act in a manner that would be expected of another LPN in a similar situation. Documentation and assessment of patient's blood glucose reading, and ensuring a proper record of what occurred regarding a patient's medication administration, are core fundamentals of an LPN's skill and core competencies.

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

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

Ms. Seanthavesouk acknowledged that her conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

> **Principle 1**: Responsibility to the Public - Licensed Practical Nurses, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 states that LPNs:
>
> - 1.1 Maintain standards of practice, professional competence and conduct.
>
> - 1.5 Provide care directed toward the health and well-being of the person, family, and community.
>
> **Principle 2**: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for clients. Principle 2 states that LPNs:
>
> - 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 states 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 4: Responsibility to the Profession – LPNs develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals. Principle 4 states that LPNs:

- 4.2 Collaborate with colleagues in a cooperative, constructive and respectful manner with the primary goal of providing safe, competent, ethical, and appropriate care to individuals, families, and communities.

Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 states 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:</u>

Ms. Seanthavesouk acknowledged that her conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

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 states 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.

- 1.9 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 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 states that LPNs:

- 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice.

- 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 states that LPNs:

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

- 4.7 Communicate in a respectful, timely, open and honest manner.

- 4.8 Collaborate with colleagues to promote safe, competent and ethical practice.

- 4.9 Support and contribute to healthy and positive practice environments.

<u>Allegation 2</u>

Kinawa Seanthavesouk admitted on or about October 3, 2017, she failed to follow a physician's order by failing to discontinue the intravenous administration of D5W NS with 20 KCL for client ED as ordered.

Ms. Seanthavesouk worked from 1500 to 2300 hours on October 3, 2017 at the Royal Alexandra Hospital. ED was one of Ms. Seanthavesouk's assigned patients.

On October 3, 2017, a physician ordered that ED's insulin drip and intravenous administration of D5W NS with 20 KCL should be discontinued.

Ms. Seanthavesouk reviewed the Physician's Order and documented an initial assessment of ED at 1530 hours.

Despite reviewing the Physician's Order, Ms. Seanthavesouk did not discontinue the intravenous administration of D5W NS with 20 KCL for ED.

The failure to discontinue the intravenous administration of D5W NS with 20KCL for ED resulted in ED's blood glucose levels rising to an unsafe level. ED's blood glucose level at 2115 hours was recorded by Ms. Seanthavesouk as 23.9.

Despite the high blood glucose level, Ms. Seanthavesouk did not discontinue the intravenous administration of D5W NS with 20 KCL for ED.

The intravenous administration of D5W NS with 20 KCL for ED was stopped by another staff member at 0800 hours on October 4, 2017.

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

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1) (pp) of the Act the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Seanthavesouk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to adhere to the physician's order of discontinuing ED's insulin drip. ED's blood glucose levels were rising to an unsafe level and Ms. Seanthavesouk did not inform the physician or discontinue the insulin drip.

Ms. Seanthavesouk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Seanthavesouk in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

Ms. Seanthavesouk's conduct harms the integrity of the regulated profession in that Ms. Seanthavesouk did not act in a manner that would be expected of another LPN in a similar

situation, as medication administration is a core fundamental of an LPN's skill and a core competency.

Allegation 3

Kinawa Seanthavesouk admitted on or about March 5, 2018, she did one or more of the following with regards to client DS:

a) Failed to document in the Nursing Assessment and Care Record DS's complaint of nausea;
b) Failed to provide and/or document any intervention to address DS's complaint of nausea;
c) Failed to document in the Nursing Assessment and Care Record the reason for not administering insulin at the scheduled time of 0730 hours;
d) Failed to notify the physician of the missed dose of insulin at 0730 hours in a timely manner;
e) Left an insulin pen on a nurses' tray in DS's room;
f) Pre-charted the administration of Humalog at 0825 hours on the Insulin and Blood Glucose Monitoring Record prior to the administration of the insulin;
g) Failed to document in the Nursing Assessment and Care Record that DS's physician was notified of high blood glucose level and missed dose of insulin at 0730 hours.

On March 5, 2018, Ms. Seanthavesouk worked a supervised practice shift on Unit 44 at the Royal Alexandra Hospital with Peggy Antonsen, RN, CNE from 0700 to 1515 hours. Patient DS was assigned to Ms. Seanthavesouk.

Ms. Seanthavesouk assessed DS at 0715 hours. At this time, DS complained of nausea. Ms. Seanthavesouk advised DS that she would research what options were available to address DS's nausea. However, Ms. Seanthavesouk did not document DS's complaint of nausea and did not research what options were available. Ms. Seanthavesouk did not provide or document any intervention to address DS's complaint of nausea.

DS was scheduled to receive a dose of insulin at 0730 hours.

Ms. Seanthavesouk did not administer DS's insulin at this time as she wanted to complete the assessments of her other patients first.

Ms. Seanthavesouk did not attempt to administer the insulin until 0915 hours. However, at this time, DS was off Unit 44 for a chest x-ray.

Ms. Seanthavesouk had pre-charted the administration of the insulin, Humalog, to DS at 0825 hours on DS's Insulin and Blood Glucose Monitoring Record. Ms. Seanthavesouk crossed out the entry after DS was not present in his room to receive the insulin.

As DS was not present to receive the insulin, Ms. Seanthavesouk left the insulin pen for DS on a nurse's tray in DS's room. When the insulin pen was found, it was unclear whether the insulin had been administered.

Ms. Seanthavesouk did not document the reason for not administering the insulin at the ordered time of 0730 hours.

Ms. Seanthavesouk did not notify DS's physician about the missed dose of insulin at this time either. The physician was not notified until 1200 hours when DS's blood glucose level was greater than 27 mmol/L.

Ms. Seanthavesouk did not make any entry in the Nursing Assessment and Care Record to document that DS's physician had been notified of the missed dose of insulin and she did not make any entry regarding DS's elevated blood glucose level.

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

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

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Seanthavesouk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to document in the Nursing Assessment and Care Record DS's complaint of nausea, nor did she provide DS with the research about the nausea as she had advised that she would. Ms. Seanthavesouk failed to communicate the change in patient DS's condition to the physician. Ms. Seanthavesouk also failed to provide DS with insulin at the time required by the physician's order. Ms. Seanthavesouk left DS's insulin pen in the patient's room which caused concern, but it was not clear as to whether DS's insulin was administered or not.

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

that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

Ms. Seanthavesouk's conduct harms the integrity of the regulated profession in that Ms. Seanthavesouk did not act in a manner that would be expected of another LPN in a similar situation, as medication administration is a core fundamental of an LPN's skill and a core competency.

Allegation 4

Kinawa Seanthavesouk admitted on or about March 5, 2018, she did one or more of the following with regards to client CB:

a) Pre-charted the administration of Humalog at 0825 hours on the Insulin and Blood Glucose Monitoring Record prior to the administration of the insulin;
b) Failed to properly correct documentation of the administration of Humalog on the Insulin and Blood Glucose Monitoring Record by writing over the initial "time administered" and "site" documented and making the documentation illegible.

On March 5, 2018, Ms. Seanthavesouk worked a supervised practice shift on Unit 44 at the Royal Alexandra Hospital on Unit 44 with Peggy Antonsen, RN, CNE from 0700 to 1515 hours.

AT 0825 hours, Ms. Seanthavesouk documented the administration of Humalog at 0825 hours on CB's Insulin and Blood Glucose Monitoring Record. Ms. Seanthavesouk had not yet administered the Humalog to CB when she made this documentation.

Ms. Seanthavesouk administered the Humalog to CB later in the day on March 5, 2018. Ms. Seanthavesouk wrote over her previous "time administered" and "site" documentation on the Insulin and Blood Glucose Monitoring Record, rendering the documentation illegible.

Ms. Seanthavesouk should have crossed out the entries and re-written the correct documentation again instead of writing over her previous entry.

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

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

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Seanthavesouk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to document medication in a manner that is expected of an LPN. Ms. Seanthavesouk pre-charted the administration of Humalog prior to the administration to patient CB. Then, when Ms. Seanthavesouk was aware of the error, instead of making a clear documentation by crossing out the entries and she should have re-written the proper documentation which is what would be expected of an LPN.

Ms. Seanthavesouk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Seanthavesouk in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

Ms. Seanthavesouk's conduct harms the integrity of the regulated profession in that Ms. Seanthavesouk did not act in a manner that would be expected of another LPN in a similar situation, as medication administration is a core fundamental of an LPN's skill and a core competency.

Allegation 5

Kinawa Seanthavesouk admitted on or about March 5, 2018, she did one or more of the following while providing care during a buddy shift:

a) Pre-poured medications;
b) Pre-charted the administration of patient medications;
c) Failed to administer medications in a timely manner;
d) Demonstrated a lack of medication administration knowledge.

On March 5, 2018, Ms. Seanthavesouk worked a supervised practice shift on Unit 44 at the Royal Alexandra Hospital with Peggy Antonsen, RN, CNE from 0700 to 1515 hours.

During the shift, Ms. Antonsen observed concerns with Ms. Seanthavesouk's practice. Some of these concerns directly impacted patient safety.

Specifically, Ms. Antonsen observed multiple medication administration errors which included Ms. Seanthavesouk pre-pouring medications, pre-charting the administration of medication, administering medications late, not properly labelling prepared medication, and preparing multiple patients' medication at the same time.

Specifically, in the Post Observation Note/Meeting Notes of the Staff Observation Report, Ms. Antonsen wrote:

> The supervised practice shift was disorganized resulting in multiple extra trips back and forth within the unit. The medication preparation and delivery concerned me greatly about the potential for multiple errors and patient safety. Most of which [Ms. Seanthavesouk] was not aware of until I brought her attention to them. Pre-pouring and false documentation is also a great concern. Communication with me during the shift was at my initiation. I am worried about her dishonesty and lack of accountability to report the facts and her responsibility in errors.

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

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

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Seanthavesouk displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by pre-pouring medications, pre-charting the administration of medications, failing to administer medications in a timely manner, and Ms. Seanthavesouk displayed a lack of knowledge in respect to medication administration.

Ms. Seanthavesouk did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Seanthavesouk in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

Ms. Seanthavesouk's conduct harms the integrity of the regulated profession in that Ms. Seanthavesouk did not act in a manner that would be expected of another LPN in a similar situation, as medication administration is a core fundamental of an LPN's skill and a core competency.

(9) Joint Submission on Penalty

The Complaints Consultant and Ms. Seanthavesouk jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #3. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

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

2. Ms. Seanthavesouk shall pay 25% of the costs of the investigation and hearing to be paid over a period of **48 months** from service of letter advising of the Decision.

    (a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Seanthavesouk shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Seanthavesouk shall provide the Complaints Consultant with a signed written declaration within **30 days** of service of the Decision, attesting she has reviewed the documents:

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

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

    iii. CLPNA Practice Policy: Professional Responsibility & Accountability;

    iv. CLPNA Practice Policy: Documentation;

    v. CLPNA Practice Guideline: Medication Management;

    vi. CLPNA Competency Profile A1: Critical Thinking;

    vii. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

    viii. CLPNA Competency Profile B: Nursing Process;

    ix. CLPNA Competency Profile D1: Communication and Collaborative Practice.

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

4. Ms. Seanthavesouk shall, complete the following nursing quizzes located on website http://www.learningnurse.org/. Ms. Seanthavesouk shall provide the Complaints

Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within **60 days** of service of the Decision:

a) **8.1 Health Assessment;** and

b) **14.2 Legal Risks.**

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

5. Ms. Seanthavesouk shall complete the course **Nursing Documenation 101** offered on-line at www.clpna.com. Ms. Seanthavesouk 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.

6. Ms. Seanthavesouk shall complete, at her own cost, the course **NURS 0161: Medication Management** offered on-line at www.macewan.ca. Ms. Seanthavesouk shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **6 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. The orders set out above at paragraphs 2-6 will appear as conditions on Ms. Seanthavesouk's practice permit and the Public Registry subject to the following:

   (a) The requirement to complete the remedial activities outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Seanthavesouk's practice permit and the Public Registry until the below orders have been satisfactorily completed;

      i. Read and review CLPNA documents;

      ii. 8.1 Health Assessment;

      iii. 14.2 Legal Risks;

      iv. Nursing Documentation 101;

      v. NURS 0161 Medication Management.

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

8. The conditions on Ms. Seanthavesouk's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 7.

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

10. Should Ms. Seanthavesouk 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.

11. Should Ms. Seanthavesouk 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. Seanthavesouk'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. Seanthavesouk's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

Legal Counsel for the Complaints Consultant submitted the primary purpose of orders from the Hearing Tribunal is to protect the public. The Hearing Tribunal is aware that s. 82 of the Act sets out the available orders the Hearing Tribunal is able to make if unprofessional conduct is found.

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should defer to a joint submission unless the proposed sanction is unfit, unreasonable or contrary to public interest. Joint submissions make for a better process and engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions and may significantly impair the ability of the Complaints Consultant to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the

parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Seanthavesouk 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. Seanthavesouk 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: The Allegations that involve Ms. Seanthavesouk were not deemed as intentional misconduct; however, these Allegations were quite serious in nature in that they were dealing with patients who were diabetics and were having extremely low and high blood sugars. In addition, the Allegations demonstrated a pattern, over a period of time, where Ms. Seanthavesouk was pre-charting or falsely charting medication administration, meaning she was not understanding the importance of medication administration. The Allegations with respect to Ms. Seanthavesouk also deal with medication documentation concerns, which are also serious in nature and could jeopardize the health and care of a patient in her care.

The age and experience of the investigated member: At the time of the Allegations, Ms. Seanthavesouk had approximately 10 years' experience as an LPN, as she was initially registered with the CLPNA in September 2008. She was not a new LPN and should have had the experience to know the various issues that she was having with medication administration, charting, and the other issues set out in the Allegations.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The Hearing Tribunal was not made aware of any prior complaints or convictions.

The number of times the offending conduct was proven to have occurred: There were five (5) Allegations in respect to Ms. Seanthavesouk and the Allegations were similar in nature, demonstrating a pattern of concern. They involved different patients over a period from September 2017 to March 2018, which is concerning as it is not limited to one patient or one period of time.

The role of the investigated member in acknowledging what occurred: Ms. Seanthavesouk did acknowledge the Allegations that were brought forward to the CLPNA by her employer. Ms. Seanthavesouk did provide the Hearing Tribunal with an Agreed Statement of Facts, which demonstrates that she took responsibility for her actions.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Seanthavesouk did incur a one (1) day suspension on July 17, 2017 as well as a three (3) day suspension that took place on October 28, 29, and 30, 2017. Then on April 18, 2018, Ms. Seanthavesouk had a meeting with her manager, as well as Human Resourses, and at that time she was suspended for an additional five (5) days and Ms. Seanthavesouk served that suspension on April 20, 21, 22, 25, 26, 2018. These suspensions were without pay.

The impact of the incident(s) on the victim: The Hearing Tribunal did not hear anything in relation to the impact of the victims; however, patient KR was found unconscious by a physician when KR's blood glucose was low and patient ED had an extremely high blood glucose. In both situations, there was a great potential for harm to be caused due to the lack of care that Ms. Seanthavesouk provided.

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: Specific deterrence is required to keep Ms. Seanthavesouk from repeating the same conduct in the future. General deterrence is required to ensure that other members in the LPN profession do not engage in this type of conduct and to make it known that this type of conduct will not be tolerated by the CLPNA.

LPNs are recognized as independent and capable members of the healthcare team and are self-regulating 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 CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

It is important to the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

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

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

2. Ms. Seanthavesouk shall pay 25% of the costs of the investigation and hearing to be paid over a period of **48 months** from service of letter advising of the Decision.

    (a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Seanthavesouk shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Seanthavesouk shall provide the Complaints Consultant with a signed written declaration within **30 days** of service of the Decision, attesting she has reviewed the documents:

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

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

iii. CLPNA Practice Policy: Professional Responsibility & Accountability;

iv. CLPNA Practice Policy: Documentation;

v. CLPNA Practice Guideline: Medication Management;

vi. CLPNA Competency Profile A1: Critical Thinking;

vii. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

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

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

   a) 8.1 Health Assessment; and

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

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

    (b) Treat Ms. Seanthavesouk'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. Seanthavesouk's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, s. 87(1)(a),(b) and 87(2) of the Act, the Investigated Member has the right to appeal:

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.
>
> **(2)** A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 26th DAY OF NOVEMBER 2020 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal